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ARTICLE

Migrants' access to healthcare services: evidence from fieldwork in Turkey

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Abstract

This study builds on an analytical framework of access to healthcare and, using notes from interviews conducted with 110 migrants of different categories, it discusses the fit between migrant patients and Turkish health services. There is an overall mediocre fit between migrant patients and the Turkish healthcare system, which varies for different migrant groups, and is influenced by the dimensions of awareness, availability, affordability, and accommodation. Migrants' social capital and socio-economic statuses affect the degree of fit, while irregularities in their legal statuses do not necessarily create a misfit. The existence of many private healthcare institutions offering various services to patients with different incomes and operating in informal ways has improved accessibility, availability, affordability, and accommodation and thus affects the fit positively. Therefore, the health reforms that paved the way for privatization, marketization, and commodification of health services in Turkey in the early 2000s also help explain the degree of fit. Migrants suffer most from language barriers in the health system, and there is an alarming decline in acceptability especially for Syrian refugees, who have reported facing discrimination while seeking healthcare.

Keywords: migrant health; access to healthcare; health reform; privatization of healthcare

Introduction

The complex relationship between migration and health has received increasing scholarly attention in recent years. Studies explore the health of migrants through various hypotheses or frameworks including "the healthy migrant effect/thesis," "migration as health transition" or "life-course models" (Spallek et al. 2016). As these models present, various factors and processes shape migrants' health. Even if migrants are exceptionally healthy when they first migrate, they are exposed to different health risks during and after migration and they may suffer from communicable diseases, occupational health hazards, injuries, physical and psychological violence, and substance addiction (Mladovsky 2007; Rechel et al. 2012; Thomas 2016). The social determinants of health approach, which studies non-medical factors to understand health inequalities, has recently began to render visible

links between migration and health, considering migration among the social determinants of health (Castañeda et al. 2015; Ingleby 2012). In this view, migration affects the social positioning of individuals, their socio-economic status and "places them in ambiguous and often hostile relationships to the state and its institutions, including health services" (Castañeda et al. 2015). In discussions of these hypotheses, models and factors, and their impact on the health of migrants, another factor, migrants' ability to access healthcare and benefit from such services, comes to the forefront. Studies demonstrate a lower utilization of health services by migrants (Badanta-Romero et al. 2021; Klein and von dem Knesebeck 2018; Sarría Santamera et al. 2016). Besides this general finding, the literature has largely neglected the issue of migrants' access to healthcare services, and theoretical frameworks for explaining migrants' health service utilization remain underdeveloped (Yang and Hwang 2016, 1).

Access to healthcare is defined as "the fit between patients and health services" by Penchansky and Thomas (1981), who suggested that it comprises different but interconnected dimensions that affect the degree of fit, including accessibility, availability, acceptability, affordability, and accommodation. Building on this analytical framework, this study explores migrants' access to healthcare in Turkey, or the fit between migrants and the Turkish healthcare system. Turkey's changing migration dynamics have led to a diverse migrant community encompassing refugees, asylum seekers, regular and irregular migrants, and international students. Notably, following the conflict in Syria, Turkey has become home to the world's largest refugee population. However, there is limited information on migrants' use of healthcare services (public, private, and between nations), the barriers they face, their strategies for overcoming them, and their preferences regarding health providers or ways of covering their medical expenses. The existing research often focuses narrowly on either the physical and mental health problems faced by the Syrian population in Turkey (Alpak et al. 2015; Cantekin and Gençöz 2017; Doğanay and Demiraslan 2016; Eryurt and Menet 2020) or their access to healthcare and integration into the health system (Özçürümez and İçduygu 2020). Although there are several studies on the health of irregular migrants and international students (Taşçı-Duran 2019; Yasin et al. 2015), the broader subject of migrants' access to healthcare services in Turkey remains understudied.

Simultaneously, Turkey's healthcare system has undergone a significant transformation since the 2000s – shifting from a primarily state-owned and centralized system to one with a greater market orientation. This transformation has been driven by comprehensive reforms introducing marketization and privatization, ultimately leading to the increasing commodification of "healthcare services" (Yılmaz 2017). Given that the changing migration dynamics have led to a large diverse migrant community and considering the ongoing transformation of the healthcare system, Turkey presents an intriguing case for studying migrants' access to healthcare services and examining how this access is evolving.

The study is built on data collected through in-depth interviews with migrants residing in Turkey. In order to capture their experiences and explore the factors influencing access to healthcare services, it focuses on six groups: regular and irregular migrants; spousal migrants; international retirement migrants; international students; and refugees and asylum seekers. It offers a holistic view and

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comparative perspective on migrants' access to healthcare services in a national setting where both health and migration dynamics are under transformation, and formality and informality coexist. As demonstrated here, due to the specific combination of these characteristics, the "fit" between migrants and the Turkish health system seems to deviate from that previously established in the literature, with the main emphasis placed on legal status as the primary influencer of migrants' access to healthcare.

Studying access to healthcare

Early studies on migration and health focused on the health risks that migrants supposedly carried and their implications for the native population (Zimmerman et al. 2011). Studies on healthcare provision, on the other hand, focused on native populations, "routinely ignoring the needs of migrants assuming they would either 'go home' or become assimilated" (Phillimore et al. 2019, 234). Recently, research on epidemiological comparisons of migrants and native populations, health behaviors among migrants, and socio-economic inequalities in accessing healthcare has increased (Phillimore et al. 2019). Studies documented that migrants utilized health services less than natives and that they lacked health insurance and full access to healthcare (Badanta-Romero et al. 2021; Sarría Santamera et al. 2016; Yang and Hwang 2016). Most of the work focused on the role of language proficiency, time in the destination country, and socio-economic factors to explain poor access and utilization (Bustamante et al. 2012). Language or communication and information barriers, insurance problems, socio-economic and cultural barriers, stereotyping, social exclusion, and discrimination are among the most reported issues (Biswas et al. 2011; Lebano et al. 2020; Rechel et al. 2012). Studies also discuss the impact of social capital and legal status on their access to healthcare (Hendrikson 2010; Nandi et al. 2008; Schoevers et al. 2010). Another group of studies discussed health reform processes and how they transformed the relationships among regulators, providers, and patients. In many countries, following those reforms, healthcare privatization followed marketization, with health increasingly viewed as a commodity to be traded, bought, or sold (Pellegrino 1999; Wildes 1999). Patients, including migrants, are increasingly defined as "health consumers" with their market positions determining their access to healthcare (Henderson and Petersen 2002).

Access to healthcare is simultaneously an operational issue, involving issues such as scheduling appointments, managing patient flow, and guaranteeing the availability of medical staff, supplies, and equipment. It also entails ensuring service accessibility for all patients, irrespective of location or financial status. This includes addressing transportation, insurance coverage, and service affordability. Despite their significance in influencing patient outcomes and healthcare organization performance, many of these operational issues were not addressed by the early studies. Access was understood only as "the potential or actual entry of a given individual or population group into the healthcare delivery system" (Aday and Andersen 1975, quoted in Gulliford and Morgan 2013, 5), and research focused on service availability, or the adequate supply of services to a population. This limited approach was later expanded by Penchansky and Thomas (1981, 127), who defined access as "the degree of fit between patients and the healthcare system" and argued that it might be influenced

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Table 1. Dimensions of access

Dimension	Definition	Description	Examples
Accessibility	Geographic accessibility, location	Distances between hospitals, clinics, providers, and patients	Existence of a provider within reasonable proximity to the patients in terms of time and distance
Availability	Supply and demand	Whether the provider has resources, such as personnel and technology, for the healthcare needs of the patient	Supply of physicians, dentists, and other providers; of facilities such as clinics and hospitals; and of specialized programs and services such as mental health and emergency care
Acceptability	Attitudes	Positive or negative perceptions related to patient–provider interactions	Gender, ethnicity, values, healthcare facility type, religious affiliation of patients and providers
Affordability	Financial cost	Patients' ability and willingness to pay for services	Lack of insurance, limited insurance coverage (underinsured patients), high out-of-pocket expenses
Accommodation	Organization	Extent to which services are organized in ways that meet the constraints and preferences of the patients	Hours of operation, operation of call centers, appointments system, facility structures
Awareness	Communication and information	Effective communication about services	Sustainable and well-targeted communication and information dissemination strategies to raise and maintain patient awareness about the existence of services and how to use them

Sources: Penchansky and Thomas (1981, 127–130); Saurman (2016, 37–38); Karuppan et al. (2016, 19–22).

by the accessibility, availability, acceptability, affordability, and accommodation of services (Gulliford and Morgan 2013, 5). In other words, the "fit" between a patient and healthcare system can be defined as the extent to which the patient's needs and preferences are met by the healthcare system along these dimensions of access. As presented in Table 1, by introducing these dimensions, Penchansky and Thomas (1981) brought personal, organizational, geographical, and financial determiners into the discussion of access to healthcare. In a recent study, Saurman (2016) added "awareness" to this model. These dimensions are independent but interconnected (Saurman 2016, 37).

Turkey's healthcare system and migration dynamics

Historically, healthcare services in Turkey have primarily been provided by the state, with state actors and institutions responsible for financing, service provision, and regulation. Following government incentives introduced in the 1980s, the number of private health institutions in Turkey increased in the 1990s (Keyder 2007). Private

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health institutions have continued to grow since the launch of a comprehensive reform program in 2003, which introduced market incentives and mechanisms to the healthcare system (Ağartan 2012; Yılmaz 2017). At the governmental level, the Social Security Institution (Sosyal Güvenlik Kurumu; SGK) and its General Health Insurance (Genel Sağlık Sigortası; GSS) provide universal coverage for Turkish citizens. A new incentive has been the integration of private hospitals as service providers for the publicly insured with the introduction of additional payments for private hospital visits (Yılmaz 2017, 92). Since 2006, SGK can selectively contract with private health providers and publicly insured patients – or "consumers" – are given choices among public and private hospitals provided that they make additional payments to private providers (Ağartan 2012, 466; interview SB_3, July 27, 2020). The aim was to encourage competition among health providers, leading, along with other incentives, to the rise of numerous private health institutions in Turkey (Keyder 2007). In 2002, there were 271 private hospitals; in 2021, there were 571. In İstanbul, for example, in 2021, there were 54 Ministry of Health (MoH), 16 university, and 164 private hospitals and 49 percent of specialist physicians in İstanbul worked for private hospitals (Türkiye İstatistik Kurumu 2023).

While market mechanisms have contributed to reshaping the health system to some extent, the state remains a key player in its regulation (Ağartan 2012). The MoH has a significant role in guiding, pricing, and overseeing the implementation of health and health-related social policies. This is reflected in its Health Implementation Communique (Sağlık Uygulama Tebliği; SUT), which covers various aspects including co-payments, additional fees, responsibilities of health providers, preparation of health reports, pricing, invoicing, and payments. The SUT also includes a pricing scale, used by the MoH to set fees for services in public hospitals. While it establishes a framework, private health institutions have greater autonomy in setting their fees within this framework. Consequently, they may charge different fees for the same services (interview SB_3, July 27, 2020).

Within the same time period, spanning from the late 1990s to the mid-2010s, Turkey's migration dynamics have also transformed. It has become a transit point for irregular migrants as well as a country of destination for European Union professionals, retirees, international students, regular and irregular migrants, and refugees. Most significantly, the Syrian conflict has transformed Turkey into a country of asylum. At the time of this writing, more than 3.3 million Syrians are under temporary protection in the country, while more than 320,000 people from other countries are under or have applied for international protection status. In addition, around 1.2 million people hold residence permits, including international students, retirees, family members of Turkish citizens, and regular migrants. Regarding irregular migration, although exact numbers cannot be known, the number of detentions gives an idea. In all, 285,027 people were apprehended in 2022 for irregular border crossings and presence in the country, which suggests that the actual number of irregular migrants may be much higher (Presidency of Migration Management 2023a).

According to the Law on Foreigners and International Protection (LFIP), migrants aged eighteen to sixty-five years are required to provide valid health insurance when applying for a residence permit in Turkey. They can present an official document proving (1) that the applicant benefits from a bilateral social security agreement,

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(2) that the applicant is covered by SGK's GSS or has applied for it, or (3) that the applicant is covered by private health insurance. According to the regulations, after one year of residency, migrants become eligible for GSS and can register for it by paying a monthly fee. International students enrolled in Turkish institutions, however, can acquire GSS coverage by applying within three months of their initial school registration, without needing to fulfill the one-year residence condition. Additionally, international protection applicants and status holders who lack health coverage and financial means have GSS coverage for a duration of one year from the registration of their international protection application (Presidency of Migration Management 2023b). The Syrians under temporary protection are also covered by GSS without any time limitations. It covers their costs in primary public health services (in public health centers, migrant health centers [MHCs], family health centers) as well as the costs of services in secondary and tertiary public institutions (public hospitals and public university hospitals) when they are referred from primary institutions. These services are only available within the province of registration, and, in cases of non-registration, Syrian refugees can receive only emergency care and essential health services at no cost (Regional Refugee and Resilience Plan 2023). Nevertheless, in 2022, the government adopted a stricter approach by imposing restrictions on the registration of new applicants seeking international protection, temporary protection, and residence permits in close to 800 neighborhoods in various provinces (Presidency of Migration Management 2022). In İstanbul, for instance, thirty-six neighborhoods have been "closed" for registration, necessitating that Syrians register at temporary accommodation centers. Following these restrictions, tighter address verification, and monitoring of the residence of Syrians under temporary protection led to around 600,000 deactivations of temporary protection statuses in 2022 (Regional Refugee and Resilience Plan 2023). Irregular migrants, on the other hand, remain invisible within the Turkish health system. They cover their healthcare expenses themselves. Healthcare services for non-citizens lacking GSS, and/or international or temporary protection status, are not regulated under SUT; instead they follow the Health Tourism Regulation (Uluslararası Sağlık Turizmi ve Turistin Sağlığı Hakkında Yoğnetmelik). An exception is the provision of free treatment for infectious diseases, including emergency services and conditions like tuberculosis and COVID-19, accessible to all individuals (Presidency of Migration Management 2023b).

Methodology

The study is based on interviews conducted with 110 migrants of different categories in 2018 and 2019. To provide a comprehensive understanding of migrants' access to healthcare services, we interviewed twenty-four regular[1] and twelve irregular

[1] Migration movements to Turkey have become complex and mixed, making it increasingly difficult to clarify which migrants fall within these categories. Additionally, until recently, Turkey maintained a liberal approach with loose enforcement of migration laws, resulting in many migrants residing and/or working in the country without the required documents. In her study on the management of regular migration and regularization practices of migrants in Turkey, Cengiz (2019) notes that the categories of irregular and regular migrants have become even more complex and intertwined, as irregularities in their statuses did not prevent irregulars' access to many public services. Cengiz (2019) refers to migrants

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migrants,[2] sixteen international students,[3] twenty-four international retirees,[4] sixteen spousal migrants,[5] and eighteen refugees and asylum seekers.[6] We selected the interviewees among those who had been living in Turkey for at least one year and had accessed healthcare services more than once. The main field of study was İstanbul but interviews were also conducted in the districts of Fethiye in Muğla and Alanya in Antalya to explore healthcare access experiences of international retirees on the Mediterranean coast. We contacted interviewees through different points of entry into the field and employed the snowballing method. In addition to the migrants, we interviewed four senior officials from the MoH (one of whom was retired and three were still working) and eighteen physicians. One-third of the physicians were working in two separate private hospitals that served migrants. We reached the rest of them through the Turkish Emergency Medicine Association (Türkiye Acil Tıp Derneği); these physicians were working in four distinct public hospitals with migrant patients. Additionally, we interviewed the president of the İstanbul Anti-Tuberculosis Association (İstanbul Veremle Savaş Derneği), which has long been advocating the right to health of migrants. The interviews were recorded and transcribed, and data were coded using MAXQDA 2020. Codes were clustered into categories and, following rounds of discussion, the data in these categories were interpreted to form themes, which are discussed using Penchansky and Thomas's (1981) modified theory of access as the analytical framework.

The fit between patients and the health services refers to the level of alignment or congruence between the dimensions of healthcare access (availability, accessibility, affordability, accommodation, acceptability, and awareness) and the needs and preferences of patients seeking healthcare services. Measuring "the fit" is complex because it involves evaluating how well the healthcare services meet the needs and preferences of the patients across these different dimensions. To overcome this complexity, we conducted a thorough analysis of transcribed interviews to assess the degree of fit between migrants and the Turkish healthcare system. Our evaluation focused on several key factors, including patient satisfaction, healthcare utilization (such as frequency of visits and the use of preventative services), health outcomes

who possess a valid residence permit or visa in Turkey but are unable to enter the labor market with a work permit as "semi-regular migrants." In this study, the category of regular migrants includes semi-regular migrants as well and they are the individuals who work in the country under some form of regularization, be it through a work or residence permit. Among our interviewees in this category, twelve held work permits, while another twelve possessed residence permits. They were from Afghanistan, Argentina, Brazil, Canada, Cuba, France, Georgia, Germany, Iran, Morocco, the Netherlands, the Philippines, Russia, Syria, the United Kingdom (UK), and the United States (US). Their ages varied between twenty and sixty-five years.

[2] Irregular migrants were from Afghanistan, Turkmenistan, Uzbekistan, Egypt, Pakistan, and Iraq.

[3] International students were from Turkmenistan, Kazakhstan, Iran, Benin, Algeria, Kyrgyzstan, Israel, Bahrein, Poland, Eritrea, Libya, Nigeria, and Iraq. Half of these interviewees were studying at various state universities, while the other half were enrolled at different private universities.

[4] The retirees were from the UK, Germany, Finland, Switzerland, the Netherlands, and Uzbekistan. Nearly half of them were aged between fifty-five and sixty-four years, while the rest fell within the sixty-five to eighty-five-year-old range.

[5] Spousal migrants were from Argentina, Austria, Brazil, Estonia, France, Greece, Iran, Mexico, Pakistan, Russia, the UK, Ukraine, and the US.

[6] Refugees and asylum-seekers were from Syria (fifteen), Iran (two), and Afghanistan (one).

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(such as improvements in health status), patient-centeredness (the availability of healthcare services tailored to the needs and preferences of migrants), and access to care (including wait times and travel distances).

The study offers valuable insights into migrants' access to healthcare services in Turkey; however, it also has limitations. Firstly, while the overall sample size is substantial, the size of each migrant group's sample might hinder the transferability of findings. Also, the number of interviews with Syrian refugees, the largest migrant group in Turkey, was only fifteen. Another limitation is the study's timeframe. Following the completion of the fieldwork in December 2019, the COVID-19 pandemic started, and it significantly affected the Turkish healthcare system. Lastly, recent years have witnessed challenging socio-economic and international developments, a rise in xenophobia, and shifts in the political atmosphere that resulted in deportations and threats thereof, contributing to an escalation of anti-immigrant sentiment in Turkey, which may also have affected migrants' and refugees' access to healthcare. The study does not fully capture the potential effects of these developments.

Findings: migrants' access to healthcare services in Turkey

Our regular migrant interviewees were of different ages, resulting in a wide range of health needs. They expressed a need for primary care to manage acute and chronic illnesses such as colds, flu, and diabetes. Female migrants emphasized the importance of reproductive health services, while emergency care services were used in cases of accidents. Dental care services were also accessed regularly. In line with the literature, our irregular interviewees were generally young and in good physical health (Biswas et al. 2011). They were hospitalized mainly due to infectious diseases and workplace accidents, and sought emergency care in cases of sudden and severe health issues such as injuries, appendicitis, or unbearable pain caused by infectious diseases. Spousal migrants required a range of essential healthcare services, including primary care for managing common illnesses, preventative and dental care, and reproductive health services. Several interviewees also mentioned seeking psychological counseling. Our interviews with retirees were consistent with findings in the literature (Hardill et al. 2005). Along with primary care, they needed geriatric care to address age-related health issues. Common operations for retirees included hip replacement, cataract, and prostate operations. International students did not report having chronic health conditions but required primary care services and emergency care for sudden illnesses or injuries. They also mentioned seeking psychological counseling. Refugees and asylum seekers spanned all age groups, resulting in a wide range of health needs, but they mostly sought primary care. Consistent with the literature (Kaya et al. 2018), many expressed a desire to access mental healthcare services, but cultural stigma prevented them from doing so.

Dimensions of choosing a health provider

Interviewees reported the existence of multiple providers, both public and private, reasonably close to their locations. The majority of them had no difficulty accessing either type of institution, indicating that *accessibility* played a positive role in their

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ability to receive the care they needed. They became *aware* of the healthcare providers and their services through recommendations from friends, family members, online sources, insurance company's list of covered institutions, and rarely through the institutions' information dissemination campaigns. Their *awareness* of the healthcare system increased as they stayed longer in Turkey. However, when it came to selecting a healthcare provider, *availability* and *affordability* emerged as the most significant dimensions influencing their decisions. More than half of the interviewees preferred private health institutions, but some used both public and private institutions. In certain categories, interviewees reported visiting MHCs.

Interviewees who preferred private health institutions primarily referred to the *availability* dimension (e.g., supply, quality, and abilities of health personnel; facilities of the hospital; technology for healthcare) and explained the reasons for their preferences as follows: "being able to communicate with physicians and health personnel," "not waiting in the hospital too long," "receiving immediate care when necessary," "not being in a very crowded environment while receiving healthcare," "for the physician to take his time and carefully examine," "because private healthcare is more effective and better," and "because there are very good physicians in private hospitals." Those who sought public health services, on the other hand, mainly referred to *affordability* and explained that they preferred public health institutions because "it was free," "it costs very little," or "it costs nothing in the emergency room."

Migrants who settled in Turkey with work and residence permits referred to *availability* and *affordability* as the main influencing dimensions in their access to healthcare. Some interviewees also referred to *accessibility*, especially in emergency situations. Most explained that they preferred private hospitals because they wanted to receive "proper" care:

> We wanted to get comfortable service. For example, in the public hospital, the physician examines you and sends you for an ultrasound. [You cannot get it done because] you have to wait in a long queue. But in private, everything is within arm's reach for the physician. He does the ultrasound exam in his room. They allocate more time to us in private hospitals. The physician we visit asks questions, talks to you. Well, at least he asks how we are (interview D_E4, January 14, 2019).

While some private hospitals charge very high fees for their services, others may offer more affordable healthcare services. In line with this dynamic, the majority of regular migrants, including those with middle and low income levels, expressed a preference for private hospitals within their budget:

> The [. . .] Hospital is a private one but they have an agreement with GSS. I go there because it's quicker. It's closer to my home, and I have very decent care there, I've been to the [. . .] Hospital, too [. . .] but in the [latter] everything seems like too much. [The former] is also private, but not too much. You don't feel like a customer (interview D_K10, May 11, 2019).

International students attending private and public universities adopted different strategies in accessing healthcare. All who attended private universities received

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healthcare only from private health institutions. They referred to the dimension of *accessibility* and explained that they chose private health service providers according to their locations: they preferred those located closest to either their school or their dormitories. Conversely, students from public universities referred to the dimension of *affordability* and indicated that their hospital choices were guided by their insurance type. Their primary preference was for public hospitals as they were covered by GSS. However, they occasionally received healthcare from private hospitals as well, due to reasons of *availability*. They visited them when they could not make timely appointments in public hospitals, or when they needed specific healthcare, such as dental treatment or psychological counseling. Similar to students at private universities, they referred to *accessibility*, too; however, they also referred to *awareness*. They stated that their preference for public or private hospitals depended not only on location but also on their knowledge of these institutions.

Among all migrant categories, spousal migrants and international retirement migrants demonstrated a higher level of *awareness* of the availability of healthcare services and navigation within the health system. Their *awareness* enabled them to make informed decisions when accessing healthcare services. Spousal migrants, in particular, preferred specific physicians over hospitals and typically received services from private health institutions catering to high-income patients. However, when they faced a serious problem or heard about a specialized physician working in a public hospital, they preferred that public hospital. Their access to services was facilitated by the personal relationships, know-how, and family networks of their spouses. This social capital played a crucial role in enabling them to access better healthcare services, placing them in a more advantageous position compared to other migrant groups. Spousal migrants benefited from the fact that their spouses were sometimes physicians, had physician friends or relatives, or their relatives knew good physicians or how to access better health services:

> Last year, I had cholecystectomy. I stayed in the hospital. While giving birth, I stayed just one day. All of these doctors are friends of my husband's friends. They are known as good doctors. My pregnancy period actually was not difficult. [. . .] Everything went pretty well. It was a private hospital in [. . .] district. Because again my husband's friends arranged it (interview GD_K8, April 9, 2019).

Retirees also had a high level of *awareness* about the Turkish health system due to their health concerns and personal experiences. Based on their knowledge of the system, they utilized both public and private healthcare providers. Almost all of them visited public family health centers for free primary care on a regular basis. They reported having positive relationships with their family physicians and expressed high levels of satisfaction with the services. For secondary and tertiary care, some visited only private hospitals, paying a premium to their GSS insurance schemes, while many others preferred public hospitals. They referred to *availability* and noted that the treatment and qualifications of the physicians were not different in public and private hospitals, but the reception, attention, care, and hygiene were far better in private hospitals. Another important point was that health providers, both public and private, seemed to approach international retirement migration as a business

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opportunity, targeting retirees as "health consumers" of medical services. While private hospitals offered medical services tailored more specifically for the elderly, such as recruiting experts on hip replacement or offering cataract or prostate operations at reduced fees, both types of institutions worked with interpreters to facilitate access.

Unlike all other migrants, irregular migrants' primary concern was their legal status while accessing healthcare. All stated that they visited private hospitals and clinics although the costs were steep. They explained that public hospitals asked for identification documents and had police officers in them, and they were afraid that they would be deported. This first concern was followed by *affordability* and *awareness* as they chose the private hospitals or services that they knew and could afford.

Another observation was that the provision of private health services to them was common. Some private healthcare providers did not turn them away or inform authorities. Instead they adopted informal methods, like treating them after visiting hours or without formal registration, even using the passports of regular migrants accompanying them. While physicians often approached this issue with humanitarian concern and voiced concerns about turning away the ill, the private health institutions' stance was not based on the belief that every individual, regardless of official papers, should access healthcare. Contrarily, in line with the marketization and commodification in Turkey's healthcare system, they viewed irregular migrants as another "health consumer" group in need of their services. Recognizing that these patients sought care informally, they engaged with these communities and raised awareness about their services by offering reduced rates. As such, during the time of data collection, irregularities in migrant status did not necessarily obstruct their access to healthcare services, provided they could afford to pay. All the same, due to being undocumented, they were very vulnerable *vis-à-vis* private health providers. They could not complain when they were misdiagnosed or mistreated, even for medical malpractice. While informal service provision allowed them the ability to access healthcare, it also exposed them to the risks of further vulnerabilities and abuses.

Interviews with refugees and asylum seekers, particularly Syrians, revealed that they had developed an *awareness* of Turkey's healthcare system. They knew about different types of health institutions, and also shared information about hospitals and doctors amongst themselves. They mentioned that they would have preferred private health institutions. However, the cost of private healthcare services was out of reach for them. As a result, their choice of healthcare institutions was primarily guided by *affordability*, leading them to seek care at MHCs, informal clinics, and rarely family health centers for minor issues. They turned to public hospitals when they required comprehensive care:

> They charge a lot in private. My daughter's eye was injured by a bomb. [The physician] would remove it and put a replacement eye. He asked for 7,000 USD [US dollars]. I can't get this much money together in my whole life. We went to [. . .] and could only get an appointment for a date a year later, we had to accept it. [. . .] is a public hospital, it will do it for free. We said, anyway, it's OK, because it's too expensive in private. We can't afford it (interview S_K3, October 1, 2019).

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Syrian refugees have also emphasized *availability* and *acceptability* in shaping their preferences for healthcare institutions. MHCs employed Arabic-speaking healthcare workers, while informal clinics were operated by Syrian healthcare workers, offering primary and secondary care. Interviewees explained that they chose MHCs and informal clinics in order to overcome the language barriers, receive healthcare from physicians who understood their illnesses, avoid long waiting times for appointments, and pay less for the services. Additionally, as informal clinics operated without licenses, outside the oversight of the MoH there was no need to provide identification and registration. Furthermore, referring to *acceptability*, Syrian refugees explained that they opted for both MHCs and informal clinics to avoid mistreatment, discrimination, and hostility when seeking care.

Affordability: limited health insurance, SGK agreements with private providers, and varying fees

In line with the LFIP's requirements, nearly all of our interviewees, except refugees and irregular migrants, were covered by health insurance. The overwhelming majority had private health insurance plans designed specifically for migrants that could only be used in some private hospitals. These plans had very limited coverage; therefore, though these interviewees had insurance plans, in reality many of them were underinsured. Needless to say, this affected the *affordability* of healthcare negatively.

Several interviewees mentioned that despite paying minimal amounts for their annual health insurance plans (as little as 25 USD as of 2019), they only realized the limitations of their plans upon visiting a hospital. They were shocked when they had to pay high out-of-pocket expenses in private hospitals. Others shared that they knew it was limited, but they took it anyway because it was a requirement. These health insurance plans seemed primarily designed to fulfill a necessary requirement in residence permit applications. Offering such health insurance plans for migrants seems to have become a business for insurance companies and, unfortunately, this is another area where migrants are abused.

Examining the interviews according to migrant categories, we see that all spousal migrants had GSS through their Turkish spouses. In addition, almost all of them had private health insurance covering inpatient treatment in private hospitals. Therefore, their *affordability* of healthcare was very high.

Regular migrants with work permits had GSS, while several also held private health insurance. Majority of the regular migrants with residence permits, on the other hand, had private health insurance, except for one who registered himself under GSS. Notably, two interviewees with residence permits mentioned that their European health insurance was valid in Turkey. The comprehensiveness of private health insurance depended on their income levels; while those with higher incomes had comprehensive coverage, those with mid-level or lower incomes had limited plans. The plans of international students, on the other hand, differed. Students attending public universities on government scholarships were covered by GSS and their premiums were paid by the government. These students told us that their insurance "covered everything" in public hospitals and that they could visit them "like Turkish citizens" without any barriers. Students attending private universities,

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on the other hand, found their own cheap and limited private health insurance. Several students reported that they were unaware of the three-month registration rule causing them to lose their chances of GSS coverage. They noted that international students should be informed more clearly about these policies.

Though health insurance is not required for the residence permit applications of migrants older than sixty-five years, all but one of the interviewed retirees had health insurance plans. Interviewees told us that they had been living in these coastal towns of Turkey for some time and that they had private health insurance plans in the past but more recently registered themselves for GSS. This allowed them to visit family health centers in their neighborhoods and public hospitals for free, and they could also benefit from GSS-contracted private health institutions with discounts. Many of them chose a combination of these services. Their main concern was that SGK had very recently annulled its contracts with several health providers and they could no longer get discounts from those institutions. They were confused and questioned the rationale of being registered for GSS if they were unable to get discounts from the private health institutions they had previously used. Several interviewees were still covered by their home country's public insurance and they benefited from GSS under bilateral social security agreements between their home countries and Turkey.

International protection applicants and status holders have GSS coverage for a year, while temporary protection status grants GSS coverage to Syrian refugees without time limitation upon registration. Syrians are by far the largest group of refugees; however, there are also significant numbers of Afghans, Iranians, and Iraqis facing serious challenges and additional barriers in accessing healthcare in the country. This differentiated access to healthcare, characterized by distinct insurance arrangements for international protection applicants and status holders on one hand, and Syrian refugees under temporary protection on the other, has worsened their vulnerabilities and contributed to unjust disparities in accessing healthcare services. In light of these complexities, it is crucial to highlight that all of our refugee and asylum-seeker interviewees were highly vulnerable. Though they developed an *awareness* of the institutions and services, they did not fully understand the legal mechanisms through which costs were paid in the health system. Only one Syrian refugee mentioned that he had acquired private insurance coverage for his pregnant wife. None of the other Syrian interviewees had any form of insurance apart from what was provided through temporary protection.

As described above, private health institutions charged varying fees for their services. In addition, the interviewees reported that these institutions charged migrants higher fees, consistently higher than those charged to Turkish citizens. This affects the *affordability* of healthcare services negatively. Moreover, though many explained that they were satisfied with the quality of the facilities, services, and health personnel, the varying fees and inflated rates made the system unreliable in their eyes.

Accommodation: interpretation services, patient accompaniment, and aftercare

According to most interviewees, the most important obstacle in accessing healthcare in Turkey is the language barrier. Interviewees reported that due to the lack of interpretation services, they faced language barriers not only when communicating with physicians but at all stages of access, such as making appointments, entering the

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hospital and getting directions from reception, or accessing test results. Many interviewees noted that even though the Central Physician Appointment System website offered options in English, Arabic, and Russian for public hospitals, they still had difficulty in making appointments on their own. These difficulties arose mainly because of differences in patient cultures, which reduced migrants' health literacy when they moved.

Retirees reported very few or no problems in this regard. They underlined the importance of communication while receiving healthcare, but explained that interpretation services were offered by several interpreters in private hospitals, while staff at information desks and also physicians spoke English. Apart from ordinary interpreters, there were also "health interpreters" in private hospitals. Though the interviewees in Fethiye said that there were interpreters in the public hospital, too, interviewees in Alanya reported that they were accompanied by interpreters if they had health insurance. Family physicians in both districts were reported to know English, but this was not sufficient for the retirees in Alanya, who, unlike those in Fethiye, did not come from countries where English is spoken.

Interviews in İstanbul revealed that although they are discussed in reference to *accommodation*, interpretation services also traverse the dimension of *availability* as most of the interviewees who received healthcare from private hospitals chose those institutions because they had interpreters. Similarly, some interviewees noted that physicians in especially well-known private hospitals had been trained abroad and could therefore speak fluent English, and that they preferred these hospitals to be able to communicate directly with physicians instead of relying on interpreters:

> There is a barrier. Like, it's not enough. I feel like I can't convey what I want to say to the physician because the interpreter would not translate what I actually feel [. . .] and always, like, miss things. I feel like you can easily get misdiagnosed [. . .] I would go to [. . .] and [. . .] Hospitals because there I would find physicians who speak English fluently (interview O_K4, April 10, 2019).

Interviewees stated that finding an interpreter in public hospitals was almost impossible. As public hospitals could not accommodate the interpretation needs of migrant patients, migrants devised different strategies: they were sometimes accompanied by a neighbor, a neighbor's child, or a friend. Sometimes, another patient acted as an interpreter, or sometimes a migrant who had already passed through these stages now spoke Turkish and knew the health system. Younger interviewees also noted that they used a translation tool when needed (interview D_K3, December 8, 2018):

> I was very lucky when I went to the hospital once. There was one patient who spoke English. He was Turkish but spoke English. He translated for me. On another visit, there was no one, we couldn't communicate (interview D_K6, January 22, 2019).

Spousal migrants again had the advantage of having family networks. They reported that family members made appointments for them, accompanied them during their visits to hospitals or clinics, and helped them with all kinds of communication needs

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in the hospital. Though their spouses and family networks provided them with an advantage in overcoming the language barrier, some interviewees underlined that this still implied a deficiency in the *accommodation* of health services. They, too, needed interpretation services to be independent and have privacy about their health problems.

Interviewees mentioned encountering mainly Arabic-speaking and rarely Persian-speaking freelance interpreters in public hospitals, available for daily hire. They made appointments, accompanied migrants and refugees in hospitals, and interpreted their communications with physicians and nurses, diagnoses, and test results. Their mobile numbers and information were shared via social media channels and could also be found on posters hung on trees or walls around hospitals. As the interviews revealed, following the mass migration of Syrian refugees, this has become a line of business for some people who can speak both Turkish and Arabic. Though freelance interpreters could help refugees overcome the language barriers in accessing healthcare, this practice also provided grounds for exploitation:

> When we first arrived, it was very difficult to get an appointment. We didn't understand because they spoke fast, [they asked for] ID number, address, etc. I didn't get it when I first came. We were paying people to make appointments [. . .] they were making the appointment for us for 10 TL (1.74 USD as of October 1, 2019) There were also Turkish-speaking interpreters, but they charged a lot when we took them to the hospital. There was no interpreter in the hospital then, so this one came with you and charged 100 TL (17.40 USD) in hospitals. Six years ago, we were, everyone, was in very bad conditions, everyone was in a difficult situation, 100 TL (17.40 USD) was too much. But you had to pay, because this is illness, you had no other solution (interview S_K3, October 1, 2019).

Patient accompaniment and insufficient aftercare were other themes mentioned when migrants spoke about *accommodation* in health services. Family support for inpatients in the form of patient accompaniment is common practice in Turkey. Social and cultural reasons, as well as the inadequacy of hospital services and staff, are the main reasons for this. In some hospitals, family members are expected to give psychosocial support to the patients; in others, they are expected to undertake their medical aftercare. Interviewees from Western societies or former Soviet countries were particularly unfamiliar with this practice, and health institutions, both public and private, failed to accommodate the aftercare needs of these migrants. Many did not have family members to accompany them when they were hospitalized. Consequently, they were left without aftercare and felt helpless and isolated:

> It's not always possible for a family member, especially, you know, to stay with somebody in the hospital. But if you don't have that person, there's no aftercare. I mean, if he can't breathe and he presses the button, they'll come, but there's not: "Help me, I need to go to the toilet. I can't reach the water." If somebody had a big operation, they need help with little things, [but] there's none of that. None of that. No. There's no nursing care, there's just the medical (interview E_K6, April 10, 2019).

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Acceptability: changing perceptions about migrants

Acceptability involves positive or negative perceptions in interactions between patients and healthcare providers. Our findings revealed a decline in *acceptability*, especially for Syrian refugees. Among all interviewees, almost all Syrian refugees shared experiences of encountering discrimination when seeking healthcare. Existing research already indicates that they face several challenges, including language barriers (Assi et al. 2019), cultural differences, and confusing regulations regarding registration (Ekmekçi 2017). Moreover, they find navigating a new healthcare system daunting and overwhelming (Bilecen and Yurtseven 2018). During research, Syrian refugees reported facing mistreatment and obstacles in accessing healthcare, primarily due to their Syrian identity. These experiences were rather attributed to nurses, other hospital staff, and even Turkish patients. Instances were shared where hospital staff and patients united in expressing negative sentiments towards Syrian refugees, leading to verbal abuse and marginalization within hospital waiting rooms:

> It happens sometimes. "Syrians always take priority over us," they talk like this. "Syrians again, all of them are Syrians, the hospital is full of Syrians." They complain like this, I hear it (interview S_K1, July 23, 2019).

The forms of discrimination varied widely, ranging from refusal to give information in the hospitals to physical violence. The experiences of Syrian women in accessing reproductive health, particularly during pregnancy and childbirth, evolved beyond discrimination. Given that Syrian refugees were already in a precarious position, the discrimination and mistreatment they experienced led many of them to avoid seeking care until their health situation reached a critical stage. They visited health institutions only when they had a pressing problem, such as acute appendicitis, unbearable tooth pain, or excessive bleeding. One interviewee stated that she would only go to the hospital "while she was dying." In recent years, rising xenophobia, anti-Syrian sentiment, and the stigmatization of Syrian refugees have further exacerbated their access to healthcare (Regional Refugee and Resilience Plan 2023).

Differently from the Syrian refugees, most of the migrants in other groups reported positive interactions with medical professionals and did not perceive discrimination while accessing healthcare. Interviewees who received healthcare from private institutions responded negatively when asked if they had experienced discriminatory behavior, while most of those treated at public hospitals felt the same way:

> Not really, when I went to [. . .] Emergency, [a public hospital], they were extremely nice. Even though they didn't speak English, they were making efforts to understand the problem, they were very kind. In the private hospital, I didn't have any problems. [. . .] On the contrary, they try to ask more questions (interview D_K10, March 11, 2019).

They believed they were treated similarly to Turkish citizens. However, the interpretation of "how Turkish citizens were treated" varied among them, highlighting the influence of socio-economic factors on healthcare access. Those

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who could visit private hospitals offering services to high-income patients stated that they received the same treatment as Turkish citizens, entailing the same high-quality health services and good reception. Interviewees who received healthcare from affordable private hospitals or public hospitals, on the other hand, complained that "just like Turkish citizens" they also waited in the hospitals or nurses "grumbled" at them as well. Additionally, some of the interviewees stated that the physicians in public hospitals had such limited time that they did not even inquire whether they were migrants.

> Sometimes I feel as if I'm not a human. This is a general problem. [Whether] you are Turkish or a migrant – they don't have time for you (interview D_E1, November 9, 2018).

A similar conclusion was drawn from the interviews with physicians. A physician working in a public hospital stated that due to the patient volume, he could spend a maximum of ten minutes per patient, and half of that time had already passed once he asked about the patient's complaints. Physicians working in private hospitals and private clinics, on the other hand, stated that foreign patients were an important source of income for their hospitals. Therefore, they tried to be more welcoming and attentive. Furthermore, all interviewed physicians stated that patients were patients, irrespective of ethnic or national affiliation, and the only problem they reported was the need for interpreters to communicate with them.

Though the issue of varying fees was discussed in reference to *affordability*, it also traversed the dimension of *acceptability* as an overwhelming majority of interviewees felt they were treated differently when it was time to pay for services. They reported that they were always overcharged because they were foreigners, suggesting that, despite their earlier claims of equitable treatment, there is discrimination when it comes to payment. But they did not conceptualize it as such:

> There is definitely no discrimination. I've never experienced it. But when you're foreign, private hospitals ask for more examinations. Physicians charge foreigners more (interview D_K2, November 22, 2018).

Finally, about one-quarter of our non-Syrian interviewees were aware that anti-immigrant sentiments had been growing. According to the majority of interviewees, the arrival of Syrian refugees made migrants more visible, increased the demand for public services, and strained access to healthcare. Interviewees revealed that with the mass migration of Syrian refugees, the way that Turkish society viewed migrants changed in a negative way, which, they hinted, might impact their access to healthcare services in Turkey:

> I have only positive [experiences] [. . .] But I have to say that because of the last years of the immigrant situation, actually the social acceptance of foreigners in Turkey, the approach has become more negative. [. . .] I only have positive experiences but what I have understood actually, for example, from my experience with physicians who I know working in government hospitals [. . .] is that the hospitals are flooded with, for example, Syrians.

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> Because of that they have created certain social things such that Turks are actually left behind. So your own people don't get the service because there are so many sick foreign people [. . .] I think because of that, discrimination has started happening, like the physicians have become more cold to the foreigners. I think it's changing in that way. I haven't experienced it, but I think it's changing because of this situation (interview GD_K3, December 16, 2018).

As these anti-refugee, anti-immigrant sentiments were growing in Turkish society, interviewees from various Middle Eastern countries mentioned that they made sure to emphasize that they were not Arabs. Individuals from other Arab nations, on the other hand, attempted to distinguish themselves from Syrian refugees when seeking healthcare. Additionally, a considerable number of interviewees revealed that they had heard accounts from friends or relatives regarding the discrimination faced by Syrian refugees within the healthcare system. Given the increasing xenophobia and anti-Syrian sentiments, it would not be wrong to assume that recent socio-economic developments, international crises, and shifts in the political atmosphere have worsened the situation and affected *acceptability* negatively, further hampering migrants' access to healthcare services.

Conclusion

Though its degree differs for different migrant groups, and *acceptability* is declining, the overall picture of the "fit" between migrant patients and the Turkish healthcare system is a mediocre one, influenced primarily by *availability*, *affordability*, *awareness*, and *accommodation*. In addition to those dimensions, migrants' personal relationships also affect the degree of fit, while irregularities in legal statuses do not necessarily create a misfit. The existence of many private healthcare institutions offering a wide spectrum of services for patients with different incomes and operating in informal ways increases *accessibility*, thus affecting the fit positively, but the quality of healthcare received increases when migrants have personal relationships or higher economic status. According to our interviews, spousal migrants enjoy the highest degree of fit with the Turkish healthcare system, followed by international retirement migrants, while refugees and asylum-seekers suffer from the worst degree of fit.

With increased privatization and marketization, the transformation in the health system seems to have influenced the fit between migrant patients and the Turkish healthcare system positively as it has led to improvements in *accessibility*, *availability*, *affordability*, and *accommodation*. However, the rise of private health institutions seeking "consumers" in a context marked by informality exposes migrants to potential abuses. Though migrants seem to access health services relatively easily in this context, there is no standard for the quality of those services, or the fees charged, leaving them vulnerable to abusive practices.

Limited health insurance, varying SGK agreements with private health institutions, and varying and higher fees for migrants in private institutions affect the degree of fit negatively in terms of *affordability*. Limited health insurance designed specifically for migrants has become a line of business. The study reveals that such plans are not only a waste of money for migrants, but they also mean that the

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opportunity to have migrants covered by effective insurance and therefore enjoy better coverage in the Turkish health system, contributing to a better degree of fit, is missed.

The findings discussed here within the dimension of *accommodation* are consistent with the literature. Migrants suffer most from the language barrier, making interpretation services the most important influencer of the degree of fit between migrants and the Turkish healthcare system. If they can afford it, migrants visit private health institutions where interpretation services are provided; if not, they improvise, bringing a friend or an interpreter to the hospital or using translation tools. The language barrier and migrants' strategies to overcome it also show us that several dimensions of the analytical framework of Penchansky and Thomas (1981) traverse and affect one another in the Turkish healthcare landscape: *availability*, *accommodation*, and also *affordability*. In addition to the lack of interpretation services, patient accompaniment and limited aftercare services are other factors reported to decrease the degree of fit between migrants and the Turkish health system.

The findings discussed within the dimension of *acceptability* are particularly alarming. Interviews with Syrian refugees and other migrants highlight the growing discrimination experienced by Syrian refugees within the health system. Although the overwhelming majority of other interviewees did not report discrimination while receiving health services, they were aware that *acceptability* has been declining. They were anxious that this might negatively affect the fit between them and the healthcare system in the near future.

In concluding, we emphasize that Turkey's MoH needs to take effective steps to prepare itself to meet the needs of the more diverse population that is in the making. Though there seems to be at least a mediocre fit between migrant patients and the Turkish health system, migrants still encounter various barriers in accessing healthcare and are sometimes exposed to discrimination and abuses in the system. Following the reforms launched in 2003, the MoH's role in the provision of health services has decreased, but migrants' experiences in accessing healthcare in Turkey reveal the necessity for the institution to adopt a strengthened role in regulating service provision and financing, including insurance and direct payments. Moreover, it should actively monitor and regulate marketization and commodification processes in the health system while safeguarding vulnerable patients, including migrants.

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