NEOLIBERAL GOVERNMENTALITY OF HEALTH IN TURKEY, A CASE STUDY OF CONSTITUTION OF "HEALTHY WOMAN" AS A SUBJECT

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Prof. Dr. Tülin Gençöz
Director

I certify that this thesis satisfies all the requirements as a thesis for the degree of Doctor of Philosophy.

Prof. Dr. Ayşe Saktanber
Head of Department

This is to certify that we have read this thesis and that in our opinion it is fully adequate, in scope and quality, as a thesis for the degree of Doctor of Philosophy.

Prof. Dr. H. Sibel Kalaycıoğlu
Supervisor

Examining Committee Members

Prof. Dr. Kezban Çelik (TEDU, SOC) _____

Prof. Dr. H. Sibel Kalaycıoğlu (METU, SOC) _____

Prof. Dr. Helga Rittersberger-Tılıç (METU, SOC) _____

Assist. Prof. Dr. Çağatay Topal (METU, SOC) _____

Assist. Prof. Dr. Yelda Özen (Ankara Yıldırım Beyazıt Uni, SOS) _____

I hereby declare that all information in this document has been obtained and presented in accordance with academic rules and ethical conduct. I also declare that, as required by these rules and conduct, I have fully cited and referenced all material and results that are not original to this work.

Name, Last name: Deniz Bilge-Ülker

Signature :

ABSTRACT

NEOLIBERAL GOVERNMENTALITY OF HEALTH IN TURKEY, A CASE STUDY OF CONSTITUTION OF "HEALTHY WOMAN" AS A SUBJECT

Bilge Ülker, Deniz
PhD, Department of Sociology
Supervisor: Prof. Dr. H. Sibel Kalaycıoğlu

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This ultimate aim of this study is to investigate particular experience of neoliberalism in Turkey by focusing on the health domain. For this purpose the study deals with the process of constitution of healthy woman subject through neoliberal discourse in Turkey. According to the literature review, in this study, neoliberal governmentality of health is operationalised with its three different dimensions namely, medicalization, commodification of health and individualization of health. These dimensions have also become the guiding principles of data analysis. Additonally as a poltical background of the study, the neoliberal transformation of health policies is examined by focusing on the Health Transformation Program of 2003. In the first phase of the field research, in order to undertand media perspective, television health programs are selected to analyse by using categorised discourse analysis, then in the second phase of the field research, in order to understand the subject perspective of neoliberal governmentality of health, semi- structured indepth interviews are conducted with women living in Ankara. By this way, the study tries to draw the picture of neoliberal governmentality of health in Turkey.

Keywords: Governmentality, Neoliberalism, Health, Women's Health, Media

ÖZ

TÜRKİYE'DE SAĞLIĞIN NEOLİBERAL YÖNETİMSELLİĞİ:
'SAĞLIKLI KADIN' ÖZNESİNİN OLUŞUMU
ÜZERİNE BİR VAKA ÇALIŞMASI

Bilge Ülker, Deniz
Doktora, Sosyoloji Bölümü
Danışman: Prof. Dr. H. Sibel Kalaycıoğlu

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Bu tezin temel amacı Türkiye'de neoliberalizmin nasıl deneyimlendiğini, sağlık alanına odaklanarak açıklamaktır. Bu amaç doğrultusunda, çalışma, sağlıklı kadın öznesinin neoliberal söylem üzerinden oluşum sürecini ele almaktadır. Neoliberal yönetimin mekanizmalarını ve stratejilerini anlamak için çalışma yönetimsellik perspektifini kullanmaktadır. Tezin litaratür araştırmasında sağlığın yönetimselliğinin üç temel boyutu olduğu ortaya çıkmıştır. Bu üç temel boyut, medikalleşme, sağlığın metalaşması ve sağlığın bireyselleşmesidir. Buna ek olarak Türkiye'de sağlık politikalarının neoliberal dönüşümü 2003 yılında yürülüğe giren Sağlıkta Dönüşüm Programı'na odaklanılarak açıklanmaştır. Medya perspektifini anlamak için televizyonda yayınlanan sağlık programları seçilirken, özne perspektifi için Ankara'da yaşayan kadınlarla yarı yapılandırılmış mülakat gerçekleştirilmiştir. Bu tez neoliberal yönetimsellik ağındaki iki farklı mekanizmaya odaklanarak Türkiye'de sağlıklı kadın öznesinin neoliberal söylem üzerinden nasıl oluştuğunun ve Türkiye'de sağlığın neoliberal yönetimselliğinin nasıl işlediğinin resmini çizmektedir.

Anahtar Sözcükler: Yönetimsellik, Neoliberalizm, Sağlık, Kadın sağlığı, Medya

This dissertation is dedicated to my parents

Fevzi Bilge and Aynur Bilge

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From İzmir to Ankara, it is 591 km. and I did it.

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CHAPTER 1

INTRODUCTION

> I think we have gone through a period when too many children and people have been given to understand I have a problem, it is the Government's job to cope with it!" or "I have a problem, I will go and get a grant to cope with it!" "I am homeless, the Government must house me!" and so they are casting their problems on society and who is society? There is no such thing! There are individual men and women and there are families and no government can do anything except through people and people look to themselves first. It is our duty to look after ourselves and then also to help look after our neighbours (Thatcher, 1987)[1] .

Margaret Thatcher[2] made these remarks during the interview for *Woman's Own* in year 1987. Actually, these sentences drawing a strict line between the responsibility of state and individual, foreshadow a social revolution in which nationally owned industries are privatized and the welfare state is drastically reduced in size. Today, these sentences are meaningful for bearing the signs of a new world era - the neoliberalism.

Historically, the neoliberal transformation is argued to have started in the end of the 1970s. In the first part of these years, with respect to the regime of capital accumulation and the form of articulation of the national economies with the world economy, there had been a significant change in the role of the state. The era as the "golden age of welfare capitalism" had many important distinctive features such as full employment, social protection and universal access to the health and education. During the deep economic crisis by the end of the 1970s, the state's associated mode

[1] Thatcher, M. 1987. 'Interview for "Woman's Own" ("No Such Thing as Society").' in Margaret Thatcher Foundation: Speeches, Interviews and Other Statements. London.

[2] Margaret Thatcher has been the Prime Minister of the United Kingdom from 1979 to 1990.

of regulation had been insufficient to overcome the economic problems of the crisis. The new regime of economic and social reproduction has been necessary for all the countries that had experienced the golden age of welfare capitalism.

At this juncture, all these transformations experienced first in Europe and United States and then in most of the world have stretched out to Turkey in 1980s. As known, Turkey entered into a neoliberal transformation process in the early 1980s. In fact, Turkey had been one of the first developing countries that implemented a neoliberal economic program. In this respect, structural adjustment programme was implemented through the so-called 24 January Stability Programme in 1980. It should be noted that this programme had two strategic goals: Changing the mode of articulation of Turkish economy with global economy and strengthening the place of the capitalist classes against organized labour.

This thesis aims to understand the particular experience of neoliberal art of government in Turkey by focusing on the health dimension. For this purpose, the study tries to answer the question of how the healthy woman subject is constituted through the neoliberal discourse in Turkey. To sum up, the study aims at grasping neoliberalism in Turkey through the formation of healthy woman subject during the neoliberal transformation of health care.

1.1. Background of the Study

The welfare states after Second World War to the 1970s, has resulted in two main consequences: the increase in public expenditures and the expansion of state bureaucracies. As the states were carrying their interventionist functions, they have to employ great number of officials which have a negative defect on economy. Neo-liberalism occurred to be the solution of these problems. Therefore, their main concern was the inflation caused by the welfare policies. The moto was: less inflation, more economic growth, less bureaucracy. It was a mixed ideology as defending liberalism in economy whereas in social and political life the conservatist elements were defending, *i.e*. individualism and free market was aimed in economy and traditional

values and authority in politics. There were some common elements helped to shape neo-liberalism. First of all, the political life is considered as a matter of individual freedom and initiative. The society structure proposed was the free market society; and the state was the minimal state. Therefore, the welfare states were said to be "over-loaded governments" which was the proliferation of bureaucratic state agencies causes diminishing individual freedom. The state is said to be strong but limited. In this sense, state should be strong within its limits to provide security to prosper the business, trade and family life and to be non-interventional. That's why it is widely considered as "the new way of the world" (Dardot and Laval, 2013).

In this new way of the world, the health care provision has become the problematic domain of governing. The shift from welfare state to neoliberalism caused the dominance of the legitimacy of free market rationalities in social policy that neoliberal principles of individualism, privatization and decentralization have been the substitute for the universal social rights and collective welfare (McGregor, 2001).

The neoliberalism has come to be featured in so many different contexts and there have been several attempts to define this new way of the world. For instance David Harvey formulates the neoliberalism as:

> Neoliberalism is in the first instance a theory of political economic practices that proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets, and free trade. The role of the state is to create and preserve an institutional framework appropriate to such practices. The state has to guarantee, for example, the quality and integrity of money (Harvey, 2005, p. 2).

Differently from Harvey, Wendy Brown argues that "neoliberalism is more than a set of free market economy policies that dismantle welfare states and private public services in north, efforts at democratic sovereignty or economic self in north" Brown adds that "contemporary neoliberalism comprises these effects but as political rationality, it also involves a specific conceptual organization of the social, the subject and the state" (2006, p. 694).

Following Brown, this thesis conceives neoliberalism as a political rationality which discursively creates certain regimes of truth and is actualized through the regimes of practices and constitutes the new mode of subjectivities acting upon these discourses and practices. Nikolas Rose also points out that:

> Political rationalities have an epistemological character, in that they embody particular conceptions of the objects to be governed –notion, population, economy, society, community and the subjects to be governed –citizens, subjects, individuals and they deploy a certain style of reasoning (Rose, 1996, p. 42).

This study is an attempt to understand neoliberalism in Turkey by looking at the health field. Health care is one of the fields that the neoliberal transformation is felt the hardest. As it is the case with many other countries, radical changes took place in the field of health due to the effects of the neoliberal policies. A governmentality perspective is a well suited to understand various ways in which neoliberal governmentality of health operates in Turkey. It is generally argued that, with the decline of welfare state, the neoliberalism redefined the roles of the state and the public sector and likewise the state-society relations in the health sector. As known, starting with the structural adjustment programs of World Bank, there have been serious attempts to transform the health care systems all over the world. In this way, neoliberalism influences socio-economic, political, managerial, clinical and cultural aspects of health care systems. Moreover, three central points of neoliberalism, namely individualism, privatization and decentralization, have also restructured the logic of health care systems. Here, it is possible to say that "neoliberalists eliminate the concept of the public good and the community and replace it with individual and familial responsibility" (McGregor, 2001, p. 84).

In the context of Turkey, we can state that the neoliberal transformation has affected healthcare field deeply. Neoliberal structuring initiated in Turkey after 1980s defined the roles of public and private sectors in the field of healthcare. Turkish healthcare system has been transformed with the implementation of Health Transformation Programme since 2003. The healthcare reform process led to restructuring in healthcare finance, provision and service regulation in Turkey (Yılmaz, 2013, p. 56).

“Turkey has undertaken the Health Transformation Programme (HTP), a comprehensive reform program that introduced market incentives and mechanisms in the healthcare sector” (MoH, 2003 cited in Ağartan, 2012, p. 457).

As a result of this neoliberal restructuring process in healthcare, primarily the role of the state in health changed. The state stepped out of being a health service provider and took on the role of control mechanism. All citizens were brought under a universal health insurance. Many steps were taken towards privatization; the number of the private hospitals soared, the state hospitals were replaced by the new ‘city’ hospitals; the community clinics were replaced by health centres where individuals choose their own family physicians, due to the unfavourable working conditions in the full time employment in the public sector, many qualified physicians preferred to work at the private hospitals and new specialization areas in healthcare emerged.

Furthermore, in recent years, we have begun to observe that healthcare content in media has increased; and many healthcare themed television shows have been introduced in various television channels. Healthcare experts have started to provide recommendations and share insights with public through not only shows but also news on television. Again, it can easily be realized that the discourse of being healthy and health risk related contents have increased significantly in the social media and on the internet.

In the process of writing this dissertation, developments in the field of healthcare in Turkey have shown that the healthcare politics has been under the influence of neoliberalism. One of the developments in this context is Department of Health’s policy aiming at the integration of modern medicine and complementary medicine. Within this scope, the Traditional and Complementary Health Directorate under the Department of Health was established in 2014. Afterwards, certain traditional medicine practices have been taken under the scope of social security and accordingly some hospitals opened specialized units. In line with the same goal, the Department of Health organized the International Traditional and Complementary Medicine Congress in collaboration with World Health Organization (WHO) in 2018. In the

light of these efforts to integrate modern medicine and alternative/complementary medicine, it can be concluded that the modern medicine is having other medical applications under its governance.

Another important progress in this field is Department of Health's 'e-pulse application' (e-nabız). With the introduction of Turkey's first personal health system 'e-pulse', all health data of individuals using this application are collected and stored in a digital environment. All health personnel and individuals have access to their own health data with the use of the e-pulse application and an internet connection. Having access to own health data as much as health personnel has, will provide individuals awareness and responsibility on their health status and control.

In order to explore neoliberalism in the process of constituting the healthy woman subject in Turkey, this thesis uses Foucault's concept of governmentality in an analytical perspective. Here, it should be mentioned that Foucault uses "governmentality to explore the regularities of everyday existence that structure the 'conduct of conduct' ultimately giving expression to distinct historical epoch characterized by particular arts of government" (Nadesan, 2008, p. 1). The concept of governmentality refers to the "reciprocal constitution of power techniques and forms of knowledge and of regimes of representation and modes of intervention. Government defines discursive field which exercising power is rationalized" (Lemke, 2007, p. 44).

To tackle neoliberalism from a governmentality perspective has the advantage of unearthing the systematic ties between structure and agency, state and society, market and state, power and knowledge. Furthermore, the most significant principle underlying governmentality studies has been the rejection of conceptualization of government only with state which is identified as centralized locus of rule and the "dualism between state and society that so much of governance literature presupposes and it doesn't deconstruct their existence as pre-existing ontological entities" (Nadesan, 2008, p. 6).

1.2. Research Problem

This study focuses on the encounter of the structure and agency on the basis of the constitution of the 'healthy woman' subject by the neoliberal discourse. This thesis aims to understand the particular experience of neoliberal art of government in Turkey by focusing on the health dimension. The perspective of governmentality is used to understand the various dimensions of neoliberal governmentality of health in Turkey. In this regard, three strategies, which constitute the main footings of neoliberal governmentality of health as medicalization, commodification and individualization of health are used as guiding categories to understand how neoliberal discourse constructs 'the healthy woman' subject in Turkey.

First of all, it should be noted that this study takes neoliberalism as a distinctive rationale and a distinctive system of behaviour management and evaluation. On this point, neoliberal forms of government do not only directly intervene by means of the empowered and specialized state apparatus but also characteristically develop indirect techniques for leading and controlling individuals without being responsible for them (Lemke, 2001, p. 201). In this way, illness has transformed from being a social risk to a problem of self-care, which is in the domain of individual responsibility. Yet, the health transformed from being a fundamental right of the citizen to the something that the citizens can only reach by their own efforts.

As differently from Adam Smith's homo oeconomicus, who is naturally an entrepreneur and economic being only in the area of economics, the neoliberal subject is a homo oeconomicus in the health care and the other fields of life. In this case, being healthy becomes an interest and in this environment of competition, it represents both means and ends as the neoliberal subject desires to be healthy. The way that this new subject relates with itself on health matters is quite different than how it was earlier. Neoliberal subject is the search of truth of its own body. As a matter of the fact, the medicine is also going through a change; the post-modern medicine does not take the body as a given and for it the body is something reproduced and recast. If we look

from the governmentality perspective, the neoliberalism discursively constitutes a new kind of subjectivity.

Viewing the current transformations of neoliberalism in health context, this study aims to understand the processes of constitution of healthy woman subject by neoliberal discourse. Based on a two stage fieldwork, which is firstly conducted through the analysis of television health programs and then through in-depth interviews with women living in Ankara for over a year in 2017 and 2018, the study aims to reveal the manifestations of neoliberal political rationality in the process of the constitution of 'healthy woman'. To this aim, three strategies[3] of neoliberal governmentality of health which are medicalization, commodification of health and individualization of health, are used as guiding principles for analysing the data obtained both from the study of television health programs and the in-depth interviews.

Rather than being a political or economic project, this study formulates the neoliberalism as a discursive phenomenon that creates certain regimes of truth and modes of subjectivation. Following Wendy Brown, the study argues that "neoliberalism is a distinctive mode of reason, of the production of subjects, a 'conduct of conduct,' and a scheme of valuation" (Brown, 2015, p. 21). Drawing on the insight from governmental studies (*e.g.* Brown, 2006; Lemke, 2001; Miller and Rose, 2008), this study explores different strategies of neoliberal governmentality of health as medicalization, commodification and individualization of health which are operational in the process of subject constitution.

Based on the aforementioned perspective, this study pursues certain answers to the following set of questions:

- How is 'healthy woman' constituted as a subject by the neoliberal discourse in Turkey?

[3] Foucault states that strategies and tactics instead of function provide the method for a state analysis which rejects conceptualizing the state as "a transcendent reality whose history could be undertaken on the basis of itself" (Foucault, 2009, p. 358)

- Who is the ‘ideal healthy woman’ for neoliberal discourse?
- What kind of a neoliberal transformation is actualized in health policy in Turkey?
- How do the strategies of neoliberal governmentality of health affect the discourse of television health programs in Turkey?
- How do the strategies of neoliberal governmentality of health affect the health perception and behaviours of the women in Ankara?
- How do women living in Ankara interact with the neoliberal health discourse?

1.3. Significance of the Study

This study provides a perspective to understand the production and circulation of some normative meanings and truths on being healthy. It also examines how these normative mechanisms shape the perception and behaviours of the subject.

By focusing on the media and subject perspectives, this thesis aims to analyse different discourses and practices in the network of neoliberal governmentality of health in Turkey. To do this, firstly the political background of the neoliberal transformation of health in Turkey is examined by looking at the Health Transformation Program (HTP) launched in 2003.Then in the field work of the thesis, two different analysis were conducted on the two different dimensions of neoliberal governmentality of health – the media and the subject formation. In order to understand the media perspective chronologically, three television health programs namely the Feridun Kunak Show (Channel 7), My Doctor (Channel D) and My Dear Doctor (NTV) are discursively analysed by using the categories of medicalization, commodification and individualization of health. In the second stage of the field research, in order to understand the subject perspective, in-depth interviews are conducted with women living in urban Ankara. The data collected are then analysed by using the guiding categories of medicalization, commodification and individualization of health.

Firstly, the contribution of this study lays in its attempt to understand the rise of neoliberal political rationality in the process of subject constitution. Then, this study

analyses the subject constitution not only through the subject itself, but also through the perspective of media as a different discourse producer in the governmentality network. Actually, all these different perspectives lead us to see the big picture of the neoliberal governmentality of health in Turkey.

This study uses governmentality as a theoretical perspective which refers to the notion of government as a 'conduct of conduct' and also as "any activity aiming to shape, guide or affect the conduct of some person or persons" (Gordon, 1991, p. 2). The governmentality perspective helps to reveal the systematic relation between agency and structure; it is also helpful to understand "how common rationalities of government and technologies of power align the institutions, authorities, and technologies of everyday life" (Nadesan, 2008, p. 4). By using governmentality perspective, this thesis focuses both on the media and subject perspectives of neoliberal governance of health in Turkey.

Moreover, the study also draws on the works of Michel Foucault. The Foucauldian account provides us a relational understanding of power in today's world, and also his notion of power-knowledge is well suited to examine the relations between power, medical knowledge and medical authorities in the contemporary society. Foucault's account also helps us to analyse different mechanisms and strategies held in the subject constitution process. Since he clarifies how technologies linked to the forms of political government are applied on the self and how 'technologies of self are integrated into structures of coercion and domination" (Foucault, 1993, p. 203). His tool kit allows us to question the norms and truths on being healthy and being ill which are discursively circulated in the process of subject constitution.

In the Turkish context it can be said that a number of studies, generally in the field of public health, are on the issue of the woman's health focusing particularly on reproduction, yet most of these are macro –level quantitative analyses.

There is also some crucial but limited number of studies about the health of the women in Turkey in the field of medical sociology. For instance, Adak's (2002) study on

women's conception of health and illness in rural and urban areas in Antalya should be regarded as the first contribution in the field. There are also notable dissertations which addresses the health issue from sociological perspective. Him Miki's (2010) study, which focuses on the reproductive practice among Kurdish rural-urban migrant women in Van, deals with the health of the women from a sociological perspective. Moreover, in the field of medical sociology, Yelda Özen's dissertation (2008) also analyses the similarities and differences in health experiences among urban poor in relation to the forms of capital. The study is also pathfinder for this thesis as the lay perspective is used to understand people's everyday life experiences in relation to health.[4]

1.4. Outline of the Study

This thesis is composed of eight chapters. Following the Introduction, Chapter Two presents the Foucauldian account on some relevant concepts such as power, subject, and discourse aiming to explain his formulation of governmentality.

Chapter Three introduces the conceptual framework of the dissertation. The chapter theoretically examines the neoliberal governmentality of health. Hence the concept of neoliberalism, neoliberal governmentality and the relation between neoliberalism and a healthy woman subject are presented here. In other words, this chapter attempts to draw the picture of neoliberal governmentality of health.

Chapter Four deals with the methodology of the study. In this chapter, firstly the research design, data collection and analysis of the study are presented and then the details of the field study as well as the limitations of the research are given.

Chapter Five presents the political background on the neoliberal transformation of the health care system in Turkey with particular emphasis on Health Transformation Program (HTP). In order to see how things have been changing in the political

[4] There are also other dissertations in the sociology of medicine or health and illness (e.g. Göç–Şavran, 2010; Bozok, 2015; Bakacak, 2008 and Terzioğlu, 1998, Yurdakul, 1998).

discourse, this chapter portrays the content of the health transformation program and its impact on various dimensions of healthcare in Turkey.

As the chapter offering media perspective of neoliberal governmentality, Chapter Six presents the discourse analysis of three TV health programs in Turkey with a focus on how the neoliberal governmentality of health are embodied in television health programs in Turkey.

Chapter Seven presents the subject perspective of neoliberal governmentality of health. The chapter is devoted to the results of the field study comprising in-depth interviews with women living in Ankara. In this chapter, the findings of the research will be analysed with reference to the strategies of neoliberal governmentality of health in Turkey. In the last chapter of this dissertation, following a brief summary of the research findings in two different perspectives, the research questions of the study are discussed in accordance with the theoretical framework.

CHAPTER 2

ON THE WAY TO GOVERNMENTALITY PERSPECTIVE: FOUCAULT'S POWER, DISCOURSE AND SUBJECT

2.1. Introduction

To begin with, Foucault's standpoint can be seen as an attempts to understand how power operates throughout the society. But, what is hidden under this attempt is to explore the main theme of his studies as the subject. As Foucault confirms that "my objective, instead, has been to create a history of the different modes by which, in our culture, human beings are made subjects" (Foucault, 1982). Mainly, most of his studies related with madness, medicine, punishment, and sexuality focus on the forms of power that subjects us, as in his later work formulated 'the techniques of government' what makes human beings as a subject. Actually, Foucault provides a rich tool kit that brings some concepts which is used for understanding the power relations as subject, state, population, knowledge, and discourse into a new configuration through the micro analytics of power.

This study aims to investigate the construction of healthy women as a subject by using the lens of neoliberal governmentality. The reason why the Foucault's governmentality perspective is used for this thesis is that; it has the advantage of revealing critical responses to the constitution of subject in contemporary neoliberal era and also provides to reveal the systematic ties between structure and agency. Since the Foucauldian perspective of governmentality with its discursive character formulates different power relations and different position of the subject, in this chapter Foucault's concepts of power, his notion of discourse and subject will be outlined. By doing this, I am aiming to draw the conceptual framework to understand the Foucauldian perspective of governmentality. Before focusing on the Foucault's

concept, I attend to give a brief introduction about Foucault and his intellectual journey.

2.2. Why Michel Foucault?

A reading of Michel Foucault does not provide or teach us something new as knowledge rather, it proves us to question the ways in which knowledge itself operates. Between the years 1926-1984, he focuses on various different subjects such as knowledge, truth, madness, medicine, discipline, and sexuality. He wrote several books but not only his books but also his interviews and his lectures in College De France from 1971 till his death 1984 were the major stops of his intellectual journey.

In his early works: *History of Madness, The Archeology of Knowledge, The Order of Things*, and Foucault defines his position as "archeology of the knowledge" in which he attempts to identify the condition of possibility of knowledge. In other words, the metaphor of archeology is used by Foucault, to emphasize that his aim is to search for the underlying conditions and determinants of knowledge. In 1970s, Foucault began to write his genealogical works in which he attempts to demonstrate how objective forms of knowledge have been made as historically contingent rather than eternal truth. With his genealogical method, Foucault began to stress on the material condition of discourse which is defined by the institutions, political events, and economic practices and on analyzing the relation between discursive and non-discursive domains in the society.

From his later works, in which Foucault was concerned with notions such as 'arts of the self', 'ethical relation to oneself', 'care of the self' and 'parrhesia, Foucault defines ethics as the relationship of the self with itself, in other words, 'self-subjection' is the central theme of Foucault's later works on ethic. Foucault argues that "ethic determines how the individual is supposed to constitute himself as a moral subject of his own actions" (Foucault, 1997, p. 263).

Since his intellectual journey took place in many different cultural areas as sexuality, madness, punishment which did not exist in the scope of political theory before, it is

hard to say that Foucault is a political theorist or he is a historical or social theorist but it is inevitable to say that; Foucault dynamically influenced the fields of history, social science even the medicine. It is hard to classify Foucault's enterprise in a single discipline as history, philosophy, sociology or medicine, hence he gave the name to his chair at the College De France as '*History of System of Thought*' which also expresses his position in the intellectual area.

Foucault's life is argued on the influence on the primary motivation that led him to write his works. In 1926, he was born in a Catholic medical family in which father is a surgeon and his antipathy towards his father may be the source of his critical view on political authority of the doctors and his distant position to modern medicine. With philosophical education, he took his second degree in psychology and his experiences in the mental hospital led him to write *Madness and Civilization* as his doctoral dissertation in 1965 (Simons, 2002).

What Foucault provides us is not an alternative theory about the social structures, institutions or the subject but awareness of their being socio-historical constructions of the power and domination. In this sense, it can be said that; Foucault's project was to write the critique of our historical era.

Contrary to modern theories which argue knowledge and truth are neutral, objective and universal and at the same time the vehicles of emancipation and progress, Foucault analysis knowledge and truths as the integral component of power and domination. By destabilizing the Western epistemology, Foucault tries to problematize the modern forms of knowledge, rationality, social institutions and the subjectivity that is seen as given and natural. For Foucault, all forms of knowledge are historically relative and contingent and rely upon the power relations in the society.

Differently, from other contemporary thinkers who tried to understand the changes which are rooted in the transformations of the political present we lived in, Foucault focused not only on the changes but also on what is constant against the transformations and why do they still exist in our life. For Foucault, we are still tied

to identities around which ethnic, national, racial, conflict have fought some forms of power that bind us these identities through the process of subjectification still operate. Jon Simon considers that we are also bound in our political thinking which was developed before The First World War and failed to express the issues of identity (Simon 2002, p. 1) In line with Simon, it can be argued that Foucauldian approach is a new way to understand the old problems and have open up new lines of enquiry.

Clearly, for Simons (2002, p. 2) this is the limiting condition of our subjectification and if the works of Foucault evaluated there are three axes of "subjectification" as; truth, power, and ethics. We are subjects of the truths of human sciences that constitute us as objects of study (such as delinquents) and define norms with which we identify (such as heterosexual).

> In the archaeological works, there is no discussion of how the determination of who we are happens. This is because of his focus on historical discontinuity. In the genealogical works, there is more of a causal story, but that story involves power. In the ethical writings, the introduction of concepts like care of the self and self-cultivation seem to lend a sense of self-control to people's construction of who they are that is missing up until that point (Simons, 2002, p. 120).

Moreover classifying Foucault's enterprise by means of three separate phases which are, archaeology, genealogy and ethics do not mean that there are sharply distinctive lines between these phases. Thus, Foucault's work should be understood as a unifying project all the phases are in relation to each other. Actually, it can be said that there are different methods and subjects in Foucault's enterprise that consists of many subjects as in his archeological works, he has studied on the madness, modern medicine and in genealogical era he focused on the discipline, relations between power, truth, and knowledge, lastly in his self-era he tries to understand the ethics of self. But these differences do not confirm that all these phases are in chronological order in which new phase starts with the end of the older. As Dreyfus Rabinow considers "there is no pre and post pre archeology or genealogy in Foucault's work, however concentration of these approaches has changed during the development of his works" (1983, p. 104).

The pivotal concern of Foucault's work is to understand the constitution of the modern subject. For him, the society is not a united whole which is governed by the center that needs to be detotalized. The subject, is also constituted more than the constituting consciousness that needs to be decentralized**.** Now, constitutive elements of Foucauldian perspective of governmentality namely, his notion of power, subject and discourse will be drawn.

2.3. The Question of Power

There are three important aspects of the power which are all at the heart of most of Foucault's analysis namely; what the power is, how does it exercise and what exactly happens when someone exercises power over another. In this point, Kelly (2008, p. 31) argues that; Foucault's notion of power can be understood in two phases: The first phase is; in 1970s when the Foucault has made his first reconceptualization of power; the second phase is after 1970s when he formulates his concept of governmentality.

In his *The Will to Knowledge*, Foucault was concerned about the notion of power but the core of his formulation has done in his *Discipline and Punish* in which power is spoken with relation to disciplinary power that affects bodies. Then, in his later work as *Society Must be Defended* it can be said that, Foucault made the genealogy of the notion of power (Kelly, 2008).

For Foucault, there are many sociological studies to answer the questions on the power as who were bosses of the industry; how politicians are formed and where they came from and also the Marxist inspired studies concerning the domination of the bourgeois class.

Furthermore, in *Society Must Be Defended*, Foucault criticizes the Marxist conception of power since the concept is only defined by the "economic functionality" which refers "the role of power perpetuate the relations of production and to reproduce the class domination that is made possible by the development of the productive forces" (Foucault, 2003, p. 14).

At this point, Foucault asks whether power is always secondary to economics and is it also modelled on the community. Following these criticism of Marxist notion of power Foucault points out that the noneconomic analysis of power is possible by affirmations which says; power is not primarily the perpetuation and renewal of economic relations but that is primary in itself relations of force and power is not something that is given and exchanged that is something that is exercised and exists in action (Foucault, 2003, pp. 14-16).

However, we should keep in mind that, contrary to the sovereign model of power, Foucault formulates his notion of power, which he says in order to catch up the political changes "we need to cut off the King's head in political philosophy that has still to be done" (1984a, p. 63). Mainly, Foucault puts the concept of power not in a specific place but everywhere, so that for him Marxist formulation of power is not in the correct place and it is far from the place where everything really happens hence it is insufficient to ask the necessary questions to understand the exercise of power.

Marxist account on power is linked to class domination in capitalist societies. What is essential in Marx approach towards power relations is that every single form of production creates its own power and legal relations. Therefore, capitalism dominates not only the economic relations, but also the social formation and form of power. Marx identifies the production as the reproduction of social relations which followed by the fact that production implies to a historical context in which it concretized and mean something. Marx defines capital economic which has connotations in the superstructural levels and in reciprocal relation it necessitates wage labour to survive. Here, state and political power developed as an instrument to advance and strengthen the dominant position of the bourgeoisie who owns the "right to decide" distribution of surplus value. Under capitalism, the whole mind-set of human beings and their consciousness, merely the reflection of the conditions in which they find themselves and of the position in the process of production in which they are variously placed (Jessop, 2012).

At this point Foucault asks different questions for the analysis of power; instead of asking who exercises power, how and on whom; he prefers to ask the questions of who makes decisions for me and who is preventing me from doing this and telling me to do that? Who is programming my movements and activities? Who is forcing me to live in a particular place when I work in another? How these decisions on which my life is completely articulated are is fundamental today? Clearly, for Foucault understanding who exercise power is directly related to how it happens (Foucault, 1988a, pp. 102,103).

In this sense, it can be argued that Foucauldian power analysis, refers to all phases of life consisting from their everyday life to their job and also all their life choices. For Foucault, power relations diffused in all levels of social life as much as in public spheres as law and economy and in the private spheres as the organization of the family and the sexuality of the individuals. Hence, the power is in everywhere, it is exercised in bedrooms of the houses as in the Parliament building. It is everywhere since it comes from everywhere. The reason for the omnipresence of power is explained by Foucault as "not because it has the privilege of consolidating everything under its invincible unity, but because it is produced from one moment to the next, at every point, or rather in every relation from one point to another (Foucault, 1988a, p. 93).

Foucault's formulation of power circulates and it is never monopolized by one center it is exercised through the net-like organization of the law, in various social hegemonies. For Foucault power can be understood as:

> Power must be understood in the first instance as the multiplicity of force relations immanent in the sphere in which they operate and which constitute their own organization; as the process which, through ceaseless struggles and confrontations, transforms, strengthens, or reverses them; as the support which these force relations find in one another, thus forming a chain or a system, or on the contrary, the disjunctions and contradictions which isolate them from one another; and lastly, as the strategies in which they take effect, whose general design or institutional crystallization is embodied in the state apparatus, in the formulation (Foucault, 1978, pp. 92-93).

Differently, from other political interpretations of power which reduce it to mere repression and banning, Foucault provides a new perspective for understanding the power as an analytic of power. In his own words:

> Power is not something that is acquired, seized, or shared, something that one holds on to or allows to slip away; power is exercised from innumerable points, in the inter-play of nonegalitarian and mobile relations **(**Foucault, 1978, p. 94).

In this regard for the aim of explaining the role of power over life in the formation of the modern subject, Foucauldian formulation of disciplinary power and biopower are needed to be discussed.

2.3.1. Disciplinary Power: Docile Bodies and Obedient Minds

According to Foucault, at the beginning of the 18th century, West witnessed a different form of power which uses control and observation as a primary tactic for exercising power which is disciplinary power. The shift from sovereign power to disciplinary power is inevitable because monarch's power is exercised through outward behavior and language which is desired by the sovereign. But in disciplinary society, controlling over the language and behavior are not enough for the new economic and political formation of the society. It was only disciplinary techniques as ongoing ever present coercion which was able to produce docile and efficient bodies.

In *Discipline and Punish* Foucault defines discipline as:

> Discipline may be identified neither with an institution nor with an apparatus; it is a type of a power, a modality for its exercise, comprising a whole set of instruments and techniques, procedures, levels of application, target it's a physics or an "anatomy" of power a technology (Foucault, 1995, p. 215).

Differently from other techniques of power, "disciplinary techniques centers on the body produce individualizing effects and manipulates the body as a source of forces that have to be rendered both useful and docile" (Foucault, 2003, p. 249).

As Foucault mentioned, it was not the first time that body became the center of the power and also the object of the pressing investments but what was new for Foucault is the techniques of power that was used for domination is new. Furthermore, these

new techniques have different characteristics as: Firstly, the scale of control changed from treating body as a whole as if it were in dissociable unity to infinitesimal power over the active body. Secondly, an object of the control has transformed to the economy of the efficiency of movements rather than signifying elements of behavior or language of the body. Lastly; modality of the technique has also changed as it focused on supervising the process than focusing on the results. Foucault also confirms that all these changes are aiming to meticulous control over the body which imposed its docility-utility (Foucault, 1984b, pp. 180-181).

Foucault formulates disciplinary techniques as the "political anatomy" and "mechanics of power" that the main aim of the control over bodies is to increase the forces of the body, in the economical term the utility of the body. By dissociating power from the body and turning it into the aptitude and capacity, discipline produces subjected and practiced bodies as docile bodies (Foucault, 1984b, p. 182).

For Foucault, this new "political anatomy" is not a sudden invention it is a multiplicity of often minor processes as in education, military and also in hospitals. Moreover, all these disciplinary processes are adopted for the particular needs of the society. For instance, a renewed outbreak of certain epidemic diseases caused disciplinary techniques to be developed in hospitals and as a result of industrial innovation disciplinary techniques entered schools.

In this period plague-stricken individuals have become the object of surveillance and every bit of information and knowledge about them collected, classified and analyzed. As Foucault claims that:

> … discipline must increase the effect of utility proper to the multiplicities, so that each is made more useful than the simple sum of its elements: it is in order to increase the utilizable effects of the multiple that the disciplines define tactics of distribution, reciprocal adjustment of bodies, gestures, and rhythms and differentiation of capacities reciprocal coordination in relation to apparatuses or tasks. Lastly, the disciplines have to bring into play the power relations not above but the inside the very texture of the multiplicity as discreetly as possible as well as articulated on the other functions of these multiplicities (Foucault, 1984c, p. 209).

There are mainly three aspects of disciplinary training for Foucault namely: hierarchical observation, normalizing judgment, and examination. Hierarchical observation means that observer monitor the observed from hierarchical distance which provides observer to be invisible gaze which has the ability to see each observed. With the help of the techniques of surveillance "physics of power" operates with laws of optics and mechanics so the power is exercised without violence and become more "physical" than corporal (Foucault, 1984d, p. 193). Another instrument of power for Foucault is normalization; for he argues that disciplinary institution compares, differentiates, hierarchizes, homogenizes, excludes and in short normalizes. It is important to note that for Foucault normalization is both homogenizing and individualizing the society. How homogeneity and individualization happen at once? Foucault answers that:

> **…**power of normalization imposes homogeneity but it individualizes by making it possible to measure gaps to determine levels, to fix specialties and to render differences useful by fitting them one another (Foucault, 1984d, pp. 196-197).

Furthermore, normalizing mechanisms; produce what is normal and what is deviant in the society. In other words, power mechanisms also define deviant behavior which needs to be normalized. Dreyfus and Robinson (1983) highlight the identical relation between Kuhn's normal science formulation and Foucault's power normalizing technologies. Kuhn notes that:

> Perhaps the most striking feature of normal research problems... is how little they aim to produce major novelties, conceptual or phenomenal... To scientists, at least, the results gained in normal research are significant because they add to the scope and precision with which the paradigm can be applied (Kuhn, as cited in Dreyfus Robinson, 1983, pp. 197-198).

Dreyfus and Robinson consider that like Kuhn's normal science, normalizing technologies of Foucault function by establishing a common definition of goals and procedures they show how a well-ordered domain of human activity should be organized (Dreyfus and Robinson, 1983, p. 198).

By referring to George Canguilhem's book, *On the Normal and the Pathological (1991)*, Foucault accepts that during the eighteenth century, there is a general process of normalization which is not simply a principle of intelligibility but an element of legitimization of the exercise of a certain power. He also adds that norm functions by linking to the positive technique of intervention and transformation rather than rejection and exclusion (Foucault, 2003, pp. 49-50). In order to explain this transformation of the power techniques, Foucault compares the cases of leprosy and plague and finds out that; the reaction to leprosy was negative and the rejection and exclusion techniques were used where the healthy part of the society is protected from the ills. Differently, from leprosy, the reaction against the plague was inclusion and accumulation of knowledge, as the strategy of power (2003, p. 48). Foucault reveals that "we pass from the technology of power that drives out excludes, banishes, marginalizes and represses to fundamentally positive power that fashions observes, knows, multiplies itself on the basis of its own effects" (as cited in Foucault, 2003, p. xxi).

Hence for Foucault, during the eighteenth century, the characteristics of power have shifted from being a part of the superstructure to dynamic strategies of distribution and more initiative rather than being conservative (2003, p. 52).

In this respect, Foucault's panopticon analogy should be pointed out. It is taken from Jeremy Bentham's project, of the ring-shaped building with a watchtower in the middle and subjects are visible but the watcher is invisible and so the observation process is functioning.

> The backlighting enables one to pick out from the central tower the little captive silhouettes in the ring of cells. In short, the principle of the dungeon is reversed, daylight and the overseer's gaze capture the inmate more effectively than darkness…(Foucault, 1980a, p. 147).
>
> The theme of panopticon –at once surveillance and observation, security and knowledge, individualization and totalization, isolation and transparency –found in the prison its privileged locus of realization (Foucault, 1995, p. 249).

In fact, the panopticon is a mechanism which clearly showed how the disciplinary power is operated in seventeenth and eighteenth centuries through the observation separation, and individualization. It can also be said that from Foucault's perspective the panopticism was not only welcomed in the prisons but also operated in hospitals, factories and schools by means of isolating and surveillance of workers, students or madman, disciplinary power controlled and normalized them.

Is it possible to say that panopticism was left in the eighteenth century? According to Foucault despite the universal juridicism in modern society which fixes the limits on the exercise of power, panopticism universally enable to operate underside of the law. Foucault adds that "they are series of mechanisms for unbalancing power relations definitely and everywhere hence the persistence in regarding them as humble but concrete form of every morality whereas they are a set of phyciso-politcal techniques" (Foucault, 1984b, p. 213).

It is important at this point to add that the Panopticon is not simply a model of prison: It is a symbolic model which provides us to understand how disciplinary power diffused in everyday life.

In *Discipline and Punish,* Foucault uses the terms 'political economy of the body' which means body is utilized, allocated in a distinct way during the process of punishment with the utilization of different techniques, material sources etc. A history of ideas would not determine that the body as the object of punishment, therefore the actual sphere that power is functioning within the concrete practices, may not be observed via such methods. The micro-physical and diffused power exercised on the body is to be perceived in the network of relations and power is not possessed but exercised at every level.

Foucault also adds in the same study that, how the transformation of the power imposition over body emerged that the old formulation of the "body is the prison of the soul "is transformed into "the soul is the prison of the body".

> The man described for us, whom we are invited to free, is already in himself the effect of a subjugation much more profound than himself. A 'soul' inhabits him and brings him to existence, which is itself a factor in the mastery that power exercises over the body. The soul is the effect and instrument of political anatomy; the soul is the prison of the body (Foucault, 1995, p. 30).

Consequently, Foucault explains that following the shift from sovereign power to disciplinary pastoral forms emerged which adheres strictly inside of the subject. In pastoral forms of power, there had been deinstitutionalization and the internalization of the control by the individuals. Foucault argues that this new form of power as pastoral power is exercised through knowing the inside of people's minds and exploring their souls and also revealing their innermost secrets. By the way of the implication of the knowledge of the conscience, the pastoral power is able to direct it.

> This form of power is salvation oriented (as opposed to political power). It is ablative (as opposed to the principle of sovereignty); it is individualizing (as opposed to legal power); it is coextensive and continuous with life; it is linked with a production of truth- the truth of the individual himself (Foucault, 1983, p. 214).

According to Foucault, differently from its early forms which had religious attachments the pastoral power which is peculiar today instead of after death salvation, it ensures the salvation in this world via "health, well-being (that is sufficient wealth, the standard of living), security, and protection against accidents" (Foucault, 1983, p. 215).

In his genealogical phase, Foucault deals with dividing practices over power. One of these practices is disciplinary techniques which use the separation and arrangement of individuals to create the docile bodies. These techniques arrange, train, and organize individuals into machine-like groups. The disciplinary practices as hierarchical observation, normalizing judgment, and the examination make docile bodies trained. In disciplinary power dividing practices affect the individual bodies but for Foucault from the 17th century onwards the incidence of power has changed from individual bodies to the bodies of all population so the characteristics of power have changed and a new form of power emerged as bio-power. Now, Foucauldian theory of bio-power and its role in transforming human beings into subjects will be discussed.

2.3.2. Bio-power: Body as a Bio-political Reality

According to Foucault, in 17th century Europe the characteristics of power began to transform to a new form of power, which is different both from the power in the classical age and from the sovereign power emerged. From the Foucauldian conceptualization, the name of this new kind of power is 'bio-power'.

Foucault firstly introduced the concept of bio-power in his lectures of Rio de Janeiro in the year 1974. In the first lecture of this Rio de Janeiro lectures titled as *The Crisis of Medicine or the Crisis of Antimedicine?* Foucault reveals that the problem doesn't lie in the opposition between medicine or anti-medicine but it is the development of the medical system and the model that existed in West from the eighteenth century. Contrary to Ivan Illich's argumentation on anti-medicine, Foucault thinks that; in order to understand the problem of modern medicine there are three main questions to be asked: (1) what was that model of development? (2) to what extent can it be corrected? (3) to what extent can it be used today in societies or populations that have not experienced the European and American model of economic and political development? Foucault answers Illich's formulation of anti-medicine which argues that negative effects of medicine remained with medical ignorance and it's being nonscientific that what emerged at the beginning of the twentieth century was the fact that medicine could be dangerous, not through its falseness, but through its knowledge, precisely because it was a science (Foucault, 2004, pp. 8,9).

Let me now present the logic and the manner behind the process of biopower, Foucault mentioned about the Beveridge Plan of England in which health had become an object of state concern not for the benefit of the state but for the health of the individuals. The Plan clearly showed how health became the part of political struggle.

> With the Beveridge plan, health was transformed into an object of State concern, not for the benefit of the State, but for the benefit of individuals. Man's right to maintain his body in good health became an object of State action. As a consequence, the terms of the problem were reversed: the concept of the healthy individual in the service of the State was replaced by that of the State in the service of the healthy individual (Foucault, 2004, p. 6).

For Foucault since the eighteenth century the state has changed its direction to the body from the soul of the citizens and this new situation can be formulated as the shift from theocracy to somatocracy, that the care of the body, corporal health, the relation between illness and health, has become the appropriate areas of state intervention (Foucault, 2004, p. 7). In this regard, it should be added that the 'right to be sick' and 'right to stop work' also became crucial. The health or the absence of health become issues for the macro-politics. The shift from theocracy to somatocracy pave Foucault the way to formulate the concept of biopower.

Another lecture of the Brazil series was "*The Birth of the Social Medicine*" that Foucault examines three stages of the formation of social medicine as; state medicine, then urban medicine, and, finally, labor force medicine. 18th century Germany was a good example for the state medicine as the 'medical police' system was used for both observation of sickness and recording the different epidemic and endemic phenomena that were observed and for the standardization of medical practice and medical knowledge in the whole state. The main goal of the state medicine is to develop strength of the state in those conflicts with its neighbors.

Another stage that Foucault developed for his analysis of social medicine was urban medicine as he suggests Paris in the eighteenth century as a typical example. This model simply shows how quarantine models developed in the cities as an emergency plan dealing the problem of the urban panic of plague or another epidemic serious illness in the city. For Foucault, differently from leprosy in plague case:

> Medicine's political power consisted in distributing individuals side by side, isolating them, individualizing them, observing them one by one, monitoring their state of health, checking to see whether they were still alive or had died, and, in this way, maintaining society in a compartmentalized space that was closely watched and controlled by means of a painstaking record of all the events that occurred (Foucault, 2000a, p. 146).

The important point that should be added in urban medicine model, medicine becomes the 'medicine of things' because issues related with living conditions of the urban population as water, air, decompositions becomes the operation area of medicine. The

third and the last stage for the formation of social medicine is the labor force medicine. For Foucault, England is the country that can be a typical case for this model since the industrial development was being experienced and the rise of the proletariat was faster than other European countries. With the rise of the labor force medicine the poor people in the city become the object of medicalization. The reasons behind the rise of labor force medicine for Foucault are, with the French Revolution underclass become the political force capable of revolting or at least of participating in revolts and they had also important tasks in postal service and a transport system of the city. Lastly the cholera epidemic of 1832, which began in Paris, then spread throughout Europe, caused political and health fears occasioned by the proletarian or plebeian population (2000a, p.152).

As stated by Foucault, it was the Poor Law which made English medicine a social medicine the idea of a tax-supported welfare, of a medical intervention that would constitute a means of helping the poorest individuals to meet their health needs at the same time it provide control over the needy class and protect the health of the wealthy class (2000a, p. 153).

Consequently, the medical police of Germany, quarantine models in Paris or the Poor Law in England, all these stages of the social medicine formation clearly demonstrate how the state intervention to the health become possible and also how the medicine become the issue in the political arena. In this sense, it can be added that throughout his analysis of social medicine formation Foucault tries to explain the conditions which make the birth of the somatocracy and then the bio-politic.

Accordingly, Foucault argues that this power over life, bio-power, beginning to emerge in 17th century has taken two basic forms. These two forms, namely, anatomo-politics of the human body and a bio-politics of the population (Foucault, 1978, p.139). The first of these forms focuses on the body as a machine. Hence, the main concerns of anatomo-politics are the body and "its disciplining, the optimization of its capabilities, the extortion of its forces, the parallel increase of its usefulness and its docility…" (Foucault, 1978 p. 139). The second form, which is bio-politics defined as

“an explosion of numerous and diverse techniques for achieving the subjugations of bodies and the control of populations” (Foucault, 1978, p. 140).

This clearly means intervention the conditions of biological processes, such as “propagation, births and mortality, the level of health, life expectancy and longevity” (Foucault, 1978, p. 139). Therefore the controlling and administrating of life has been achieved by these two forms of biopower; by disciplining the body and regulating the population**.**

In this regard, at beginning of the nineteenth century with the development of capitalism, remarked the socialization of body as a factor of productive force, of labor power. Differently, from the Marxist perspective of ideology as society’s control over individuals through consciousness, Foucault argues that body was the object of control. He claims that “for capitalist society it was biopolitics, the biological, the somatic, the corporal that mattered more than anything else. The body is a bio-political reality; medicine is a bio- political strategy” (Foucault, 2000a, p. 137).

Moreover, Foucault states that the emergence of biopower is directly related to the requirements of capitalism. In other words, it can be said from Foucauldian perspective that the regulation, normalization of the life of the individuals means an efficient workforce for the factories of the new industrialization. For Foucault, this controlled insertion of bodies into machinery production would be formulated as the adjustment of the phenomena of population to economic processes (1978, pp. 140-141).

After two year from the Brazil Seminar Foucault has focused on the concept of biopower in his book of *Society Must Be Defended (2003).* In this study, Foucault distinguishes the relation between power, life and states that sovereign power has the right of life and death as an influence on the life of the individuals. In other words as a “rather precisely opposite right” sovereign has the power to “make live” or “let die”. Foucault emphasizes that the reason behind mentioning about the transformation of the relation between power and life is not for analyzing in the political theory level but

for the understanding mechanism, techniques, and technologies of power (Foucault, 2003, p. 241). In eighteenth-century techniques of power has changed and focuses on the body of the individual. With the help of the separation, alignment and surveillance bodies of individual, held under the control of power. Foucault described all these rationalizing and economizing techniques on power as the "disciplinary techniques of labor" (2003, p. 242). So in the second half of the eighteenth century, the new and non-disciplinary techniques of bio- power emerged.

Differently, from disciplinary techniques, biopower is applied 'not to man as a body' but to the 'living man' or 'man as a living being' or as 'man as species'. According to Foucault, there are three main starting points of biopolitics which also distinguish the operation of mechanisms and its intervention fields of a new mode of power these points explained by him as:

> First, depending on the relation between knowledge and power, biopower derived its knowledge from and define its power's field of intervention in terms of birth rate, the mortality rate, various biological disabilities and the effects of the environment.
>
> Second; the phenomena addressed by biopolitics are essentially aleatory events that occur within population that exist over time.
>
> Third; the mechanism introduced by biopolitics includes forecasts, statistics estimates and overall statistics, to intervene at the level of their generality. The mortality rate has to be modified or lowered, life expectancy has to be increased, and the birthday has to be simulated (Foucault, 2003, p. 245).

For Foucauldian formulation of biopower all the results of these statistics, overall measurements are the mechanism for the definition of norm. Differently from disciplinary power biopower uses the result of all these different statistics to intervene generality of population rather than modification of any given individual's behavior. However, the concept norm also circulates between the disciplinary power and biopower since can be applied both the body and the population not only for disciplining the body but also for regulation of population.

The important point here is; although Foucault formulates them as two different forms of power, disciplinary power and biopower, they only be defined in a relationship each

other. It impossible to say that disciplinary power gets out the game, then biopower entered as a new player. On contrary, Foucault states that biopower subsumes the disciplinary power.

> The normalizing society is a society in which the norm of discipline and the norm of regulation intersect along an orthogonal articulation. To say that power took possession of the eighteenth century… is to say that it has thanks to the play of technologies of discipline on the one hand and the technologies of regulation on the other hand succeeded in covering the whole surface that lies between organic and biological between body and population (Foucault, 2003, p. 253).

It is the 17th century when the meaning of the people's life and death for power has changed. In line with these transformations the bio-power as a new form focuses on the life as an issue which needs to be regulated, normalized and controlled. For Foucault speaking on bio-power means designating "what brought life and its mechanisms into the realm of explicit calculations and made knowledge – power an agent of transformation of human life" (1978, p. 143).

Bio-power is the term Foucault uses to explain the new mechanisms and tactics of power focused on the life of human. The main aim of biopower is to control social body and also with the purpose of attaining the knowledge of each individual. Hence, bio-power functions by both totalizing procedures and individualizing techniques.

Simply, governing strategies of bio-power explained by Foucault in two ways; firstly for the aim of attaining the knowledge of each individual, biopower labels them as a unique and inimitable subjects. This subjective individualization technic also provide bio-power govern the divided whole easily. Secondly, the unique information of each individual are integrated to the totalizing strategies. In this regard life of each individual become the object of the power investment. These two ways of governing strategies as "individualization techniques" and "totalization procedures" are combined and used by biopower (Foucault, 1978, p. 213).

2.3.3. Power/Knowledge

In order to understand the Foucauldian notion of 'discourse' his formulation of the relation between power and knowledge should be clarified. In his essay of *Prison Talk*, he builds upon his own account of the power-knowledge relations:

> Knowledge and power are integrated into each other, and there is no point in dreaming of an aim when knowledge will cease to depend on power… It is not possible for power to be exercised without knowledge, it is impossible for knowledge not to engender power (Foucault, 1980b, p. 52).

Consequently, Foucault's main concern is how we know something as a fact, in other words; the processes whereby something becomes established as fact or as a knowledge. As in his works "*The Order of Things*" and "*Archeology of Knowledge*" Foucault mainly focused on the process of knowledge production as abstract institutional processes. Foucault evaluates the knowledge production process as the selection process in which some statements discredited or denied and some of them established as a fact or truth. In this point, power relations play a pivotal role, instead of being neutral and impartial selection of truth power operates in that process which labelled some statement as a truth.

According to Foucault, the only way for knowledge to diffuse into the social realm is the approval and exercise of power. Power/knowledge relation has two dimensions as in macro-level, knowledge enable power to rule over the population and also the individual in micro-level. Thus, Foucault uses these two terms united as 'power/knowledge' to highlight their inseparability and togetherness. But this relation is not one-directional and server–servant relation for Foucault as he explains:

> We should admit rather that power produces knowledge (and not simply by encouraging it because it serves power or by applying it because it is useful); that power and knowledge directly imply one another; that there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations.
>
> In short it is not the activity of the subject of knowledge that produces a corpus of knowledge, useful or resistant to power, but power-knowledge, the processes and struggles that traverse it, and of which it is made up that determines the forms and possible domains of knowledge (Foucault, 1984e, p.175).

In this regard, Sara Mills (2003, p. 69) finds that discussion of Foucauldian notion of knowledge is theoretically important, it shows us the way that knowledge is not impartial but is an integral part of struggles over power. She also adds that if one produces knowledge he/she also makes claim for power. Mills also points out another important point about the Foucauldian formulation of power/knowledge that there is a close relation between knowledge production and imbalance of power as she argues that:

> Thus, where there are imbalances of power relations between groups of people or between institutions/states, there will be a production of knowledge. Because of the institutionalized imbalance in power relations between men and women in Western countries, Foucault would argue, information is produced about women; thus we find many books in libraries about women but few about men, and similarly, many about the working classes but few about the middle classes (Mills, 2003, p. 69).

On that account, it can be said that Foucault warns us to be suspicious of the knowledge since it plays the role in the maintenance of status quo and affirmation of current power relations. Rather than being the search for the objective truth, Foucauldian knowledge is the result of the processes in which power operates and something labelled as truth.

In this regard, Foucault argues that; the truth is also connected with power/knowledge relation and it is also produced and transmitted in every society in the different forms of discourses by its own regime of truth. Here how he puts the matter:

> Truth is a thing of this world: it is produced only by virtue of multiple forms of constraint. And it induces regular effects of power. Each society has its regime of truth, its 'general politics' of truth: that is, the types of discourse which it accepts and makes function as true; the mechanisms and in stances which enable one to distinguish true and false statements, the means by which each is sanctioned; the techniques and procedures accorded value in the acquisition of truth; the status of those who are charged with saying what counts as true (Foucault, 1980c, p. 131).

'Political economy' of the truths for Foucault has different characteristics and for the perspective of this study, two of them should be pointed out. Firstly Foucault sees truth as it centered on the form of scientific discourse and the institutions which produce it and it is also subject to constant economic and political influence. Secondly, following

Louis Althusser's notion of ideological state apparatus, Foucault argues that truth is both produced and transmitted by great political and economic apparatus (if not exclusive under the control of dominant) namely; university, army, writing and the media.

On that account; Foucault argues that rather than releasing the truth from every system of power the matter should be detaching the power of truth from the forces of hegemony social, economic and cultural within which it operates at the present time (1980c, p. 133).

> According to the power/knowledge thesis, "Truth is linked in a circular relation with systems of power that produce and sustain it, and to effects of power which it induces and which extend it" (EW3, 132). Specific genealogical analyses show the contingent manner in which certain rational discourses became true by presenting historical versions of the systems of exclusion that determine what is true or false (Simons, 2013, p. 304).

In order to explore power/knowledge thesis both in *Discipline and Punish* and *History of Sexuality,* Foucault focuses on the emergence of human sciences in an early nineteenth century and there is a new technologies of government for Foucault should be considered. In this regard by rendering the social world into a form that is both knowable and governable, power relations and scientific discourse constitute related with each other. For Foucault, when something was constituted as an area of investigation this clearly shows that it was established as an object by power relations (Foucault, 1978, p. 98).

Basically, the mechanism functions as Foucault (1980d, p. 93) explains as the relation of power can only be established by the production and circulation of the certain discourse of truth. But for him, the point is not the mechanism itself. Specifically, we are forced to produce the truth of power that our society demands, power never give up its registration of truth and in order to produce the wealth, we must produce the truth. In the end, as Foucault considers "we are judged, condemned classified, determined in our undertakings destined to certain to a certain mode of living or dying as a function of true discourses…" (Foucault, 1980d, p. 94).

2.4. Discourse as a Political Commodity

Rather than studying language Foucault prefer to use the concept of discourse as a system of representation. Differently, from other approaches which use discourse as a linguistic concept, Foucault interested the rules and the practices that produce meaningful statements and regulated discourses in the different historical period (Hall, 2001, p. 72). Similar to his other concepts, there had been clear shift in his notion of discourse from his archeological works to his genealogical works.

In his *Archeology of Knowledge* Foucault explains discursive formation as:

> Whenever one can describe, between a number of statements, such a system of dispersion, whenever, between objects, types of statement, concepts, or thematic choices, one can define a regularity (an order, correlations, positions and functioning, transformations) , we will say, for the sake of convenience, that we are dealing with a discursive formation (Foucault, 1972, p. 38).

In this regard discourse for Foucault is not one statement or one texts or one sentence, it is a choice of concepts, statements, themes, and it is an order and regularity. Clearly, Norman Fairclough (1992, p. 39) argues that in his archeological studies there are two insights about the discourse. Firstly; discourse is seen as actively constituting or constructing society on various dimensions. Mainly the forms of self, social relations and the objects of knowledge is constructed by discourse. Secondly; discourse is interdependent to practices of society and institutions which means that meanings of any discourse practices can be understood with regard to other discourse practices, this characteristic can be defined as the intertextuality of the discourses (Fairclough, 1992, pp. 39-40).

At this point, Fairclough argues that in the archeological period Foucault's position in the discourse as constituting and constructing both the object and the subject. Moreover, Fairclough explains that by object Foucault means object of knowledge and constitution of madness (from Foucault's example) as an object in the discourse of psychopathology since the nineteenth century and mental illness was constituted by all that was said in all the statements that named it divided it up described it, explained it (as cited in Fairclough, 1992, p. 32). He also adds that madness is not a stable object

but subject to continuous transformation both between discursive formations and within a given discursive formations (as cited in Fairclough, 1992, p. 32).

As Stuart Hall (2001, pp. 72-73) argues by defining the object of our knowledge, discourse influence how ideas transformed to practice and it also limits, restricts other ways of constructing knowledge about any statements. Hall also adds that subjects that Foucault interested as madness, punishment and sexuality only exist meaningful for him within the discourses about them. The fact that in his earlier works Foucault focuses on the discursive formations as types of discourse but than in his genealogical works his notion of discourse has become related with power and knowledge. Richard A. Lynch explains this shift as:

> The way power relations permeate sexual discourse is illustrated, for example, by repression and resistance to it. It has been argued that we repress our sexuality, and so we can free ourselves from repression by engaging in more open discourses about sexuality. On the contrary, Foucault argues, these attempts at resistance merely serve to reduplicate and multiply the already existing discourses about sexuality – discourses that facilitate control and normalization of sexuality – and so attempts to break out from repression serve merely to play into and reinforce the normalization of sexuality that we were seeking to escape (Lynch, 2014, p. 124).

In this regard, from his genealogical perspective it can be argued that some statements or some issues are socially defined and these definitions constructed the discourses about them in this process some definitions are included some of them excluded and at the end, a discourse which represents truth regime of the society is constructed. There are many instances that Foucault uses but one of them is the definition of homosexuality in medical discourse and how this discourse plays a role in normalizing techniques in the society. Foucault considers that there is a strong mutual relationship between power relations and production and also circulation of discourse. To quote Foucault's own words:

> In a society such as ours, but basically in any society, there are manifold relations of power which permeate, characterize, and constitute the social body, and these relations of power cannot themselves be established, consolidated nor implemented without the production, accumulation, circulation and functioning of a discourse (Foucault, 1980d, p. 93).

Remembering the Foucault's notion of power as everywhere and productive, and what he says about managing the population in the modern society, it can be said that the concept of discourse has a pivotal role in Foucauldian micro-techniques of modern power.

> Discourses not only exhibit immanent principles of regularity, but they are also bound by regulations enforced through social practices of appropriation, control and policing. Discourse is a political commodity (1980e, p. 245).

To sum up, discourse is not only one text, one action or speech, but also the apparatus for Foucault which inscribed in the play of power and has a strong linkage with knowledge. The concept of discourse as developed and presented by Foucault in his many works is one of the most fruitful ways to analyze both the historical development of neoliberalism as a whole in Turkey in the period of post-1980 and the construction of healthy women as a subject by neoliberal discourse. It has many influences in modern society especially on the way of conducting with others, constructing the object of knowledge and as Foucault emphasized the subject is also discursively constructed and ideas become a practice by the influence of discourse (Fairclough, 1992).

2.5. Subject

How is the status of the subject in Foucauldian thought? What is the position of the Foucault's subject in relation to the power? Is the subject passive receiver who produced by the power relations or active self-creative of the conditions of her existence?

Foucault reveals that power along with the other axes constitutes the condition of possibility of our subjectivities (2000b, p. 118). When we look at the three different eras of the Foucault's work, there are mainly two different perspectives for the meaning of the subject is provided by him as; subject as a subject to someone else by control and dependence and subject and the subject who tied to his own identity, by his own self-knowledge and consciousness.

Similar to the concept of power Foucauldian notion of subject is also changes across his intellectual career. When he starts considering about disciplinary power or biopower, the fact that he points out how the disciplinary power and biopower produces subjects by their own technologies of power. Clearly as it is mentioned before disciplinary normalization constitutes subjects with regard to dividing practices and distinguishing the mad and the sane, the sick and the healthy (2000b, p. 326). But Foucault's notion of power has never been merely oppressive that he insisted power produces, it produces reality, it produces domains of objects and rituals of truth" (1995, p. 194).

In *History of Sexuality* volume one, subject is formulated as being subject to control, the particular subjects formed through the apparatus of sexuality as the hysterical woman, the masturbating child, the perverse adult, and the Malthusian couple (1978, p. 105) By the help of the sexual technologies of discipline, surveillance, the woman was medicalized, the child pedagogized, the pervert psychiatrized, and the couple socialized (1978, pp. 104,105,116).

According to Kelly (2009, p. 80) Foucault's works of *The Ethics of Concern for Self as a Practice of Freedom* and second volume of *History of Sexuality*, *The Use of Pleasure* do not show us a shift in Foucault's thinking about subject but it is a shift in the change of the focus from discourse to power and then lastly towards subjective. This shift for Kelly:

> does not imply that the subjective perspective is exclusive of the analysis of power, any more than the analysis of power excludes the analysis of discourse; rather, the three are complementary while remaining irreducible to one another (Kelly, 2009, p. 80).

In his *Technologies of Self*, Foucault proposes four titles for the categorization of the technologies which train, modify individuals and produce knowledge of individuals as:

> (1) technologies of production, which permit us to produce, transform or manipulate things; (2) technologies of sign systems, which permit us use signs, meanings, symbols or signification; (3) technologies of power, which determine the conduct of

> individuals and submit them to certain ends or domination, an objectivizing of the subject; (4) technologies of the self, which permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immorality (Foucault, 1988b, p. 18).

Since the way that the contact between the individual and herself differs from other individuals, these technologies plays initial role in the process of individualization and they are formulated by Foucault as the 'technologies of self'. When any individual produces her own knowledge of self she also cultivates an interest in herself and develops some practices in her daily life related to this interest. As Foucault pointed out that:

> I am more and more interested in the interaction between oneself and others and in the technologies of individual domination, the history of how an individual acts upon himself in the technology of the history of how an individual acts upon himself in the technology of self (Foucault, 1988b, p. 19).

In the *Technologies of Self* Foucault aims to discuss the subject not only in theory but in relation to a set of practices in late antiquity. By turning back the Hellenistic and Roman times and trying to understand their principle of taking care of oneself, Foucault aims to understand modern mode of subject.

On that account from the Foucauldian perspective, it can be said that the constitution of a discourse of taking care of oneself is the starting point for conceiving the formation of modern subject today. In fact, caring of self is not an individual activity for Foucault, it also paves the way of caring for others and response to the complex social relations. As Foucault points out:

> Around the care of the self, there developed an entire activity of speaking and writing in which the work of oneself on oneself and communication with others was linked together. Here we touch on one of the most important aspects of this activity devoted to oneself: it constituted, not an exercise in solitude but a true social practice (Foucault, 1986, p. 51).

Regarding the above-mentioned questions about the Foucauldian formation of the subject and the possibility of the freedom for the subject, Foucault answers in the interview shed light on our effort to understand. He emphasizes that:

> He had to reject a priori theories of the subject in order to analyze the relationships that may exist between the constitution of the subject or different forms of the subject and games of truth, practices of power, and so on (Foucault, 1997, p. 290).

In the same interview, he points out that rather than the word power, he used power relations and differently from general thought on power which is explained by institutions, dominant social class, the master and the slave by power relations, he means every forms of humans relations which are not fixed and reversible and the "power relations are possible only insofar as the subjects are free" (Foucault, 1997, p. 292).

To sum up, the main focus of Foucault's studies as creating the history of different modes by which "human beings are made subjects" in Western history. As he didn't provide a theory of power, he didn't develop any theory about the formation of the subject too. What is significant for him is that he proposes an affirmative project to understand the historical formation of subject in different modes of power relations. By proposing the possibility of freedom he never thought that power relations are not fixed or asymmetrical but he argues that if there are relations of power in every social field this is because regardless of its limits there is freedom in everywhere. For Foucault, it is the power that transforms individuals into subjects. For him, "discourse itself is a power." Power is not something to be avoided. Indeed, it cannot be avoided since it is everywhere. It has two dimensions; power that you are submitted to and power that you oppose to. Here it is understood from Foucauldian account that: "Where there is power, there is resistance" (1978, p. 95).

2.6. Chapter Summary

This chapter presents conceptual framework for understanding Foucauldian perspective of governmentality by focusing on his concepts of power, discourse and subject. All these Foucauldian concepts helps us to understand firstly; how the subject is constructed in both micro and macro power relations in which there is no repressive state apparatus acting to upside down. Secondly, these conceptual elements make us

to understand how the modern subject is constructed with discursive formations which orchestrate the truth regimes in the governmentality network.

In this chapter, it is pointed out that, Foucault proposes an affirmative project to answer the question of through which mechanisms the life and body and human are controlled, disciplined and normalized. Hence; Foucauldian oeuvre sheds light on understanding the normalization and disciplinary mechanisms of public health from past to present.

Especially his suspicion towards the scientific knowledge, enables us to question the authority of the medical knowledge in modern society. If we look from the Foucauldian perspective of power, knowledge and subject relation, we can question the relationship between health policy, medical power, medical knowledge and the subject in the neoliberal era.

Moreover, Foucault's formulation of power and his effort to cut the King's head helps us to unearth the constitution of subject through many strategies of governmentality. In this regard his concept of discourse is essential to understand how medical discourse and discourse of being healthy are constructed and circulated across the social realms.

CHAPTER 3

NEOLIBERAL GOVERNMENTALITY OF HEALTH

3.1. Introduction

This chapter aims to define the theoretical and conceptual framework of the neoliberal governmentality of health. Hence, firstly Foucauldian concept of governmentality is introduced; then neoliberalism with its different dimensions outlined in this part as the theoretical premise of this thesis. By following the governmentality studies scholars, the neoliberal governmentality is also outlined. Lastly, neoliberal governmentality of health with emphasis on its three footings as medicalization, commodification of health and individualization of health are discussed. The main question in this part is: "Who is the neoliberal healthy women subject?"

3.2. Governmentality

Michel Foucault, introduced the term governmentality in 1978 in a lecture series at the Collège de France called *Security, Territory and Population* which would guide his previous studies in a retrospective manner.

This concept, semantically linking the terms *governing* ("gouverner") and *modes of thought* ("mentalité"), implies that it is not possible to study the technologies of power without an analysis of the political rationality underpinning them (Lemke, 2001, p. 191). Or, as he put it a couple of years later summarizing the 1979–1980 course titled as '*On the Government of the Living'*, governmentality is understood as: a "techniques and procedures for directing human behavior. Government of children, government of souls and consciences, government of a household, of a state, or of oneself" (Foucault, 1997, p. 81).

What is of interest to Foucault among these different definitions of government is that till the sixteenth century "one never governs a state, a territory, or a political structure. Those whom one governs are people, individuals, or groups" (Foucault, 2008, p. 122) so as to lead, guide or direct them.

As Lemke (2001, p. 191) points out that Foucault has shown that until the 18th century the problem of government was placed in a more general context, mainly; the term government was discussed not only in the political field but also in philosophical, religious, medical and pedagogic texts. In its broad sense, Foucault defines government as the 'conduct of conduct' which can have different meanings from governing self to governing others. Here how he puts the concept:

> To govern in this sense is to structure possible fields of action of others. The relationship proper to power would not, therefore, be sought on the side of the violence or of struggle nor that voluntary linking (all of which can be at best only by the instrument of power) but rather in the arena of singular mode of action upon action of others, when one characterizes these actions by government of men by other men- in the broad sense of the term includes an important element: freedom (Foucault, 1982, p. 790).

Foucault also points out that:

> Governing people, in the broad meaning of the word, is not a way to force people to do what the governor wants; it is always a versatile equilibrium, with complementarity and conflicts between techniques which assure coercion and processes through which the self is constructed or modified by himself (Foucault, 2016, p. 26).

The term government from Foucauldian formulation as the "conduct of conduct" opens numbers of different meanings, as Dean (1999) considers that from to conduct someone as the lead, direct and guide someone to the ethical perspective of to conduct oneself, self-regulation and self-direction. Moreover, the word conduct also refers to a normative code of conduct in which some standards and norms are defined by some professional groups whose responsibility is to ensure that regulations in the society as teacher or professional associations.

In identifying the forms and procedures of conduct, Foucault sees governmentality as a complex set of relations that cultivate responsibilization of self, actively seeking to

calculate and minimize one's privatized risks through a number of techniques in diverse social domains. This way of understanding departs from a conception of power merely exercised through state sovereignty. As Burchell (1996, p. 19) states, the conduct of conduct are dispersed mechanisms which are manifest in interpersonal relations, as well as relations with institutions. It may act upon numerous social entities ranging from specific micro-settings (like individuals, families, communities and so forth) to larger units (like population, nation, and society). What differentiates governmentality from state domination is its way of exercise of power over subjects. In Foucault's (1982, p. 789) words, "[governmentality] acts upon their actions: an action upon an action, on existing actions or on those which may rise in the present of the future". Here, the state is conceived as a specific institutional form in which these modes of power relations are intensified. That is to say, state cannot be merely understood as a ruling body; it is simultaneously a productive force that regulates relations between people and institutions.

In *Security, Territory, Population: Lectures at the Collége de France, 1977-78*, Foucault (2008b, pp. 108-109) conceives three different ways of government; namely (i) the assemblage of institutions, ways of thinking, calculations and techniques, (ii) as a particular form of knowledge guiding this assemblage, and (iii) specific apparatuses, or dispositif, involving technical instruments.

Accordingly, his way of thinking puts forward the idea of government as a process deploying complex set of relations to shape bodies under the guise governmental knowledge. Lemke (2007, p. 44) suggests that Foucault's conception of governmentality introduces a novel understanding in two ways: First, it makes possible to discern government as "the reciprocal constitution of power techniques and forms of knowledge and of regimes of representation and modes of intervention" (see also Simons, 2002). Second, it provides and understanding of "the multiple and diverse relations between the institutionalization of a state apparatus and historical forms of subjectivation". In other words, Foucault's conception opens up a space for

understanding relationality between modern state and autonomous subjects, in which selves are responsibilized, active agents in their relations with modern state[5].

Therefore, this perspective identifies the state-society relations as a productive force that creates and maintains particular subjectivities generating the self-formation as a domain of conduct of conduct. This process is delicately produced through complex ties between "the technologies of domination of others and those of the self" (Foucault, 1988b, p. 19). This is to suggest that, according to Lemke (2012, p. 29), governmentality should be understood not only in terms of discursive formation but also through the concept of technology:

> Governmental technologies denote a complex of practical mechanisms, procedures, instruments, and calculations through which authorities seek to guide and shape the conduct and decisions of others in order to achieve specific objectives (Lemke, 2012, p. 29).

Hence, they involve numerous techniques including specific methods of examination and evaluation, notation, numeration, specification in terms of time and space, formulations and diverse pedagogic and therapeutic activities (Rose and Miller, 1992, p. 183). By these means, governmentality is not an act of government through discursive practices but a matter of intervention directly or indirectly performed through techniques. Miller and Rose (1992, p. 32) suggests:

> If political rationalities[6] renders reality into the domain of thought, these technologies of government seek to translate thought into the domain of reality and to establish in the world of persons and things, spaces and devices for acting upon those entities of which they dream and scheme (Miller and Rose, 2008, p. 32).

[5] Foucault intricately analyzes historical development of state through a genealogical analysis its transformation from Ancient Greece to neoliberal state formation, as Lemke (2007, p. 44) notes.

[6] Miller and Rose explain that, they use the term "technologies to suggest a particular approach to the analysis of the activity of ruling, one which pays great attention to the actual mechanisms through which authorities of various sorts have sought to shape, normalize and instrumentalize the conduct, thought, decisions and aspirations of others in order to achieve the objectives they consider desirable"(Miller and Rose, 2008, p. 32).

Foucault develops the analytics of government through the translation of discourses into lived experiences on the basis of a typology of power relations. His prominent studies, namely *Discipline and Punish* (1995) and *the History of Sexuality (1978),* are the examples of the ways that he conceived different dimensions of technologies of power, such as discipline, biopolitics and technologies of self (see Chapter 2 for detailed examination of these concepts). As Lemke (2007, p. 49) notes, these different dimensions provide an analytical lens to dissect how processes of surveillance of bodies (discipline), regulation of population (biopolitics) and self-guidance (technologies of self) are complexly intertwined. In this way, it helps us understand complexities of subject formation in these processes. However, Miller and Rose (2008, p. 33) suggests:

> This should not be understood simply as a matter of the 'implementation' of ideal schemes in the real, still less as the extension of control from the seat of power into the minutiae of existence. By drawing attention to the technological dimension of government, we do not mean to summon up an image of a 'totally administered society' (Miller and Rose, 2008, p. 33).

Foucault's way of analyzing governmentality does not simply schematize power relations through mechanistic determinism. Instead, he regards these processes as the structuring field of possible actions in diverse domains of social life including family relations, consumption choices, bodily practices, dietary habits, etc. As Trent H. Hamann (2009, p. 55) notes, governmentality is not a direct exercise of power over individuals forcefully obliging them to practice in specific ways. It is rather an exercise of power setting the milieu for people freely conducting themselves.

Today, the question of governmentality attracted a great deal of interest beyond the circle of Foucault's direct associates. Especially with the publication of *The Foucault Effect: Studies in Governmentality* (Burchell, Gordon and Miller, 1991) a collection of articles which directed many studies in universities in Great Britain, Australia, New Zealand, the USA, and Canada, more and more use was being made of Foucault's concept of governmentality. It can be stated that most of this work used Foucault's instruments to analyze processes of contemporary social transformation.

Contemporary debates are mostly held in the light of Peter Miller, Nikolas Rose, Mitchell Dean and Thomas Lemke's works. Peter Miller and Nikolas Rose are key figures who are fundamentally interested in the 'conduct of conduct' in governmentality studies. They especially theorize neoliberal governmentality and how it affects institutional and individual behaviors, how individuals are autonomous and self-responsibilized subjects with the effect of changing political rationalities. In their view, neoliberal governmentality is a distinct political rationality having indirect mechanisms for aligning individual or institutional conduct (Miller and Rose, 2008a). Similar to that, Mitchell Dean's works (*e.g.* 1999) on governmentality have been influential for developing Foucault's conceptual sets and a theory of governmentality.

In the light of these theoretical efforts, studies in governmentality has turned out to be a popular field of study especially in 1990s and 2000s. What makes this field of study quite popular in diverse disciplines are widely debated in many studies. According to Dean:

> The study of governmentality can be placed among myriad forms of analysis that have arisen uncertain present. This present is marked three major phenomena: the long term recession of form of economic liberalism in liberal democracies; the collapse of early existing socialism, often with catastrophic and tragic consequences in eastern Europe; and the erosion of the claims of the liberal constitutional state by movements for indigenous rights and cultural recognition and by the exposure of its colonial legacy (Dean, 1999, p. 2).

In addition, Lemke answers that question as follows:

> This boom in studies of governmentality occurred for theoretical as well as political reasons. … Economist modes of explanation that relied on a dogmatic model of base and superstructure, and functionalist concepts of ideology as "false consciousness," have lost a great deal of theoretical credibility since the early 1980s. While some scholars tried to combine Marxist concepts with poststructuralist theory, others regarded their interest in cultural forms, subjectivity, and discursive processes as an expression of a "post-Marxist" orientation (Rose et al. 2006: 85–89). But the growing reception of the concept of governmentality did not only evolve on a purely theoretical level, it was also linked to a changing political context. In the 1980s and 1990s Fordist and welfarist modes of government in many countries were increasingly replaced by neo-liberal programs and market-driven solutions. These radical transformations called for new theoretical instruments and analytical tools to account for the social and political ruptures (Lemke, 2012, p. 78).

These accounts suggest a need for a renewal of conceptual tools for understanding and criticizing the neoliberal phenomena in contemporary society. The rise of governmentality studies is deemed to be a response to these requirements. This theoretical model could be understood as a response and alternative to conceptions of power and government in neoliberal times.

3.3. Neoliberal Governmentality for Analyzing Our Modern Subjectivities

Given that the perspective of governmentality is widely used to understand neoliberalism, this section aims at understanding diverse definitions of neoliberalism, how neoliberal rationality constructs subjectivities and technologies of neoliberal governmentalization.

The concept of neoliberalism denotes many different contexts. The most common conceptualization of the concept addresses the shift in the political-economic sphere from welfarism towards a new political and economic agenda which favors the operation of the market. According to this perspective, throughout history, the capitalist system has been transformed through very stages regarding world politics and economics. The years 1978–80 was defined as revolutionary turning-point in the world's social and economic history, when there had been significant restructuring of the state-market relationship and also in financial and labour markets of many countries.

In the 1970s with respect to the regime of capital accumulation and the form of articulation of the national economies with the world economy, there had been a significant change in the role of the state. The era as the "golden age of welfare capitalism" had many important distinctive features which were full employment, social protection and universal access to health and education. When there had been a deep economic crisis at the end of the 1970s, the state's associated mode of regulation had been insufficient to overcome the economic problems of the crisis. The new regime of economic and social reproduction has been necessary for all the countries who experienced the golden age of welfare capitalism. Beginning with Chile the

neoliberal transformation had already started. As David Harvey (2005) argues that in 1970s group of economists in Chile known as Chicago Boys played a key role in the emergence of neoliberal transformation than at the end of 1970s the striking rise of new era occurred in the advanced capitalist world as the rise of Power of Thatcher in Britain and Reagan in the United States (Harvey, 2005, p. 9).

According to Harvey's definition, the 'neo-liberalism" can be understood as new forms of political-economic governance premised on the extension of market relationships.

David Harvey formulation of neo-liberalism depends on the theory of political economic practices "can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets and free trade" (2005, p. 2). For him, neoliberals suggests that:

> State interventions in markets must be kept to a bare minimum because the state cannot possibly possess enough information to second-guess market signals and because powerful interests will inevitably distort and bias state interventions (particularly in democracies) for their own benefit (2005, p. 23).

Actually, without mentioning the cries of capitalism in the 1970, neoliberal transformation in economy and policy would not be understood. Neoliberalism was seen as a response of the over-accumulation crisis of capitalism in the 1970s when the "structural coherence" of the Golden age entered a period of crisis. Harvey briefly explains this crisis as:

> Toward the end of 1960 global capitalism was falling into disarray. A significant recession occurred in early 1973- the first since the great slump of the 1930s.The oil embargo and oil price hike that followed later year in the wake of the Arab –Israel war exacerbated critical problems. The embedded capitalism pf postwar period with its heavy emphasis on uneasy compact between capital and labor brokered by an interventionist state that paid great attention to the social (ie. Welfare programs) and individual wage was no longer working (Harvey, 2005, p. 27).

But as England and Ward consider that it is very hard to select any single definition for the concept since there are many ways to refer to a whole range of things,

outcomes, and processes (2011, p. 11). By this way, England and Ward suggest four distinct ways of understanding neoliberalism. First, neoliberalism is understood as a hegemonic ideology, clearly dominant group of people produce and circulate their programs of ideas and images of the world and they also decide about its problems and solution. Secondly; neoliberalism as policy and program which refers the transferring in the ownership structure from the public to the private sector the context to which the policy. There are many elements for understanding neoliberals as a policy which are; the context (which the policy is a response), the logic underpinning the policy, the agencies and institutions involved in the doing and evaluation of policy, and the intended audiences for the policy.

Thirdly, neoliberalism as state form which refers to the quantitative and qualitative restructuring of nation-states, involving redrawing the boundary between civil society, market, and state. Lastly; Neoliberalism as governmentality: This understanding argues that autonomous, self-responsibilized ‘‘neo-liberal subjects’’ constructed in the alliance of state and economy (Rose, 1996). By referring Nikolas Rose, England and Ward point out that:

> Through privatization and personalization, neoliberal govern(mentality) aims at transforming recipients of welfare and social insurance into entrepreneurial subjects, who may be motivated to become responsible for themselves (Rose, 1996, p. 13, cited in England and Ward, 2011, p. 13).

Having drawn upon England and Ward’s (2011) arguments, the concept of neoliberalism addresses many different dynamics and it is clear that different understandings of neoliberalism also depend on contesting theoretical debates. Viewing through this lens, below I present main lines of arguments in Foucauldian conception of neoliberalism.

3.4. Foucault’s Neoliberalism

In, 1978-79 lectures, Foucault argues that liberalism should be analyzed as a historical form of biopolitical governmentality and “principle and method of the rationalization of the exercise of government” (Foucault, 2008a, p. 318). His genealogical analysis of

liberalism, paved him to analyze the two different schools of thought: German ordo-liberalism and American neo-liberalism of Chicago Schools. In the detailed analysis of historical development of neoliberal ideas Foucault states that, German ordo-liberalism was a response to Nazi Germany's fascisms and the neoliberalism of Chicago School was dealing with Keynesianism. Their intellectual traditions differed especially in terms of state's role in the nature of economy and freedom. Ordo liberals identified the state as a key institution to facilitate competition, but for Chicago School the development of theory depends on human capital (Brown, 2015, pp. 59-60).

As Hamman (2009, p. 41) points out that, for Foucault "both forms of neoliberalism were conceived from the very beginning as interventionist and critical responses to specific forms of governmentality." For him what affected Foucault on American neoliberals is also its difference from German Ordo-liberals was that "their unprecedented expansion of the economic enterprise form to the entire social realm" (2009, p. 41).

In this point, it will be helpful to mention about the theory of the 'human capital' which Foucault uses as an example for concrete analysis of the neoliberalism. As Lemke examines that theory of human capital emerges with the critique of the problem of definition of the labour within economic theory and differently from the former ones, "the neo-liberals adopt the subjective vantage point of the person doing the work" (Lemke, 2001, p. 199).

> For a wage labourer the wage is by no means the price for selling his/her labour power, but instead represents an income from a special type of capital. This capital is not capital like other forms, for the ability, skill and knowledge cannot be separated from the person who possesses them. This 'human capital' is made up of two components: an inborn physical-genetic predisposition and the entirety of skills that have been acquired as the result of 'investments' in the corresponding stimuli: nutrition, education, training and also love, affection, etc. (Lemke, 2001, p. 199).

What is significant in this model is that, it opens a way for new forms of subjectivation especially related with the relations of the subject with him/herselves or in Foucauldian conceptualization this new type of human capital lead us to understand

the neoliberal forms of technologies of self. Because with this new capital rather than being employees dependent on company and

> labourers become an "autonomous entrepreneurs with full responsibility for their own investment decisions and endeavouring to produce surplus value; they are the entrepreneurs of themselves" (Lecture 14, March 1979, cited in Lemke, 2001, pp. 197-198).

By the neoliberal reason, the essence of the market has transformed from exchange to the competition which also changed all the actors of markets , the owners, workers, and consumers of the old system has become as little capitals competing with each other's (Brown, 2015, p. 36). The aim of all these little capitals are:

> whether studying, interning, working, planning retirement, or reinventing itself in a new life, is to entrepreneurialize its endeavors, appreciate its value, and increase its rating or ranking. In this, it mirrors the mandate for contemporary firms, countries, academic departments or journals, universities, media or websites: entrepreneurialize, enhance competitive positioning and value, maximize ratings or rankings….This figure of the human as an ensemble of entrepreneurial and investment capital is evident on every college and job application, every package of study strategies, every internship, every new exercise and diet program (Brown, 2015, p. 36).

Moreover, while Foucault genealogically analyze the liberalism, he also examines the conditions that permit the emergence of this new version of liberalism and also the what are the differences between the new version of liberalism and the former one.

According to Foucault, social insurance models in classical-liberal rationalities has started to collapse especially since 1970s. This crisis hardly deals with capital accumulation and Fordist regulation (Lemke, 2016 p. 337). In Foucault's views, contemporary neoliberalism develops three types of response to this crisis of capitalism:

> The first is that from the economic point of view neo-liberalism is no more than the reactivation of old, second hand economic theories. The second is that from the sociological point of view it is just a way of establishing strictly market relations in society. And finally, the third response is that from a political point of view neo-liberalism is no more than a cover for a generalized administrative intervention by the state which is all the m ore profound for being insidious and hidden beneath the appearances of a neo-liberalism (Foucault, 2008a, p. 130).

Moreover, Thomas Lemke states that, for Foucault there are two points which differ neoliberalism and liberalism as re-definition of the relation between the state and the economy and the basis of government. Firstly, rather than a liberal understanding of absolute power of state for neo-liberals, "state does not define and monitor market freedom, for the market is itself the organizing and regulative principle underlying the state" (Lemke, 2001, p. 200).

The second point which differs neoliberalism and liberalism in the Foucault's account for Lemke is on the basis of government, differently from homo oeconomicus of liberal thinker. The economic individual of neoliberals rationally calculates the cost and benefits. The "neo-liberalism admittedly ties the rationality of the government to the rational action of individuals; however , its point of reference is no longer some pre-given human nature, but artificially created form of behavior" (Lemke, 2001, p. 200).

Following the Foucault's own definition, Brown argues that the radicalism of Foucault's scholarly intervention for understanding the political debates especially the ones in neoliberal era, is based on his understanding of*:*

> Neoliberalism is not about the state leaving the economy alone. Rather, neoliberalism activates the state on behalf of the economy, not to undertake economic functions or to intervene in economic effects, but rather to facilitate economic competition and growth and to economize the social, or, as Foucault puts it, to regulate society by the market (Brown, 2015, p. 62).

Clearly Foucault identifies the concept as:

> Neoliberalism is not Adam Smith; neoliberalism is not market society, but "the problem of neoliberalism is rather how the overall exercise of political power can be modeled on the principles of the market economy… in order to carry out this operation that is to say to discover how far and what extends formal principles of market economy can index the general art of the government (Foucault, 2008, p. 131).

Two dimension of the exercise of rule identified by Foucault first that of political rationality and secondly that political invention or the art of government. Here, following Foucault, neoliberalism will be examined neoliberalism as a political rationality.

3.5. Neoliberalism as a Political Rationality

Following the Foucault and many governmental studies scholars, it can be argued that neoliberalism may best defined as representing a distinctive political rationality. Since the notion of a political rationality provides a useful way of understanding how a number of contemporary governmental practice managed to both governing the society and governing the self by the discursive and normative techniques and strategies. The concept of political rationality for Dean is:

> the relatively systematic explicit discourse, problematization and codification of the art of practice of government as a way of rendering the objects of government in a language that makes them governable (Dean 1994, p. 187)

> Political rationality may generally codify and assemble particular technologies within various programmes but the technologies themselves are a condition for that rationality and have forms of rationality inscribed within them (Dean, 1994, p. 188).

According to Rose (1996, p.42) political rationalities have a moral form in so far as they concern such issues as proper distribution of tasks between different authorities and the ideals or principles to which government should be addressed. He also adds that:

> Political rationalities have an epistemological character in that they embody particular conceptions of the objects to be governed-notion population, economy, society, community and the subjects to be governed-citizens, subjects and individuals (1996, p. 42).

Nikolas Rose also argues that by Foucault's account on governmentality:

> One could identify specific political rationalizations emerging in precise sites and at specific historical moments, and underpinned by coherent systems of thought, and that one could also show how different kinds of calculations, strategies and tactics were linked to each (2004, p. 24).

In this sense, Rose implies that, not only liberal forms but also many other forms of government has also the capacity to operate in accordance with certain political rationality. For him political rationalities have some common characteristics or tactics for exercise of the power as:

> (i) They have distinctive moral form that provide them to embody conceptions across the different spheres from political to pedagogic context from ideals to principles which guide the exercise of the power (ii) They are characterized by regularities (iii) They have an epistemological character (iv) They are articulated in relation to some understandings (v) They have a distinctive idiom or language (Rose, 2004, pp. 25-26).

Differently from all other forms of political rationalities for Rose, neoliberalism provide a way to link all these above mentioned tactics and integrates them in thought in the way that all these tactics attends in a coherent logic. Rose claims that:

> And once they did so, once a kind of rationality could be extracted from them, made to be translatable with them, it could be redirected towards both them and other things, which could now be thought of in the same way as for example in the various deployment of notion of entrepreneurship. And such rationalities were then embodied or came to infuse whole variety of practices assemblages for regulating economic life, medical care, and welfare benefits, professional activity so forth (Rose, 2004, p. 27).

Additionally, for Wendy Brown the notion of political rationality is critical to understand the neoliberal mode of government so she defines the neoliberalism as:

> Certainly neoliberalism more than a set of free market economic policies that dismantle welfare states and private public services in north efforts at democratic sovereignty or economic self-direction in South… Neoliberalism comprises these effects but as apolitical rationality. Political rationality is not equivalent to an ideology stemming from or masking an economic reality nor is it merely a spillover effect of the economic on the political or the social. Foucault infected the term a political rationality is a specific form of normative political reason organizing the political sphere governance practices and citizenship (Brown, 2006, p. 694).

In that regard, if we think through the lens of governmentality, neoliberalism with its constructivist and normative character operates on truth, knowledge and the norms of the society. Political ratinalities for Rose "discursive fields characterized by a shared vocabulary within which disputes can be organized, by ethical principles that can communicate with one another… by commonly accepted facts" (Rose 2004, p. 28).

In this regard for Brown there are two salient features of neoliberal political rationality, as in her own words:

> The state itself must construct and construe itself in market terms as well as develop policies and promulgate a political culture that figures citizens exhaustively as rational

> economic actors in every sphere of life…. Many privatization and out sourcing schemes for welfare education prison the police and the military but this aspect of neoliberalism also entails a host of policies that figure and produce citizens as individual entrepreneurs and consumer who moral autonomy is measured by their capacity for self-care –their ability to provide their own needs and service their own ambitions whether as welfare recipients medical patients consumer s of pharmaceuticals (Brown, 2006, p. 694).

When the neoliberalism is considered as political rationality, it is seen as a normative way of governing of the self and others in every sphere of economic, political and social life. Transformations of the operations of the state to the non-state actors by the way of supporting and promoting the privatization, individual responsibility and risk management paved the way for this political rationality to generalize the entrepreneurial model to the all society. In this regard neoliberalism. In the same vein, Lemke points out that with neoliberalism, rationality of government and rational action of individual are tied.

> By encoding the social domain as a form of the economic domain, cost-benefit calculations and market criteria can be applied to decision-making processes within the family, married life, professional life, etc. The economic individual who rationally calculates costs and benefits is quite unlike the homo oeconomicus of the eighteenth-century liberal thinkers….Now, neo-liberalism admittedly ties the rationality of the government to the rational action of individuals; however, its point of reference is no longer some pre-given human nature, but an artificially created form of behavior (Lemke, 2001, p. 200).

If the neoliberalism is understood as a distinctive political rationality, it's necessary to stress on its discursive dimension. Through the perspective of governmentality, neoliberalism is considered with its constructivist, normative character that operates on truths and the norms of the society.

3.6. Neoliberal Governmentality and Its Techniques and Strategies

> …. if the state is what it is today, it is precisely thanks to this governmentality that is at the same time both external and internal to the state, since it is the tactics of government that allow the continual definition of what should or should not fall within the state's domain, what is public and what private, what is and is no within the state's competence, and so on. So, if you like, the survival and limits of the state should be understood on the bases of the general tactics of governmentality (Foucault, 2008b, p. 145).

By formulating neoliberalism as a new mode of governmentality, which refers "the way in which one conducts the conduct of men is no more than a proposed analytical grid of for these relations of power"(Foucault, 2008a, p.186) Foucault states that the neoliberalism should be identified with permanent vigilance, activity, and intervention (Foucault, 2008a, p. 132).

The neoliberal governmentality as social fields as market, population as a heterogeneous spaces which constituted by the multiple systems of power, networks of control and also strategies of resistance (Nadesan, 2008, p. 10). It becomes a new perspective to understand the new strategies and tactics of power and the new ways of subject formulations in neoliberal era. Since the beginning of the 1990s, the rise of studies of governmentality could be read as a response to analysis of this new forms of governmentality.

Given that neoliberalism is a form of governmentality which regulates all spheres of our life, how does neoliberalism manage to diffuse all these domains? Or as Nikolas Rose asks: "how and in what ways and to what extent the rationalities devices and authorities for the government of conduct in the multitude of bedrooms, factories, shopping malls…have become linked up to a political apparatus?" (Rose, 1996, p. 38). In order to answer this question, it is worth mentioning the attention of the techniques and strategies of neoliberal governmentalization. Following the scholars of governmentality studies, I will explain the techniques and strategies of neoliberal governmentality diverse patterns.

To begin with as a logic of the neoliberal governmentality, the line between personal and political has been blurred. Therefore, the neoliberal form of power is:

> not so much a matter of imposing constraints upon citizens as of making citizens capable of bearing a kind of regulated freedom, personal autonomy is not an antithesis of political power but a key term in its exercise the more so because individuals are not merely the subjects of power but play a part of its operations (Miller and Rose, 2008a, p. 53).

According to Rose with change in the welfare state in the last fifty years, on the one hand, different critiques which problematized the public finance, private rights and individual's morals has been raised. On the other side, it has been possible to proliferate the new devices for governing conduct which rooted in the success of welfare state's expertise in many social objectives. As Rose argues that "in the multiple encounter between these two line of force a new formula of rule is taking shape one that we can perhaps term advanced liberal" (1996, p. 40). Rose suggest that advanced liberal mode of governing has three different features. Firstly in advanced liberalism there is a new relationship between expertise and politics, secondly advanced liberalism engenders a pluralization of social techniques and lastly the subject of government differently specified in advanced liberal mode of rule (1996, pp. 54-57).

In this regard for Rose and Miller (1992), in the modern forms of government, the link between sociopolitical objectives and daily experiences of people is created by forms of expertise. In this picture, expertise have double sided duties as, on the one side, with political authorities they focus on their problems and problematizing new issues; and, on the other side, they seek to form alliances with individuals for transferring their daily worries into a language claiming the truth (1992, p. 68). It is understood from their formulation that expert is considered as a significant actor in the process of conceptualizing what is healthy or what is normal in the society and in this way knowledge becomes central to the act of modern form of government (1992, p. 55). In this process of knowledge production, Rose (1996, p. 41) suggests, experts are relocated within the market so that they facilitate a competitive and accountable rationalization.

In Rose's (1996, pp. 53, 54) formulation, the second dimension is about the pluralization of social techniques. Accordingly, such techniques govern the social field through creating and maintaining a distance between ruling bodies and governed subjects through decision-making mechanisms. They implant normative schemes and patterns of calculations that serve for competition-based market rationalities; yet this

mechanisms do not imply a mode of 'totally administered society' but of "governing at a distance through the instrumentalization of regulated autonomy" (Rose, 1996, p. 57).

Viewing through this lens, I take into account media discourse as a particular mode of governing at a distance that guide people's conduct of conduct. As Rose (1996, p. 58) conceives:

> To such basic notion-forming devices as a common language skills of literacy and transportation networks, our century has added the mass media of communication with their pedagogies through documentary and soap opera, opinion polls and other devise that provide reciprocal link between authorities and subjects. The regulation of lifestyle through advertising, marketing and the world of goods and experts of subjectivity.

In line with Rose, for Lupton the mass media is also a 'less direct strategies' of governmentality in neoliberal forms of governing. In her own words:

> The strategies of governmentality, expressed in the neoliberal states that emerged in the west in late modernity, include both direct, coercive strategies to regulate populations, but also, and most importantly, less direct strategies that rely on individuals' voluntary compliance with the interests and needs of the state. These strategies are diverse and multi-centered, emerging not only from the state but also other agencies and institutions, such as the mass media (Lupton, 2005, p. 89).

Techniques of governing at a distance through media can be understood as a distinct technology that creates and circulates normative meanings between government, expertise and subject. In that regard, it can be understood as a symbolic device, echoing Lemke's (2007) conception:

> Analytic of governmentality operates with a concept of technology that includes not only material but also symbolic devices. It follows that discourses, narratives, regimes of representation are not reduced to pure semiotic propositions; instead, they are regarded as performative practice (Lemke, 2007, p. 50).

The third dimension is about specific ways of creating subjectivities in advanced liberal societies. This process conceives the construction of subject as an active, rationally calculating body through techniques mentioned above:

> A new specification of subject of government: The enhancement of the powers of the client as customer –consumer of the health services of education of training of transport specifies the subject of rule in a new way. As active individual seeking to enterprise themselves to maximize their quality of life through act of choice according to their life a meaning and value extent that it can be rationalized as the outcomes of choices made or choices to be made (Rose, 1996, p. 57).

Responsibilization of individuals as active subjects here assumes a particular mode of freedom that specifies the conduct of conduct. What is significant here is that, for Rose, through the freedom, there is a new specification of subject in advanced liberalism. According to Rose, in our recent history, there were many different formulations of freedom that political arguments from radicals of the right to conventional liberals, civil libertarians and modern European socialists each attempt "to ground the imperatives of government the self-activating capacities of free human beings, citizens, subjects" (Rose, 2004, p. 64).

Rather than understanding the freedom as a formula of resistance or as a formula of power, Rose prefers understanding the freedom in a way that it is "instantiated in government". The way that Rose suggests is,

> (To look at the freedom) as it has been articulated into norms and principles for organizing our experience of our world and of ourselves; freedom as it is realized in certain ways of exercising power over others; freedom as it has been articulated into certain rationales for practicing in relation to ourselves (Rose, 2004, p. 65).

For Rose, in advanced liberal era, there has been a new way of acting upon human beings as a subject of freedom. He examines the strategies of governing individuals through their freedom as:

> The problem of freedom now comes to be understood in terms of the capacity of an autonomous individual to establish an identity through shaping a meaningful everyday life. Freedom is seen as autonomy, the capacity to realize one's desires in one's secular life, to fulfil one's potential through one's own endeavors, to determine the course of one's own existence through acts of choice… [T]he kinds of people we take ourselves to be at particular times, in particular places and contexts, and the ways in which varying presuppositions about the nature of human beings are embodied in technologies that will enable people to be governed, and to govern themselves (Rose, 2004, p. 84).

Additionally, there are two interrelated clusters of technologies in governing through the freedom of autonomous individuals: technologies of consumption and psychological technologies. These two technologies are linked for Rose because:

> Consumption technologies have utilized psychological knowledges and techniques – attitude surveys, psychodynamics – to chart the reasons that lie behind the act of consumption for different sectors, ages, sexes, personality types, and to adjust and segment selling techniques (2004, pp. 84-85).

The technologies of consumption refer to the relations between persons and products:

> For the first time, this power of goods to shape identities was utilized in a calculated form, according to rationalities worked out and established, not by politicians, but by salesmen, market researchers, designer's and advertisers who increasingly based their calculations upon psychological conceptions of humans and their desires (Rose, 2004, p. 85).

In Rose's understanding, consumption practices are made meaningful so that specific commodities help people locate themselves in a certain form of life. Particularly through advertisements, objects are imagined as symbolically charged entities that render individuals and collectives possible to identify themselves with. In this way, consumers can be possibly transformed "into certain kinds of person living a certain kind of life" (2004, p. 86). That is to say, consumption bear the marks of a plurality of pedagogies for conducting one's own life to lead a pleasurable and respectable life. It involves a particular discourse of ethics and techniques of living a 'good' life.

Here, freedom is a key term to understand the process of identification through certain kinds of lifestyles. There lies a specific mode of conforming to norms and values through specific lifestyles choices (including marriage and diverse domestic arrangements) which are responsibilizing autonomous individuals to realize themselves and sustain their happiness and wellness.

> Through the transformation of all these institutional presuppositions, modern individuals are not merely **'**free to choose'**,** but obliged to be free, to understand and enact their lives in terms of choice. They must interpret their past and dream their future as outcomes of choices made or choices still to make. Their choices are, in their turn, seen as realizations of the attributes of the choosing person – expressions of personality –and reflect back upon the person who has made them. As these mechanisms of regulation through desire, consumption and the market – civilization

> through identification – come to extend their sway over larger and larger sectors of the population, earlier bureaucratic and governmental mechanisms of self-formation and self-regulation become less salient… (2004, p. 87).

Besides, psychological technologies provide a know-how of active individuals seeking to cultivate themselves as rational, calculating subjects. Rose (2004, p. 90) refers to specific disciplines that he conceives 'psy' knowledges, that is the significance of psychology in subject formation within advanced liberal societies. Here, he defines two interrelated routes:

> This know-how has been disseminated by two intertwined routes. The first route works through reshaping the practices of those who exercise authority over others – social workers, managers, teachers, nurses – such that they exercise their powers in order to nurture and direct these individual strivings in the most appropriate and productive fashions. Here one sees the elaboration, in a plethora of self-instruction manuals, training courses and consultancy exercises, of a new set of relational technologies that appear to give professional authority an almost therapeutic[7] character. The second route operates by what one can term the psychotherapies of normality, which promulgate new ways of planning life and approaching predicaments, and disseminate new procedures for understanding oneself and acting upon one self to overcome dissatisfactions, realize one's potential, gain happiness and achieve autonomy (Rose, 2004, p. 90).

According to Rose, governmental technologies transforms the everyday life into an object of analysis and treatment of clinical reason through psychotherapeutic techniques. Diverse life events including debt, marriage, divorce, (un)employment, reproduction become passages that needs to be conducted and adjusted through psychological techniques. Subjects under neoliberal governmentality become dependent on therapeutic techniques to play out specific skills to overcome lack of self-esteem, stress, neurosis, depression and so forth. These techniques play a fundamental role to conduct one's own life and optimize oneself to governmental rationalities.

These governmental techniques are strongly concatenated to Wendy Brown's concept of economization in neoliberal strategies of government. Brown uses the concept of

[7] Here Rose uses the "therapy in the broadest sense, as a certain rationality for rendering experience into thought in a way that makes it practicable, amenable to having things done to it"

‘economization’ to examine the transformation which is organized by neoliberal political rationality[8]. This is a process of remaking domains in economic terms which are noneconomic before. As Brown (2015, p. 31) adds that “such economization does not always involve monetization. That’s the way to think and act like contemporary market subjects even when wealth generation is not the immediate issue”.

According to Brown, today’s economic man is very different from Adam Smith’s homo oeconomicus, differently from being a merchant or trader who relentlessly pursued his own interests through exchange today’s homo oeconomicus significantly reshaped by neoliberalism as a homo oeconomicus not only in economic context but also in every sphere of its existence. For Brown neoliberalized subject’s project is self-investment in ways that enhance its value or to attract investors through putting emphasis on credit rating, and to do in every part of his life (2015, p. 32).

Accordingly, Gordon (1991) also examines the idea of ‘enterprise of oneself’ in neoliberal rationality as follow:

> The idea of one 's life as the enterprise of oneself implies that there is a sense in which one remains always continuously employed in (at least) that one enterprise, and that it is a part of the continuous business of living to make adequate provision for the preservation, reproduction and reconstruction of one 's own human capital. This is the 'care of the self' which government commends as the corrective to collective greed (1991, p. 44).

To sum up, Brown also argues that, through the discourse, neoliberalism produces rational actors, govern the truth criteria of the domains and imposes the market rationality to all spheres of life, mainly as she states, both the meaning and the nature

[8] According to Brown (2005, p. 38), some referents of neoliberalism, which reduce the concept to economic policies with inadvertent political and social consequences, fail to address the political rationality which organizes these policies and reaches beyond the market. By referring the Foucault, Brown conceives the term a political rationality as a specific form of normative political reason which organizes the political sphere, governance practices, and citizenship (Brown, 2006, p. 693). For Brown, “neoliberal political rationality is based on a certain conception of the market, its organization of governance and the social is not merely the result of leakage from the economic to other spheres but rather of the explicit imposition of a particular form of market rationality on these spheres” (2006, p. 704).

of the social and also political articulated by neoliberalism as form of political reasoning (Brown, 2005, p. 40; 2006, p. 693). That rational actor is simultaneously self-responsibilized subject who is supposed to calculate and minimize her/his own risks.

In this way of risk management, discursive boundaries between risk and safety is a fundamental element of governmental rationality. Such discourses identifies the risk and diverse ways of governing it. According to Castel, these discursive schemes imply a new mode of monitoring which aims to anticipate and prevent the emergence of some undesirable events as illness, deviant behaviors and abnormalities (Castel, 1991). It can be understood from Castel's study that, with its risk discourse, new prevention realm entails infinite multiplication of possibilities of intervention. Differently from former one, rather than addressing the subject, the new preventive policies focuses on corrections of heterogeneous elements.

> These practical implications may also have a political significance to the extent that … these new formulae for administering populations fall within the emerging framework of a plan of governability appropriate to the needs of 'advanced industrial' (or, as one prefers, to 'post-industrial' or 'post-modern') societies (Castel, 1991, p. 281).

In a similar vein, from the Foucauldian perspective of risk and governmentality, Lupton states that

> The risk may be understood as a governmental strategy of regulatory power by which populations and individuals are monitored and managed through the goals of neo-liberalism .Risk is governed via a heterogeneous network of interactive actors, institutions knowledges and practices (Lupton, 2005, p. 89).

Following Lupton, from Foucauldian perspective it can be understood there is no objective risks which are all the products of discourses, strategies, practices and institutions with relation to the political realm of advanced liberalism (Lupton, 2005). Moreover Lupton also adds that for the 'governmentality' perspective,

> risk discourses contribute to the constitution of a particular type of subject: the autonomous, self-regulating moral agent who voluntarily takes up governmental imperatives (Lupton, 2005, p. 106).

To conclude, I consider the neoliberal governmentality as an aggregate of technologies, mechanisms, procedures and calculations including expertise, pluralization of social techniques and deployment of freedom. These complex dynamics of governing incorporate diverse techniques and strategies that involve technologies of consumption, psychological technologies, risk management and economization, which intricately configure new formulae of relations between government and subjects.

3.7. Neoliberal Governmentality of Health

Since the main concern of this thesis is to analyze the impact of neoliberal discourse on the formation of healthy women subject, it would be a good starting point to provide a brief debate on meaning of neoliberalism in political economy of health care before understanding the embodiment of neoliberalism in health through the perspective of governmentality studies.

McGregor (2001, p. 84) summarizes the neoliberalism with three assumptions: Individualism, free market/ privatization and the decentralization. Firstly; individualism reflects the idea that "human beings will always try to favour themselves and, as they do this, they need have no concern for others or the environment". The concepts as public good and the community are replaced by the individual responsibility within the neoliberalism. Secondly, under the neoliberalism, all public and state-owned enterprises, especially in education and health, are deregulated and privatized to create a free market. "Social policy that targets certain groups in society (*e.g*. welfare, children, aged) is seen as preferential because not all are seen to benefit from the government intervention" (2001, p. 84). Thirdly, the decentralization is another assumption of neoliberalism for McGregor, since neoliberal system supports transferring responsibilities and accountability of central state power to provincial, individual state, or municipal and regional governments.

When it comes to health care policies and regulations in health systems, for McGregor;

> (All these assumptions are seen as) the cost cutting for efficiency, decentralizing to the local or regional levels rather than the national levels and setting health care up as a private good for sale rather than a public good paid for with tax dollars (McGregor, 2001, p. 83).

Viewing through this context, this study aims at understanding neoliberalism as a discursive domain and its complex embodiment in health sector through the lens of governmentality studies. It provides an account of constructing novel subjectivities through specific technologies under the guise of neoliberal rationality. As Gordon (1991, p. 2) states:

> A governmentality perspective is well suited to examine the various ways in which neoliberal governance of health operates at and through a diverse range of social sites. From the perspective of governmentality the notion of government refers to the conduct of conduct or more specifically to any activity aiming to shape guide or affect the conduct of some persons or to persons (Gordon, 1991, p. 2).

Considering in this way, in the light of analytical tools of governmentality studies mentioned above, construction of neoliberal subjectivities cannot be merely understood through political economic restructuring of adjustment programmes. Instead, governmentality studies help understanding the deployment of different technologies for discursively constructing subjects in the field of health. For that reason, I suggest analyzing these processes through three distinct technologies of government that has a specific influence over constitution of healthy subject by neoliberal discourse.[9] Below, I will briefly illustrate the manifestations of neoliberal discourse in the field of health in terms of medicalization, commodification of health and individualization of health and as the facets of neoliberal governmentality.

[9] In this point, it is important to state that, in their study, in order to analyze the health discourse of health professionals in Turkey, İnceoğlu, Y.et al, (2014) also use the same three themes with this thesis, namely; medicalization, individualization and commodification of health. With its themes and its perspective of neoliberal governmentality, the study of İnceoğlu, Y. et al, has become guiding source for his study.

3.7.1. Medicalization as Neoliberal Governmentality

Although medicalization is not a new term but dates back to 70s' debates[10], this term informs a new epoch of regulation of everyday life through medical reason, particularly by means of neoliberal governmentality. Actually, Foucault does not focused on medicalization rather he mentions in his few works. However, Foucauldian overall approach to medicine has a strong relation with the social constructionist approach focusing on the medicalization thesis.

On the medicalization of the family, childhood individuals, Foucault (1984f) mentions about how changing approach to childhood leads to a focus on the family, which makes being healthy and consulting the medical profession a responsibility:

The family is assigned a linking role between general objectives regarding the good health of the social body and individuals' desire or need for care. This enables a "private" ethic of good health as the reciprocal duty of parents and children to be articulated onto a collective system of hygiene and scientific technique of cure made available to individual and family demand by a professional corps of doctors, qualified and, as it were, recommended by the state (Foucault, 1984f, p. 281).

Now, I will provide a brief definition of medicalization. As Ivan Illich (1976) argues that modern medicine was both physically and socially harms the health of the individuals, because of the professional control over medicine. From Illich's perspective; medical autonomy has become a major threat to health as a result both of the 'medicalization of life' and the development of medical iatrogenesis (negative effects of medicine on health).

In his book *Medical Nemesis* (1976), Illich argues:

> Medicine is a moral enterprise and therefore inevitably gives content to good and evil. In every society, medicine, like law and religion, defines what is normal, proper, or

[10] The early works focused on the medicalization belongs to Szasz (1970) and Illich (1976), Freidson (1970) and Zola (1972).

> desirable. Medicine has the authority to label one man's complaint a legitimate illness, to declare a second man sick though he himself does not complain, and to refuse a third social recognition of his pain, his disability, and even his death (1976, p. 45).

Here, Illich also challenges the pharmaceutical invasion as a process of medicalization of life, for him there is no need to doctors to medicalize a society's drug since each culture has its remedies. For Illich, these cultural remedies are destroyed by powerful medical drugs and this pave the way to perceive the 'body as machine' run by mechanical and manipulating switches (1976, p. 63).

As Peter Conrad clearly argues that "medicalization describes a process by which nonmedical problems become defined as medical problems, usually in terms of illness and disorders" (2007, p. 4). In his article on *Medicalization and Social Control*, he points out that medicalization as social control occurs in three levels. Namely: (1) at a conceptual level: medical vocabulary or model is used to "organize" or define the problem, (2) at the institutional level: organizations may adopt a medical approach to treating a particular problem, in which the organization specializes, (3) at the interactional level, physicians are most directly involved (Conrad, 1992, p. 211).

From that point Irving Kenneth Zola's critique of medicine gains significance, especially on the concept of medicalization. Zola (1972) perceives medicine as a major institution of social control. For him, by taking the place of religion and law as a 'repository of truth' medicine becomes repository of truths. Zola states that, "Today, we make judgments not in the name of virtue or legitimacy, but in the name of health" (Zola, 1972, p. 487). For him medicalization of society is a process that categorized in four concrete ways. First, through the expansion of what in life is deemed relevant to the good practice of medicine. The second process is through the retention of absolute control over certain technical procedures. The third is through the retention of near absolute access to certain "taboo" areas. Lastly, through the expansion of what in medicine is deemed relevant to the good practice life (1972, pp. 492-497).

At this point Conrad asks the question of: "What type of conditions and problems get medicalized?" He answers with a list of Davis (2010) which is also depend on Conrad

(1992). According to this list there are four different kinds of problems that have been medicalized as:

> (i) Deviant behaviors such as attention deficit hyperactivity disorder (ADHD), alcoholism, and addictions of various sorts, mental illness, eating disorders, and such. (ii) "Natural life events" such as childbirth, menstruation, menopause and andropause, aspects of aging such as baldness, and even death and dying.(3) "Problems in everyday living" such as anxiety, normal sadness, erectile dysfunction, lack of libido, shyness, bad temper, overweight, difficulty becoming pregnant, and the like (Conrad, 2013, p. 197).

As it is clearly understood from the above mentioned list, the childbirth, menstruation, menopause as women's natural life events have been disproportionally medicalized. There are many medicalization studies especially by feminist scholars have shown that reproduction and birth control, childbirth, infertility, premenstrual syndrome, fetal alcohol syndrome, eating disorders, sexuality, menopause, cosmetic surgery, anxiety, and depression as women's life experiences have become the major subject of medicine (Conrad, 2013).

In this regards, Lupton mentions about the women's position in medical discourse which is "the 'sick' or incomplete version of men: as weaker, unstable, the source of infection, impure, the carriers of venereal disease or the source of psychological damage to their children" (Ehrenreich and English, 1974, p. 6, cited in Lupton, 2003, p. 144). To quote from her:

> On the one hand, the capability of women to bear and breast-feed children and the changes in their bodies associated with menstruation, pregnancy and menopause have been valorized as constitutive of femininity, as evidence of women's specialness and power, as experiences to be enjoyed and welcomed as essential to femininity. On the other hand, concern about the ways in which such phenomena have historically been defined by patriarchy as the basis for women's inferiority and their exclusion from the public and economic spheres has led some feminist writers to deny women's embodiment, to seek to reduce differences between the sexes and to view women's physical experiences as purely social constructions constituted by medical and scientific discourses (Lupton, 2003, p. 142).

Today, there are a lot of disease categories found in our daily life conversation to define some feelings or conditions like; hyper- activity, claustrophobia, anxiety, bipolar disorder which are mostly psychosomatic illnesses. As Bozok puts "the over-

medicalization of our everyday lives shows that, in the age of postmodern medicine the borders of normal and pathological is resetting" (Canguilhem, 1991 cited in Bozok, 2015, p. 75).

Moreover, for Zola and Crawford, the healthism is the product of medicalization process. In his work *Healthism and Disabling Medicalization,* Zola (1977) considers that that number of social functions are addressed by the medicine because of the cultural understanding of fixing the issues by relying on technical expertise. Zola suggests that "health itself became not merely the means to some larger end but the end in itself, no longer is one of the essential pillars of the good life but the very definition of what the good life" (Zola, 1977, p. 51).

In line with Zola for Crawford (1980) contemporary societies are characterized by 'healthism' which is "a form of medicalization" (1980, p. 381). The health for Crawford "focus for the definition and the achievement of well-being; a goals which is to be attained primarily though the modification of life styles, with or without therapeutic help" (Crawford, 1980, p. 368).

Although healthism is regarded as the product or the form of medicalization, Mauro Turrini's (2015) definition may help us to understand healthism as a form of medicalization in neoliberalism, as Turrini suggests:

A sort of medicalization without doctors, healthism may be defined as the analysis of a set of attitudes, behaviours, and emotions that result from the elevation of health to a pan-value and committed to a more active engagement of patients in the process of healthcare (2015, pp. 17-18).

In this regard, we may reconsider Rose's (1999, p. 90) conceptualization of psychological technologies as a part of techniques of neoliberal governmentality (see previous section). The significance of life events involving marriage, giving birth, divorce, employment, etc. as problematic stages to be governed within therapeutic cultures can be understood as an extension of medicalization in everyday life. Here

‘psy’ sciences play a fundamental role in identifying these issues as psychological states to be medicalized and governed via psychological expertise.

Moreover, it can be argued that the ‘healthism’ as a form or the different version of medicalization also refers the lifestyle modification. The healthy lifestyle is the concern of contemporary public health promotion because for the new public health, individuals have the role in in advancing ‘the public’s’ health by choosing healthy lifestyle as healthy dietary, exercising and preventive testing etc. (Petersen and Lupton, 1996).

3.7.2. Commodification of Health as Neoliberal Governmentality

Starting with the late 1970s, health care systems have been the major target of neoliberal reforms, since the amount of expenditures and the volume of workforce employed has become problematic for the new system. These reforms have been presented as aiming to reduce cost, improve the quality and increase the throughput of the patient.

The neoliberal restructuring in public policy should be seen in “the shift from ‘welfares’ to ‘neo-liberal’ politics in health care” (Henderson and Petersen, 2004, p. 2). According to Harvey (2007, p. 369) “the corporatization, commodification, and privatization of hitherto public assets have been signal features of the neoliberal project”. Following Harvey, it can be argued that all three phases have been seen in the field of health. Namely; especially by 1990’s when the emphasis on a “health crisis” became dominant worldwide, with the health care system, the health has been also corporatized, privatized and commodified.

In explaining neoliberal transformation in health field, Nikolas Rose and Peter Miller (1992, p. 189) suggested that those ‘‘aspects of government that welfare constructed as political responsibilities are, as far as possible, to be transformed into commodified forms and regulated according to market principles’’. These dynamics are also manifested in neoliberalization of health care in ways that redefines health as a commodity and patients as consumers. At a macro scale the neoliberalism can be seen

as set of governmental reforms for the dissolution of the welfare for cutting public spending, and promoting private investment and competition. This transformation can be understood as a marketization of health care, as illustrated below:

> Marketization can broadly be defined as the introduction or strengthening of market incentives and structures in the healthcare sector. Marketization is closely related to another trend, namely commodification, which can be defined as the extent to which a country's provision of healthcare services relies on the market and prices are determined by markets. The implications of marketization are clearly observed for the citizens whose access to these services becomes increasingly dependent on their market position (Ağartan, 2012, pp. 458-459).

In this neoliberal transformation of health policies, there lies a dramatic change in the role of the states; that is to say, state's role has transformed from a service provider into controller and regulator of health services. These transformations also shifts existing power structures into an aggregates of specific dynamics, involving Foucauldian terms such as surveillance and biopolitics:

> Efforts to rationalize healthcare costs produce wide network of surveillance, responsibilized individuals and targeted governance of risky persons whose unhealthy threatens national vitality .Simultaneously the neoliberal imagination constitutes health related biotechnology as a vital space for market capitalization and strategy for national competitives generating resistance from leftist and socially biopolitic authorities (Nadesan, 2008, p. 94).

From the perspective of governmentality, it can be argued that; the neoliberal discourse constructed the new form of subjectivity who perceive the health as a something to consume rather than the social right, who is self-responsible for his/ her health, therefore he/she is also free to choice from various alternatives in health market, ranging from the healthiest food to eat, the best hospital to go, the most successful doctor to be treated.

As it is conceptualized above, construction of self-responsibilized subjects to optimize one's health status assumes an active, rationally calculating subject in its relations with health experts. This is a particularly neoliberal mode of relation between neoliberal subjects and experts within governmentality networks.

Here, Wyatt, Harris and Wathen consider how self-responsibility and commodification of health interrelated each other under idea of the empowerment of the patients. In their own words:

> Empowerment' and 'consumerism' are two of the central concepts embedded in the narrative of personal responsibility. Providing health information, especially via the internet, through e-health initiatives such as government-financed health web portals, is expected to 'empower' members of the lay public (often described as consumers) not only to participate more actively in their own care, but also to take more responsibility for their health-related decisions (even those as significant as selecting treatment options). Information delivered via health promotion programmes is also expected to result in behavior changes, specifically, the adoption of 'healthier lifestyles', including improved dietary habits and avoidance of risky activities, such as smoking and excessive sun tanning, that are intended to improve public health and reduce health care costs. Other examples of strategies intended to empower health system consumers include training patients to ask their doctors more questions, teaching patients to 'self-manage' chronic illnesses, providing family members with results of genetic testing for heritable health conditions and encouraging the home use of self-monitoring equipment (Oudshoorn, 2008, cited in Harris et al., 2010, p. 2).

Reconsidering the technologies of consumption as it is discussed in previous section, the prevalence of commodified health offers a diversity of possible actions for individuals' free choices. In this reformulation, health-seeking subject is responbilized to have an active relation with experts so that to govern their own everyday life, enterprise themselves and to sustain their healthiness. In this way, health status becomes an integral part of individuals' human capital that is sought to be economized within neoliberal governmentality. Miller and Rose (2008) identify this particular relation as a reconceptualization of one's self in diverse discursive settings:

> In a whole range of sectors individuals came to reconceptualize themselves in terms of their own will to be healthy to enjoy a maximized normality surrounded by images of health and happiness in mass media and marketing strategies deployed in commodity advertising consumption regimes narrativizing their dissatisfactions in the patient language of rights they organized themselves into their own associations contesting the power of expertise protesting against relations that new appeared patronizing and meaning of their autonomy ..Claiming and say in the decision that affected their lives (Miller and Rose, 2008, p. 211).

This is a particular mode of health provision that generates various settings for health-seeking technologies of self. Nadesan (2008, p. 111) addresses particular ways of targeting consumers through specific products and services:

> In addition to being targeted by corporate sponsored wellness programs more prosperous consumers are targeted by an ever expanding range of markets agents offering products and techniques for maximizing health ranging from organic and vitamins training (Nadesan, 2008, p. 111).

To sum up, transformation of health sector into consumer-oriented regime redefines health and healthy body to be purchased in the market. This transformation rearticulates health as a commodity rather than a social right; and citizens become consumers actively seeking to optimize their health status. In this transformation, experts' role is particularly important as they are the agents of guiding individuals to inform about norms of acquiring and maintaining healthy lifestyles. Besides, marketization of health care also relocates the individual as subject freely choosing healthy lifestyles.

3.7.3. Individualization of Health as a Neoliberal Governmentality

Another dimension of neoliberal government of health is remaking individuals as new subjectivation in terms of enterprising self, agency, responsibility for her/his own health. In this novel subjectivation, individuals are responsibilized to gain knowledge about one's risks and govern these risks.

This transformation leads to a reformulation of medicine as 'surveillance medicine' in the new late twentieth century, as Armstrong (1995) suggests. Accordingly, 'surveillance medicine' re-ordered the conceptual and practical field of clinical medicine and public health. For him with the 'surveillance medicine' the medical vision extends from scrutiny of strict anatomy of the body to multidimensional space and this shift in medical perception paves the way for the emergence of new risk factors in the society. Thanks to the new exploratory techniques, there has been a parallel shift in the conceptual organization of illness as the relationship between symptoms. Sign and illness were reconfigured, new medical vision subsumed all these signs and symptoms under a more general category of predictive factor that pointed to and did not necessarily produce, some future illness. For him such contingency was expressed by the concept of risk (Armstrong, 1995, p. 403). Clearly, symptoms and

signs could be re –read as risk factors by extended vision of surveillance medicine. As Armstrong adds that:

> Moreover, whereas symptoms, signs and diseases were located in the body, the risk factor encompassed any state or event from which a probability of illness could be calculated. This meant that Surveillance Medicine also addressed an extra-corporal space – often represented by the notion of 'lifestyle' – to identify the precursors of future illness. Lack of exercise and a high fat diet could be joined with angina, high blood cholesterol and diabetes as risk factors for heart disease. Symptoms, signs, illnesses, and health behaviors simply became indicators for yet other symptoms, signs, illnesses and health behaviors (Armstrong, 1995, pp. 400-401).

According to Armstrong, surveillance medicine entails to the shift from binary problem of health and disease to the more generalized population problem of symptom and illness in medical perception. However, individual attitudes, beliefs, behaviors more generally his or her life style as an indicator of new symptoms have become preoccupation of health care rhetoric.

Another important case for Foucauldian scholars is the health promotion strategies of what Petersen (1997) calls 'new public health'. They emphasize the regulatory effects of risk and prevention by the strategies of health promotion in modern societies. For Petersen, health risk discourse focuses on internalizing risk in the consciousness of individuals and force them to be active in maintaining their health. Petersen states that "an emphasis on self-management of risk and self-care has become increasingly evident in the health promotion strategies of governments as well as in the economic rationales of private companies" (Petersen, 1997, p. 197). Petersen also adds that:

> Individuals whose conduct is deemed contrary to the pursuit of a 'risk-free' existence are likely to be seen, and to see themselves, as lacking self-control, and as therefore not fulfilling their duties as fully autonomous, responsible citizens(1997, p. 198).

In line with Petersen, Armstrong (2002) also states that the new public health medicine discovered the new dangers which represent a contamination of nature by human interaction/production. These risk factors are everywhere, unavoidable and unseen:

> (As like) noxious gases from car exhausts; chemicals from aerosols attacking the ozone layer; acid rain from industry in the water and pollution in the soil; radiation from power stations, X-rays and work environments; electromagnetic fields from

> power cables, additives and harmful processing in food; 'unnatural' animal husbandry, genetic manipulation of 'natural' foods (Armstrong, 2002, p. 114).

What can people do to challenge these new risks factors? For Armstrong, no simple strategies as sanitary regime or interpersonal regime is enough for the guard against these new risk factors. Hence, the only solution that health promotion strategies suggest is the behavior both personal and collective. From personal perspective, health promotion strategies are expected people to achieve a healthy 'lifestyle and as a collective behavior people are also expected to improve their ecological awareness and getting more politically active to promote 'environmentally-friendly' policies. Armstrong concludes that:

> The new public health was concerned with generating, monitoring and maintaining this communal vigilance and ensuring that the subjective, reflexive body – or in terms of the contemporary slogan, the whole-person – was fully politicized (Armstrong, 2002, p. 115).

According to Lupton (2005) risk discourse is another important strategy of neoliberal governmentality which aims to make people active citizens who are responsible for their own health. For Lupton "risk may be understood as a governmental strategy of regulatory power by which populations and individuals are monitored and managed through the goals of neo-liberalism" (2005, p. 89). She also adds that:

> A crucial aspect of governmentality as it is expressed in neo-liberal states is that the regulation and disciplining of citizens is directed at the autonomous, self-regulated individual. Citizens are positioned in governmental discourses, therefore, as active rather than passive subjects of governance (2005, p. 89).

Including the health risk factors and subject's responsibility to manage their own relationship with health risks, Petersen and Lupton states that:

> In contemporary Western societies the health status and vulnerability of the body are central themes of existence. Individuals are expected to take responsibility for the care of their bodies and to limit their potential to harm others through taking up various preventive actions. Increasingly they are also expected, as part of their responsibilities of citizenship, to manage their own relationship to the risks of the environment, which are seen to be everywhere and in everything (Petersen and Lupton, 2000, p. ix).

For Petersen and Lupton, it is the risk assessment which provides an opportunity to what Miller and Rose mention 'governing at a distance' in advanced liberal societies, by this way the “health promoters are not clearly seen to be directly intervening, or coercing or punishing” (2000, p. 19).

On the responsibility for social risks, Lemke (2001) argues that these techniques facilitate control mission of government “without being responsible for them” (p. 201). Lemke (2001) details this strategy as follows:

> The strategy of rendering individual subjects ‘responsible’(and also collectives, such as families, associations, etc.) entails shifting the responsibility for social risks such as illness, unemployment, poverty, etc., and for life in society into the domain for which the individual is responsible and transforming it into a problem of ‘self-care’ (2001, p. 201).

Furthermore, according to Brown today’s economic man is very different from Adam Smith’s homo oeconomicus, differently from being a merchant or trader who relentlessly pursued his own interests through exchange today’s homo oeconomicus significantly reshaped by neoliberalism as a homo oeconomicus not only in economic context but also in every sphere of its existence. For Brown neoliberalized subject’s project is self-invest in ways that enhance its value or to attract investors through putting emphasis on credit rating, and to do in every part of his life (2015, p. 32).

The contemporary “economization”[11] of subjects by neoliberal rationality is distinctive in at least three ways: (1) the subject is everywhere homo oeconomicus and only homo oeconomicus (2) neoliberal homo oeconomicus takes its shape as human capital seeking to strengthen its competitive positioning and appreciate its value, rather than as a figure of exchange or interest (3) the specific model for human capital and its spheres of activity is , not only productive or entrepreneurial capital but increasing financial or investment capital (2015, p. 33).

[11] For the concept of economization see the Çalışkan, K. & Callon, M. (2009). Economization, part 1: Shifting attention from the economy towardsprocesses of economization. Economy and Society, 38(3), 369-98.

Additionally, Rose indicates that the new pluralization of social techniques of advanced liberal government which aims to implement particular modes of calculations on the agents, mainly focus on the replacement of certain norms which are service and dedication by others as the competition, quality and customer demand (Rose, 1996, p. 57).

According to Rose, specification of subject of rule has shifted in a new way in which: “As active individuals seeking to enterprise themselves to maximize their quality of life through act of choice, according their life a meaning and value to the extent that it can be rationalized as the outcome of choices made or choices to make” (Rose, 1992, cited in Rose, 1996, p. 67). Here Rose emphasizes the double meaning of the word enterprise; firstly it can be understood as “a kind of organizational form - individual units competing with one another on the market” secondly it “provides an image of a mode of activity to be encouraged in a multitude of arenas of life” (Rose, 1998, p. 154).

Hence the vocabulary of enterprise links political rhetoric and regulatory programmes to the 'self-steering' capacities of subjects themselves. Enterprise here designates an array of rules for the conduct of one’s everyday existence: energy, initiative, ambition, calculation and personal responsibility. The enterprising self will make a venture of its life, project itself a future and seek to shape itself in order to become that which it wishes to be. The enterprising self, is thus a calculating self, a self that calculates about itself and that works upon itself in order to better itself. Enterprise, that is to say, designates a form of rule that is intrinsically 'ethical': good government is to be grounded in the ways in which persons govern themselves (Rose, 1998, p. 155).

Accordingly, Gordon (1991) also examines the idea of ‘enterprise of oneself’ in neoliberal rationality as follow:

> The idea of one 's life as the enterprise of oneself implies that there is a sense in which one remains always continuously employed in (at least) that one enterprise, and that it is a part of the continuous business of living to make adequate provision for the preservation, reproduction and reconstruction of one 's own human capital. This is the

> 'care of the self' which government commends as the corrective to collective greed (1991, p. 44).

Regarding the health issue, it can be argued here that, the life as continuous business of living and 'being enterprise of one self' in this business necessities being calculating self in order to better health of self. By the surveillance medicine, self-management of health risks, neoliberal governmentalization of health makes people responsible for their own health.

3.8. Who Is The Healthy Woman For Neoliberal Subject?

In the light of aforementioned discussions, it can be argued that neoliberalism as a form of governmentality constitutes particular rationality and through its strategies of governing, it also constructs the new subjectivities. In this subsection, in order to understand the construction of healthy woman by neoliberal governmentality, firstly I will try to identify some characteristic of the subjectivation promoted by neoliberal rationality, or in Brown's (2015) words I will try to answer the question of who is the subject that neoliberalism interpellates? To begin with, Ferguson (2010) defines the position of the subject formulated by neoliberalism as follows:

> Neoliberalism … puts governmental mechanisms developed in the private sphere to work within the state itself, so that even core functions of the state are either subcontracted out to private providers or run (as the saying has it) "like a business"…. Rather than shifting the line between state and market, then, neoliberalism in this account involved the deployment of new, market-based techniques of government within the terrain of the state itself. At the same time, new constructions of "active" and "responsible" citizens and communities are deployed to produce governmental results that do not depend on direct state intervention. The responsibilized citizens comes to operate as a miniature firm, responding to incentives, rationally assessing risks, and prudently choosing from among different courses of action (Ferguson, 2010, p.172).

As Petersen and Lupton (2000) consider:

> New specialist knowledges such as medicine, sociology and psychology, and new institutions such as prisons, schools and hospitals, were part of an expanding apparatus of control, discipline and regulation that involved micro-political processes whereby individuals were encouraged to conform to the morals of society (2000, p. 14).

Regarding neoliberal governing of health, it can be argued that the "new imperatives surrounding health are seen to reflect the emergence of new forms of citizenship and conceptions of self" (Petersen et al., 2010, p. 392).

> Governmentality-inspired work has emphasized the mundane striving for 'good' or 'perfect' health involves intensive 'work on the self' or self-governance, and despite the language of empowerment and freedom, this striving for health entails compulsion, added responsibilities to others, and often punishment and social exclusion in the case of those who fail to conform (Petersen et al., 2010, p. 392).

In the light of aforementioned section, it can be argued that the strategies of neoliberal governmentality as commodification and individualization of health, and medicalization or healthism come into being through the constitution of healthy subjects.

Viewing through all the aforementioned discussion on the constitution of the subject by neoliberal rationality I will summarize the characteristic of neoliberal subject as follows:

Neoliberal form of subject is an individual who is responsibilized citizen, who is the entrepreneur of herself and rationally assesses her own risks; who is active and free agent to make the optimum choice among an array of courses of life; who is homo oeconomicus in all fields of life; who invests in herself as an automatized individual acting upon competitive logic, whose lifestyle is reshaped by the truths and knowledge gained via expertise; and finally, whose wishes, world of thought and the even sense of him or herself are governed by the modern forms of governmental rationality. According to Petersen et al. (2010) in neoliberal societies:

> The rhetoric of empowerment, choice and self-determination dominate 'healthy living' discourse (since) 'taking responsibility' for one's own health and exercising choice is portrayed as the path to freedom' and 'fulfilment' constructs the subject whose life is under the control of medicalization and who perceive the health as him/her self-responsibility and commodity (Petersen et al., 2010, p. 394).

In order to focus on the women as the subjects of neoliberal discourse, from Foucault's conception of human capital to the Brown's enterprising self, it is significant to ask now; who is healthy women for neoliberal discourse? As Petersen and Lupton (2000,

p. 79) point out from the new public health perspective, women "are encouraged to protect their own health, not simply for their own interests but because of their responsibility to others." If so, how does the self-enterprising women become responsible for others' health?

Here, Brown's argument is important to understand the women's subjectivity in neoliberalism, she states that neo-conservatism functions as a supplement of neoliberal policy through religious discourses and practices. She argues that conservative rationalities are important supplementary to generate normative political reason that is compatible with neoliberal mechanisms. In addition to the religious norms, Brown emphasizes the family values which are also an important factor for neo-conservative reason, in order to formulate the moral subjects, although it may clash with the neoliberal aim of promoting self-interested subjects on the basis of productivity and profits.

Additionally, Rose states that neoliberal police's imposition of "traditional agencies of moral authority-church, school, public figures- whose teachings and preaching would denounce bad or inferior forms of life conduct". This could be considered as a dilemma for Rose because before the neoliberalism welfare regimes weakened these traditional ties. Rose (2004) adds: "demands for traditional agencies of moral authority threaten the very basis of the economic development of the West since the 1960" (2004, p. 185).

Although the collective responsibility and neoliberal individuality seem contradictory to the new collectivization of political subjectivity, they may be linked through the process of government through the community. That is to say, subjects become socially ordered individuals within the communal ties. As Rose states:

> The subject is addressed as a moral individual with bonds of obligation and responsibilities for conduct that are assembled in a new way – the individual in his or her community is both self-responsible and subject to certain emotional bonds of affinity to a circumscribed 'network' of other individuals (2004, p. 176).

Following the Brown and Rose, it can be concluded that, when neoliberal healthy women is considered, it is important to reveal that neoliberal forms of governing promote the family as a traditional agency and family values . In this view, family is redefined through neoliberal forms of governing as a specific form of human capital in terms of homo economicus. In Brown's (2015, p. 102) view, on the one hand side, neoliberal reason cultivates a responsibilized subject actively investing in one's own bodies, practices and conduct. On the other hand, there lies a set of family relations, values and familialist mode of life that is based on self-denial and altruism. That said, Brown deals with this tension as follows:

> When homo oeconomicus becomes normative across all spheres, and responsibilization and appreciation of human capital become the governing truth of public life, social life, work life, welfare, education, and the family, there are two possibilities for those positioned as women in the sexual division of labor that neoliberal orders continue to depend upon and reproduce. either women align their own conduct with this truth, becoming homo oeconomicus, in which case the world becomes uninhabitable, or women's activities and bearing as femina domestica remain the unavowed glue for a world whose governing principle cannot hold it together, in which case women occupy their old place as unacknowledged props and supplements to masculinist liberal subjects. As provisioners of care for others in households, neighborhoods, schools, and workplaces, women disproportionately remain the invisible infrastructure for all developing, mature, and worn-out human capital — children, adults, disabled, and elderly. Generally uncoerced, yet essential, this provision and responsibility get theoretically and ideologically tucked into what are assumed as preferences issuing naturally from sexual difference, especially from women's distinct contribution to biological reproduction. It is formulated, in short, as an effect of nature, not of power (Brown 2015, pp. 104-105).

In this way, Brown sees the responsibilization of self as a gendered process "in the context of privatizing public goods uniquely penaliz[ing] women to the extent that they remain disproportionately responsible for those who cannot be responsible for themselves" (Brown, 2015, pp. 105-106). Therefore, familialism becomes an imperative, rather than the enemy, of neoliberal political rationality.

Viewing through this lens, in order to answer the question of who the healthy women subject that neoliberalism favors is, it can first be argued that neoliberal healthy women is entrepreneur of herself; she is responsible for her own (and also her significant others') health, thus she rationally asses and manage the health risks.

Moreover, she is also health consumer of the health service providers; she is free but responsible for choosing from all different hospitals, doctor's health centers etc. Additionally, neoliberal healthy women is also homo oeconomicus while making a decision about her health behaviour so she tends to enterprise herself and to do this, she spent her time on investing in her health such as consuming healthy products.

With neoliberal governance of health, it becomes a common idea that health is something to be achieved through the health promoting and risk reducing behaviors. The information about how to improve health with individual will and effort becomes available and accessible with the mass media and health has been not only a topic of everyday conservations but also individual preoccupations (Polzer and Power, 2016). Besides, neoliberal healthy women's lifestyle is medicalized through the discourses of medical experts and the desire of being healthy becomes a main goal for her life and this goal also shaped her sense on herself. Finally, as she is responsible for all her health behaviors, neoliberal idealized women thinks that she has to know medical knowledge and seek out for it which is necessary for her healthy living.

In short, neoliberal healthy woman is responsible for remedying the disappearance of public health services historically provided by the welfare state. She is responsible for caring about children, elderly and disabled in terms of improving human capital. Their responsibility assumes familialism as a 'natural' ground that binds women morally and emotionally to this conduct of life. Thus, neoliberal healthy women is responsible for both her and her family's health.

3.9. Chapter Summary

This chapter presents the main theoretical and conceptual framework of this dissertation. In the first part of the chapter, Foucauldian perspective of governmentality is presented. This chapter argues that Foucault's governmentality opens up a space for understand the process of subject constitution in neoliberal era. Moreover, firstly Foucault's and then, the scholars' of governmentality studies conceptualization are introduced. In this part neoliberalism's capacity to operate in

accordance with certain political rationality is emphasized. Then techniques and strategies of neoliberal governmentality are presented in order to understand the neoliberal art of governing the subject.

Since this thesis tries to understand the subject constitution in the health field, neoliberal governmentality of health and its techniques and strategies are presented. After all, three techniques of neoliberal governmentality of health as; medicalization, commodification of health and individualization of health are introduced which also form the guiding categories of the analysis of this dissertation.

In the last part of the chapter, the question of who the healthy woman subject is in the neoliberal discourse is answered. Along these lines, the differences between the neoliberal conception of healthy women and Adam Smith's homo oeconomicus are introduced.

CHAPTER 4

RESEARCH METHODOLOGY

This chapter introduces the conceptualizations and research methodology of the study, including the operational definitions of the concepts, aim of the research, sampling selection, data collection and analysis methods. The details of the research process are also explained in this chapter.

4.1. Aim of the Research

This thesis aims to understand the particular experience of neoliberal art of government in Turkey by using the perspective of governmentality. Approaching neoliberalism with a governmentality perspective, helps us to reveal the systematic ties between structure and agency, subject and power, market and the state, power and knowledge. Rather than as an ideology or political-economic project, this thesis approaches neoliberalism as a political rationality, a normative reason which discursively constructs the new forms of subjectivities. From the perspective of governmentality, the relation between agent and structure is considered as the historical and contingent effects of power relations, with the tactics and strategies of governmentality.

By focusing on the neoliberal governmentality of health, this thesis attempts to answer the question of how 'the healthy woman' is constituted as a subject by the neoliberal discourse in Turkey. In this regard, three consistent processes, which constitute the main footings of neoliberal governmentality of health, are focused on. Medicalization, commodification and individualization of health are used as guiding categories to understand how neoliberal discourse constructs 'the healthy woman' subject in Turkey.

In this vein, these three strategies of neoliberal governmentality of health are used to analyze the subject constitution in the health field. Accordingly, in this dissertation, answers to the following questions will be sought: What is the role of the media in the formation of 'healthy woman' subject by the neoliberal discourse in Turkey? What kind of discursive regularities and strategies are employed in TV health programs to legitimize the neoliberal rationality concerning the health of women? What do the discourses of TV health programs say on women's health and how do they say it? Then in order to understand the subject perspective, the question of how women position themselves as healthy women subjects while acting upon the neoliberal discourse in Turkey will be answered.

Since this study draws on governmentality as an analytic tool, a specific technique to governmentality studies as "analytics of government" provides a fruitful analytic strategy. Differently, from other perspectives which aim to analyze the government, Dean claims that:

> Government concerns not only practices of government but also practices of the self. To analyze government is to analyze those practices that try to shape, sculpt, mobilize and work through the choices, desires, aspirations, needs wants and lifestyles of individuals and groups. This is a perspective, then, that seeks to connect questions of government, politics and administration to the space of bodies, lives, selves and persons (Dean, 1999, p. 20).

Following Dean, it can be argued that since the main aim of this study to understand the process of the subject constitution by neoliberal discourse, the concept of governmentality gives us a methodological perspective to understand the linkage between government, authority, politics and the formation of the subject by itself and by the others. The analytics of government investigates "the conditions under which regimes of practices come into being, are maintained and transformed" (Dean, 1999, p. 21). The most interesting point of this approach for Dean is to provide a language and framework for thinking about the linkages between the questions of government, authority, politics and the questions of identity, self and person. Regarding this study, the governmentality perspective provides us with a framework to understand different parties of the health issue, which are the construction of the neoliberal health discourse

in media contents in the media perspective, and how women achieve their subject position as healthy women of neoliberal discourse in the subject perspective.

Dean's analytics of government focuses on the question of "how?" and it has four different dimensions which are: (1) Characteristic forms of visibility of government, ways of seeing and perceiving, (2) Distinctive ways of thinking and questioning, relying on definite vocabularies, (3) Specific ways of acting, intervening and directing made up of particular types of practical rationality and techniques and technologies (4) Characteristic ways of forming subjects (Dean, 1999, p. 33).

This study aims to investigate how the healthy woman subject is constituted by the neoliberal discourse. To this end, two different mechanisms in the health network of neoliberal governmentality are analyzed as the media and the subject perspectives. By adopting Dean's perspective of analytics of government, this dissertation analyzes the constitution of the healthy woman subject by the neoliberal discourse on two levels:

- The mechanisms which put this political rationality into practice
- The constitution of subjects in the neoliberal discourse both by themselves and by others. In the neoliberal governmentality network, there are mechanisms which both directly intervene in and which indirectly govern the process.

At this point, in this study, the media is chosen as a 'governing at a distant' mechanism which regulates the subjects with its normative and informative structure (Miller and Rose, 2008a).

The above mentioned analytical framework makes it possible to understand neoliberalism as a discursive formation that creates and circulates some truths, regimes of practices and constitutes different forms of subjectivities.

4.2. Conceptual Framework of the Thesis

4.2.1. The Health

Although we all have an idea about the meaning of health, it is very difficult to provide a definition of the concept.[12] There are two main paradigms for the definition of health, which are the biomedical model and the sociological model. Bryan S.Turner (1995) also summaries the characteristics of the biomedical model as (1) a disease is regarded as the consequence of certain malfunctions of the human body (body as biochemical machine); (2) the medical model assumes that all human dysfunctions might eventually be traced to (such) specific causal mechanisms within the organism; (3) this model excludes alternative models; (4) the medical model presupposes a clear mind-body distinction where ultimately the causal agent of illness would be located in the human body. Following Turner, it can be added that with the mind and body dualism, the separation of causes of diseases as mental and somatic has become clearer in the medical model (1995, pp. 9-10).

Accordingly, with the advancement of science in general, the roots of scientific medicine as modern medicine are traced to Enlightenment. However, during the 19th and 20th century, there were many developments in the medical area which marked major changes in medicine. The development of bacteriology, the invention of penicillin and antibiotics and the pathological anatomy caused remarkable changes in both practices and understandings in medicine.

Beginning in the 1990s, the medical paradigm has been progressively questioned by many thinkers. There has been a paradigm shift in the conception of health and illness, the sociological model of health and illness emerged as an antithesis of the medical model. Differently, from the biomedical model, the sociological model argues that health, disease and illness can't be reduced to biochemical indicators since they are influenced and shaped by wider socio-economic context. Actually, the sociological

[12] On the other hand, the official definition of health by World Health Organization (WHO) has been in use since 1948. According to this definition, "health is a complete state of physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 1946).

model advocates that in order to understand the health status and illness experiences in society, the social inequalities and power relations of the society should be understood.

In this sense, Turner (1995, p. 10) indicates that: (1) the sociological model treats the concepts of medical science as products of cultural changes; (2) it denies the mind/body distinction through the development of embodiment; (3) it suggests that disease, like crime, cannot have a single causal framework; (4) according to this model, the sickness of the patient cannot be understood outside the historical, social and cultural context of the person.

In addition, Nettleton and Gustafsson (2002, p. 3) also argue that the social model espouses the idea that like all scientific knowledge, medical knowledge can never be objective and as a subject of medical practice the body itself is assumed as a social construction. What lies behind under the sociological model of health and illness is the social constructivist perspective.

This thesis defines the health from a social constructivist perspective in which truth is closely related to the power relations. Therefore the truth is seen as a product of manipulation of power relations. In terms of the definition of health, by following the social model paradigm, this thesis argues that the meaning of health is not only determined by the biological process, but as a social and cultural process with its emphasis on ‘given meanings’ by the power holders. For this thesis, the health is a social product to consider the new mode of subjectification generated by the proliferation of discourses on health under the neoliberalism.

4.2.2. The Health of the Women

What constitutes the health of women? Is it the total fertility rate, the maternal mortality rate or the prevalence of infertility that totally constitute their status of health? It is generally known that, in the medical and political fields, women’s health is defined in relation to reproductive health. The existence of gynecology as a field of

expertise in medicine and the dominance of motherhood discourse in the texts of the social policy clearly demonstrate this.

In general, in the conceptualization of the health of woman, there are two different paradigms, which are the biomedical paradigm and social paradigm. On the one hand, the "dominant biomedical conceptualization of health with its narrow disease focus, inadequately represent the health because biomedical paradigm only nominally considers the social forces and contexts that shape women's health and women's lives" (Ruzek et al., 1997, p. 12). On the other hand, the social paradigm claims that women's health is not an isolated individual and biological issue and that there are many sociological factors that affect the health status of women.

According to Annandale, the "binary sex/gender differences have not so much been supplanted as combined with diversity in late modern neo-liberal economies, which profit from chronically unstable identities." (2009, p. 8) As she puts it:

> In the 'new single system', destabilized sex/gender identities have become an indispensable condition for the cross-marketing of products and lifestyles that were once readily identified with either men or women with dubious benefits for health. It is argued that the rigid orthodoxies of the past are indeed breaking down, but they are being reconfigured in new, more complex ways, with implications for health (Annandale, 2009, p. 9).

In this study, the health of the women is not only perceived through fertility and motherhood but also a general understanding of well-being and it is suggested that the health of women cannot only be grasped from a biological perspective and it is equally constructed socially, culturally and economically.

4.2.3. Neoliberalism

According to David Harvey "neoliberalism has, in short, become hegemonic as a mode of discourse. It has pervasive effects on ways of thought to the point where it has become incorporated into the common-sense way many of us interpret, live in, and understand the world" (2007, p. 3).

This thesis operationalizes the neoliberalism by following Brown's arguments as "more than a set of free-market economy policies that dismantle welfare states", that is to say a political rationality which "involves a specific and consequential organization of the social, the subject and the state" (Brown, 2006, p. 694). Neoliberalism is a distinctive mode of reason, of the production of subjects, a "conduct of conduct" and a scheme of valuation (Brown, 2015, p. 8).

By defining neoliberalism as political rationality, the study also argues that neoliberalism is a discursive realm which produces its own truth regimes, problematizes its own aims, and defines its own normalities and models of behavior. In this thesis, the neoliberalism is accepted as a distinctive rationality and a distinctive system of behavior management and evaluation. Since it is believed that neoliberal forms of government do not only directly intervene by means of the empowered and specialized state apparatus, but also characteristically develop indirect techniques for leading and controlling individuals without being responsible for them (Lemke, 2001, p. 201). In line with all these conceptualizations, it is argued that the neoliberalism discursively constitutes its own mode of subjectivities.

4.2.4. Governmentality

As defined earlier Foucault's formulation on governmentality refers that there is a "certain mentality, that he termed governmentality, had become the common ground of all modern forms of political thought and action" (Rose et al., 2009, p. 6). In this thesis, the governmentality is operational as an analytical grid to understand the relations of power, which mediates in two different aspects: Between power and subject and also between "the technologies of domination of others and those of the self" (Foucault, 1988, p. 19).

For this study, the governmentality is also operationalized as a research perspective, which emphasizes the technological aspect of government. Here, the concept of technology means technical artifacts, strategies, and technologies of the self; it refers to both arrangements of machines, networks, recording and visualization systems, to

a many different devices through which individuals and collectives shape their behavior of each other or themselves (Bröckling, Krasmann and Lemke, 2011, pp. 11-12). The reasons for choosing governmentality as the research perspective for this thesis are firstly its discursive character; secondly its critical perspective as opposed to sovereign or state-centered notions of political power; and thirdly it enables us to understand the process of subject constitution.

As Miller and Rose (2008a, p. 30) states that the governmentality has a discursive character, to analyze the conceptualization, explanation and calculations that inhabit the governmental field requires attention to language. In this line of thought, through the governmentality perspective, the discourse becomes a technology of thought requiring attention to the particular technical devices of writing, listing, computing that render a realm into discourse as a knowable, calculable and administrable object, and knowing an object as it requires an invention of procedures of notation, ways of collecting and presentencing statistics transportation of these to centers where calculations and judgements can be made (Miller and Rose, 2008a, p. 30). They also add that through these procedures, the diverse domains of governmentality such as family, economy etc. are rendered into particular conceptual forms and made amenable to intervention and regulation (Miller and Rose, 2008, p. 30). In line with the Miller and Rose, this thesis argues that the health issue can be considered as a domain of governmentality which was rendered in particular conceptual form for making it more amenable to intervention through the discursive procedures.

4.2.5. Neoliberal Governmentality

The neoliberal governmentality is operationalized in this thesis as: A new mode of governmentality which has its own tactics, strategies and techniques. These techniques of neoliberal governmentality might be summarized as the economization of every domain of life (Brown, 2015); governing at a distance through creating new relations between expertise, politics and subject, a new polarization of social technologies (Rose, 1996); a new formulation of freedom which does not reflect the freeing of the market but "organizing all features of one's national policy to enable a market to exist,

and to provide what it needs to function" (Rose, 2004, p. 141); and producing a new rationality of risk and its techniques (Dean, 1999).

> (Differently from liberal art of government), the neoliberal forms of government featur direct intervention by means of empowered and specialized state apparatuses, but also characteristically develop indirect techniques for leading and controlling individuals without at the same time being responsible for them (Lemke, 2001, p. 201).

The operation of neoliberalism targets the desires, interests, aspirations rather than through rights and obligations. The body is not diretly marked "as a sovereign power, or even curtail actions, as disciplinary power; rather, it acts on the conditions of actions" (Read, 2009, p. 29). Here, mass media is important for this thesis as it is seen a discursive mechanism in neoliberal governmentality network and as a 'notion - forming devices' that reciprocally links authorities and subjects and regulate the lifestyles through the experts and the world of goods (Rose, 1996, p. 58).

Neoliberalism constitutes a new mode of subjectivity as a way in which individuals become "human capital" or as Brown says:

> It includes a new specification of the subject as neoliberal rationality remakes the human being as human capital, an earlier rendering of homo oeconomicus as an interest maximizer gives way to a formulation of the subject as both a member of a firm and as itself a firm, and in both cases as appropriately conducted by the governance practices appropriate to firms (Brown, 2015, p. 34).

This thesis operationalized the subject of neoliberalism as; firstly "one who strategizes for her or himself among various social, political, and economic options, not one who strives with others to alter or organize these options" (Brown, 2005, p. 43). Secondly, the neoliberal subject for this thesis is a self-responsible, ready to risk person, therefore it can be considered that the concepts such as lifelong learning, creativity, and empowerment reflect new technologies of establishing a relation between neoliberal self and state (Bröckling, et al., 2011, p. 15). Thirdly, the neoliberal subject is "responsible" for social risks such as illness, unemployment, poverty, etc. and for life in society, because neoliberal political rationality has transferred all these social risks into the domain for which the individual is responsible and has transformed it into a

problem of "self-care" (Lemke, 2002, p. 59). Fourthly for this study, the neoliberal subject is “everywhere homo oeconomicus and only homo oeconomicus” (Brown, 2015, p. 33). Finally, the neoliberal subject is an active individual seeking to enterprise oneself to maximize the quality of life through act of choice, giving one’s life a meaning and value to the extent that it can be rationalized as the outcome of choices made or choices to make (Rose and Miller, 1992 cited in Rose, 1996, p. 67). Here, it can be added that the enterprising self will make a venture of its life, project itself a future and seek to shape itself in order to become that which it wishes to be. The enterprising self, is thus a calculating self, a self that calculates about itself and that works upon itself in order to better itself. Enterprise, that is to say, designates a form of rule that is intrinsically 'ethical': good government is to be grounded in the ways in which persons govern themselves (Rose, 1998, p. 155).

4.2.6. Neoliberal Governmentality of Health

Neoliberal governmentality of health is a highly debated concept as any consensus cannot be formed due to its complex nature. Here, in the thesis the concept will be operationalized through the following three strategies; medicalization, commodification of health and individualization of health.

4.2.6.1. Medicalization

The commodification of health mentioned above is closely inter-related with the process of medicalization. Here, the concept of medicalization is firstly used in 1970’s (Conrad, 1975) and then peaked in 1980’s with the rise of neoliberalization of health. Medicalization could be defined as the hegemony of medicine over the domains which are not considered as medical before that time. At this point, it can be said that the power of values attributed to the concepts related to medicine (like the definition of pathological or healthy) belong to the medical professionals. This power transforms the medicine into a social control mechanism which could be used to manipulate the subjects in terms of interests of the power holders.

In this study, two basic phases of medicalization is operationalized as emphasized in the theoretical framework. These two stages are: Medicalization of the natural cycles of the female body (like menstruation, giving birth, motherhood, menopause etc.) Medicalization of everyday life.

The natural cycles of women's lives like menstruation and/or menopause have been covered by a medical control making these individuals dependent on health professionals and this resulted in the medicalization of these cycles. For instance, child raising becomes a topic for medicine and through this the motherhood becomes a medical issue. Mothers become dependent on the knowledge of medical professionals in terms of raising "healthy" children. At this point, it is essential to define the medical professionals as the new experts with the rise of neoliberalism; the professional has been proliferated. Besides the medical doctors, other new professions have been arisen like *doulas* (birth coaches), yoga instructors (for pregnant women), and dieticians (specialized on baby feeding). The natural processes like birth, baby feeding, etc. are approached as complex knowledge which necessitates professionals to be handled.

Moreover, there are two important issues, namely the traditional healing methods and self-care that needs to be added to the discussion of the process of medicalization. Certainly, some traditional healing methods applied by ordinary people for help most of the time are outside the scope of the modern medicine; especially the use of prayers for healing can be considered as the de-medicalization of the health related practices in the literature. However, it should also be noted that many other traditional healing methods are now offered at hospitals by the officially recognized experts of the field in Turkey, even though this is still a matter of debate in the country. Therefore, the border between the two fields (medicalized and traditional) are blurred. Still, with respect to the case in Turkey, it is possible to call an individual's referral to a traditional healer in today's healthcare system as an example of medicalization.

Similarly, self-care replacing medical treatment is also considered a kind of medicalization in this study. Because also in the self-care process, the individuals take active steps to become healthy: They seek advice from other experts; they make their

own remedies and they consume certain ingredients for preparing these remedies. All of these makes them active health consumers whose lives are medicalized in the network of neoliberal governmentality of health.

A similar obsession on knowledge could be seen on the medicalization of everyday life with its special focus on the discourse of a healthy life. At this point, one can say that everyday routines of the subjects are controlled by the medicalization as the impact area of the latter expand with the articulation of the concepts like healthism and/or healthy lifestyle. Here, this articulation is typically promoted by the contents focusing on health information on visual and social media. As Rose (2004) also mentions, the social techniques have been proliferated with a diversity of the medical knowledge sources.

At this point, the dietary choices need to be focused in the context of the subjects' relationship with health. This study operationalizes the subjects' relationship with health through dietary habits as social control which is an aspect of medicalization. This is due to the fact that dietary practices cover a major part of everyday life and the social control imposed in this way proliferates. Healing through dietary habits instead of using medication also entail the medicalization of everyday life as these individuals take active action to become healthy.

4.2.6.2. Commodification of Health

In this thesis, the health has been approached as a commodity as a consequence of neoliberal governmentality of health, both in the sense of the transformation of health care services and a new mentality of health which constructs the neoliberal healthy women subject. This transformation can be explained as follows.

In the early 1970s, due to the increase in the taxes used for the state expenditures, the profit proportion of the capital begun to decrease. Thus, through the late 1970s, the end of Keynesian policies came in to existence and the transition from consumption side to the production side was realized with the mediation of the state. The prevalence of neo-liberal policies and the proliferation of health care service also changed. The

economic problems of the welfare state that originated from the crisis in the early 1970s caused a change in the structure of government at the national level. In the case of investments, the role of local level increased and the negotiation process between international finance capital and local powers started (Harvey, 1991, p. 5). Therefore, the health's exchange value gained significance and it began to be transformed on the basis of attracting the capital. As a result of this transformation in health care services, health becomes a commodity.

This thesis operationalizes the process of commodification of health in two phases, namely the privatization of healthcare services and consumption of goods. The privatization of healthcare services focuses on the domination of profit-making which are supported by the introduction of private hospitals owned by the profit-making companies. Here, especially after 1980s, the neo-liberal transformation has dominated the health field as well as political, social, economic and cultural life in Turkey. In the 1980s, the central policy shaping the economy changed from ISI (import substituting industrialization) to export promoting strategy with the influence of IMF and World Bank (Şengül, 2003, p. 163). The decrease in investment in the industry led the state and the private capital to invest in health. The speculative investment gained significance in the respect that healthcare services themselves became the part of these finance capital led investments. That means, big capital (national and international) begun to invest in health. That implies a rise in the exchange value of health rather than use value. With this transformation, "health is viewed as a 'commodity' and individuals are defined as health care consumers" (Henderson and Petersen, 2004, p. 1).

The second phase is based on the consumption of health products which are not only limited to pharmaceuticals but also includes organic food, supplements, healthy cleaning products, organic clothes etc. The individuals, who are held responsible for their own health, have been made to believe that they have to "consume" these products to be healthy. The motive behind these consumption habits is the desire to be healthy which is supported by the broad range of products.

Especially being healthy become an issue of dietary choices which are also observed in the in-depth interviews held by the interviewees. Here, buying/eating healthy food becomes the dominant strategy to have a healthy body. As Rose and Miller indicate:

> The health consumer transformed to a person who was to be actively engaged in the administration of health, if the treatment was to be effective and prevention assumed" rather than being a passive receiver of the administration of pharmaceuticals (Miller and Rose, 2008, p.76).

This will also lead us to the blurred relation between health and beauty as the marketing of beauty products have also been provided with their reference to health. Such aestheticization of health has gained strength from women who are the target consumers as beauty products market themselves as "being healthy". Here, when women purchase cosmetics with the motivation of being healthy, this process nourishes the commodification of health.

As argued before, the neoliberal subject becomes a 'human capital' as the economization become dominant in every aspect of life. Here, he/she turned into an entrepreneur as invest in himself/herself by consuming the health products served to the market. Besides, the belief in having a choice in healthcare institutions means practicing their freedom.

> Healthy bodies and hygienic homes may still be political objectives, but they no longer require state bureaucracies inspecting and instrumenting us in habits of eating, of personal hygiene, of tooth care and the like. In the new modes of regulating healthy individuals are addressed on the assumption that they want to be healthy and enjoyed to freely seek out the ways of living most likely to promote their own health (Rose, 2004, pp. 86-87).

4.2.6.3. Individualization of Health

This study operationalizes the individualization of health in two ways in the neoliberal discourse. Firstly, the individual is held responsible for his/her own health with the transition from the welfare state to neoliberalism. The subject is in charge of his/her own health and this responsibility directs the individual to certain distinctive behaviors and imposes certain duties.

The subject feels responsible to attain health related knowledge and to inquire about these. The new public health paradigm enters into the scene with the discourse of empowerment to push the individual to learn more about health. Miller and Rose point out "the patient (is) also actively enrolled in the government of health, educated and persuaded to exercise a continued informed scrutiny of health consequences of diet, lifestyle and work" (Miller and Rose, 2008, p. 76).

The individualization of health also gives the individual the responsibility for managing health risks. This is why the individual becomes aware of the risks and tries to manage them with his/her own choices. Identification of risks and managing them are the new responsibilities of individuals. Lupton states that:

> Risk avoidance has become a moral enterprise relating to issues of self-control, self-knowledge and self-improvement. It is deemed people's own responsibility to take note of risk warnings and act on them accordingly (Lupton, 2006, p. 14).

The subject relates the reasons for being healthy or ill to his/her own behaviors and choices. At this point, health is an important of area of investment for the individual who self-invests and considers himself/herself as a kind of human capital. The proliferation of the discourse of being one's own doctor is also seen as a step taken towards the individualization of health.

Another aspect of individualization of health as can be seen in this study is the level of the individual's relationship with one's own health. It is worth asking the following questions about this aspect: Does the individual answer the health related questions as an individual or under the influence of one's role in the family? Does the individual perceive health as an extension of his/her individuality or as a social construct?

Perception of health as a social construct entails the adoption of the social roles and relating with health through such roles for the individual. On this matter, the use of illness as social labelling and attaching other meanings when calling a person ill shows that health is perceived as a social construct rather than an individual condition. When we look at the situation of female subjects, the fact that women perceive health in

relation with their roles in the family and relating to health as a mother or wife, demonstrate that health is a social construct.

4.2.7. Discourse

In this thesis, by analyzing the discourse of media in the neoliberal governmentality of health network, it is aimed to understand how these discursive structures, which engage in the formation and capacities of the self, problematizes the healthy woman subject.

Foucauldian formulation of discourse is central for this thesis. Moreover, in this thesis Foucauldian perspective of governmentality is used to understand the process of subject constitution, therefore, Foucauldian formulation of power helps us "to re-evaluate the role of language/discourse/texts in the process of the constitution of subjects within a hierarchy of relations" (Mills, 2004, p.38). From the perspective of Foucault's genealogy, it is seen that there is no neutral relationship between the subject and the circulating discourses, widespread beliefs or common understandings.

By following the Foucault, this thesis conceptualizes the discourse as mechanisms which enable power relations, and provide a ground for the knowledge production; constitute the mechanisms of normalization process; ensure the regimes of truth and also represents general definitions out of which knowledge is produced.

In this respect, this thesis operationalizes the discourse produced in television health programs as structures which provide a ground for medical knowledge; define the truths about being healthy; normalize some attitudes as healthy; represent some definitions on health and illness and also problematize the issue of being healthy. On the Foucauldian perspective, discourse is considered to be general politics of truth. As in his own words:

> Truth is a thing of this world: it is produced only by virtue of multiple forms of constraint. And it induces regular effects of power. Each society has its regime of truth, its "general politics" of truth : that is, the types of discourse which it accepts and makes func-tion as true; the mechanisms and instances which enable one to distinguish true and false statements, the means by which each is sanctioned; the

> techniques and procedures accorded value in the acquisition of truth; the status of those who are charged with saying what counts as true (Foucault 1980c, p. 131).

Here, it can be argued that mass media is a mechanism for circulation of information by producing discourse. Hence analyzing the discourse enables us to unearth how the regimes of truth operate in the subject constitution, as Foucault argues that:

> In a society such as ours, but basically in any society, there are manifold relations of power which permeate, characterize, and constitute the social body, and these relations of power cannot themselves be established, consolidated nor implemented without the production, accumulation, circulation and functioning of a discourse (1980d, p. 93).

Depending on the Foucauldian formulation of power with its productive aspect and as a relational network of forces in the society, this thesis argues that power operates throughout the circulation of discourses which produce new forms of subjectivity that are governed through different technologies of neoliberal governmentality. In this regard, the discourse for this thesis is understood as text, speech or practice which is organized, used and circulate the knowledge and truths (Kendall and Wickham, 1999).

4.3. Field Study

The field study of the thesis has two analytical methods: a discourse analysis on media and following that in-depth interviews conducted with the women living in Ankara. In this respect in order to understand media perspective of neoliberal governmentality of health in Turkey, the details of discourse analysis on media will be examined. Chronologically, the first method is discourse analysis as the data derived from this analysis support the formation process of interview questions. For this reason, firstly discourse analysis will be carried out in detail focusing on the production dynamics of television programs which will followed by the discourses produced by the latter. Then in-depth interviews will be examined according to the data obtained from discourse analysis.

4.3.1. Understanding the Media Perspective: The Discourse Analysis of Television Health Programs

In the first phase of the field study, the media content is chosen to be analyzed as a mechanisms of truth regime and the discourse which is produced in neoliberal governmentality network. According to Stauff, from the governmentality perspective, all procedures, institutions, regulated practices and discourse that produce the knowledge about subject can be seen as "technologies of government" (Stauff, 2010). Following Stauff, this study also adopts the governmentality as a way to understand the discourse of television health programs in Turkey. In this point, media as an institution and discursive field should be considered as "technologies of government".

4.3.1.1. Sampling

In order to understand the role of the media content in constructing the healthy women subject by neoliberal discourse, television health programs are chosen. Television content are chosen instead of printed media or social media, because it is argued that television is still the most widespread means of mass communication, and it is at the center of all media theories and practices. Secondly, it is known that the target audience of the media content on health on daytime shows is the group of women who are at home when the programs are broadcasted. As a result, this study argues that health programs on television provide the necessary data to analyze the discourse on women's health in the media. Thirdly, according to Television Watching Tendencies Survey conducted by the Radio and Television Supreme Council of Turkey in year 2018, the women watch more television compared to men between 12.00 am and 18.00 pm (RTÜK, 2018, Table 7, p. 41).[13] Since the health programs are generally categorized as daytime programs, it is seen in the same report that women watch daytime programs more than men due to the fact that women spend more time at home

[13] For details, please see the report of the Radio and Television Supreme Council Television Watching Tendencies Survey from: https://www.rtuk.gov.tr/rtukkamuoyuarastirmalari/3890/5776/televizyon_izleme_egilimleri_arastirmasi_2018.html. Accessed on 22.04.19

during those hours and they find these program informative and relevant for fulfilling their daily tasks (RTÜK, 2018, Table 12, p. 55-56).

In another survey by the same agency, when women are asked the most popular day time program and the television channel, their most common reply was "Doktorum (My Doctor)" health program on Kanal D (RTÜK, 2010, p. 12).

Based on such data, it is possible to conclude that the target audience of the day time health programs on television are women. Therefore it is also possible to say that the discourse of health programs on television play an important role in the formation of the healthy woman subject.

Moreover, in the second part of this study, it is seen that many women watch such programs on television and they learn from them. At this point, it is possible to say that the findings from the interviews in this study overlap the results of RTÜK Surveys.

For analysis, the programs called Doktorum (My Doctor), which is broadcasted on Kanal D (Channel D), Dr. Feridun Kunak Show on Kanal 7 (Channel 7) and Canım Doktorum (My Dear Doctor) on NTV were chosen with the purposeful sampling technique.

> The logic and power of purposeful sampling lie in selecting information-rich cases for study in depth. Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the inquiry, thus the term purposeful sampling… Studying information-rich cases yields insights and in-depth understanding rather than empirical generalizations (Patton, 1990, p.169).

The programs which were aired between 2016 and 2017 on Kanal D, NTV and Kanal 7, which are channels considered to represent different ideologies in Turkey, were reached online and to add variety, the shows aired in the summer and the winter seasons were included.[14] The reason why programs are chosen both from the winter

[14] In their study Atabek et al, consider that Kanal D and Kanal 7 present different ideologies. Moreover NTV as a news channel broadcasts programs on economy, arts, culture, life-style alongside the news.. For more, please see:

and summer seasons is to convey the seasonal differences in the contents of the programs.

Table 1.

Television Health Programs which are chosen as a sampling for analysis

Name of the Program	Channel of the Program	Broadcasting Time of the Program	Duration of the Program
Doktorum	Channel D	12.00 am	75 minutes
Feridun Kunak Show	Channel 7	9.30 am	60 minutes
Canım Doktor	NTV	11.15 am	30 minutes

4.3.1.2. Collecting and Analyzing Data

Discourses produced in the media reinforce the represented ideologies and become a part of everyday life. Van Dijk (2006) contends that ideologies are typically expressed through discourses. Discourses, which he terms as persuasive discourses, are presented as media content and aim to affect the future actions of the audience. Two of the most important public functions of media are to inform the society and to mediate discussions of certain subjects by providing public sphere. For this reason, media also serves as a means of conveying medical knowledge to the public. The medical media content forms social norms via discourses and establish what is right or wrong related to the subjects in question, and thus guide people in their everyday actions. Discourses influence perceptions and attitudes through the media, and as a result, they affect behaviors. The discourse analysis of the media content addressing women in health programs on television will reveal how women are positioned in the

http://www.dogusyayingrubu.com.tr/hakkimizda/markalarimiz/Televizyon/ntv (Accessed on 10.04.19.)

field of medicine and how medical knowledge and sickness or health behaviors are reproduced via discourses.

As it was mentioned before, the programs which were aired between 2016 and 2017 on Kanal D, NTV and Kanal 7, were reached online and to add variety, the shows aired in the summer and the winter seasons were included. For each program, 20 shows were analyzed, which makes 60 shows in total.

In order to analyze the data of the media analysis, the textual and visual content of 3600 minutes was analyzed firstly in terms of production practices and then using categorized discourse analysis technique. By using categorized discourse analysis, I considered television health shows as a discursive domain which construct the categories of being healthy and being ill and they also define the normal and pathological health behaviors in addition to providing a truth regime on being healthy. The television health shows were analyzed with respect to its semantic and symbolic elements.

When collecting the data, it is aimed to understand how these discourses, which engage in the formation and capacities of the self, problematize the healthy woman subject. Here it should be added that the discourse used in the media shape the desires, capacities and attitudes of the subject. By "discursive practice of problematizing," Foucault means:

> Discursive practices problematize domains of objects (*e.g*. life, language, labor) within the production of knowledge; governmental practices problematize certain objects of knowledge (madness, poverty, illness, crime, delinquency) in so far as they are implicated in the exercise of power; and ethical practices problematize the formation of the self in certain knowledges as a practice of freedom (Dean, 2003, p. 195).

According to Dean, the "problematizations are made on the basis of particular regimes of practices of government, with particular techniques, language, grids of analysis and evaluation, forms of knowledge and expertise" (Dean, 1999, p. 38).

In the data collection stage, I sought to answer the following questions: Which discourses related to women's health are produced by the health programs on TV? How do these programs define the healthy woman subject? What kind of health behaviors do they normalize? What kind of a truth regime related to being healthy do they produce? In the sampling, the discourse of health programs addressing directly the women were analyzed. During the data collection, I took notes, and transcribed the related parts of the programs.

As it was mentioned in Chapter 3, I analyzed the literature in the main theoretical frame and elaborated some important concepts which I defined as medicalization, commodification of health and individualization of health. Then the data collected from the television health programs in three different channel is analyzed with reference to these guiding categories. Now, the details of the second method of the field study of this thesis will be presented.

4.3.2. Understanding Women's Perspective: In-depth Interviews with Women Living in Ankara

In this stage of the research, in-depth interviews with the women living in Ankara are used to gather data. The details of the selecting the correspondents, data collection and the data analyzing are presented in this section.

4.3.2.1. Sampling

Interviewees were selected by the snowball sampling technique. The snowball sampling technique identifies the "cases of interest from people who know people, who know what cases are information-rich; that is, good examples for study, good interview subjects" (Wengraf, 2001, p. 102). With this technique, one interviewee introduced me to the next and this made the new interviewee trust me. With theoretical sampling, on the other hand, it is aimed to select the participants with theoretical purposes rather than statistical ones (Glaser and Strauss, 1967). Hence, the participants were selected purposefully, paying attention to the inclusion of women in different age groups and different educational levels. Another important point of consideration

for me was that the women included in the sample group had not received any education in the fields of medicine or health.

The number of interviewees was determined by the principle of data saturation, which means that, when I realized that there was no new data which was meaningful for the study, I stopped doing interviews. The principle of data saturation is the condition which is formulated by the Strauss and Corbin as:

> When no new or relevant data seem to emerge regarding a category; the category is well developed in terms of its properties and dimensions demonstrating variation, and the relationships among categories are well established and validated (Strauss & Corbin, 1998, p. 212).

4.3.2.1.1. Introducing the interviewees

Finally, the interviews were conducted with 30 women living in urban Ankara between December 2017 and March 2018. Five of these 30 interviews were later excluded from the sample group. One of the interviewees did not understand the questions because of hearing impairment and gave totally irrelevant answers. Three of them gave very short answers in a reluctant manner and without providing any clear explanations although they had given consent to be interviewed in the beginning. The interview conducted with the fifth interviewee, on the other hand, was constantly interrupted and when she came back, she could not concentrate on the questions. For these reasons, the interviews conducted with these five participants are not included in the analysis. The lists and the profiles of the participants with their educational level, marital status, number of children and social security status are presented below in Table 2.

Table 2.

The profile of the respondents in the research

NO	NAME - SURNAME	AGE	EDUCATIONAL LEVEL	MARITAL STATUS	CHILDREN	SOCIAL SECURITY STATUS
1	I.K.	48	HIGH SCHOOL	MARRIED	2	SSI
2	N.E.	65	HIGH SCHOOL	MARRIED	2	ES

Table 2. (continued)

3	D.G.	40	UNIVERSITY	MARRIED	2	SSI[15]
4	S.D.	35	PRIMARY SCHOOL	MARRIED	2	DEPENDENT SSI
5	N.C.	48	HIGH SCHOOL	MARRIED	2	SSI
6	D.I.	31	UNIVERSITY	MARRIED	none	DEPENDENT SSI
7	N.K.	48	UNIVERSITY	SINGLE	none	SSI
8	Z.A.	48	UNIVERSITY	MARRIED	2	SSI
9	H.V.	61	HIGH SCHOOL	MARRIED	2	DEPENDENT SSI
10	R.G.	53	PRIMARY SCHOOL	MARRIED	6	DEPENDENT SSI
11	G.K.	54	UNIVERSITY	MARRIED	1	SSI
12	D.A.	56	PRIMARY SCHOOL	MARRIED	2	SSI
13	A.Ü.	37	HIGH SCHOOL	SINGLE	1	SSI
14	A.Y.	45	PRIMARY SCHOOL	MARRIED	4	SSI
15	Ö.O.	48	PRIMARY SCHOOL	MARRIED	1	SSI
16	V.I.	59	HIGH SCHOOL	MARRIED	2	DEPENDENT SSI
17	D.S.	35	PRIMARY SCHOOL	SINGLE	2	SSI
18	G.E.	59	HIGH SCHOOL	MARRIED	3	DEPENDENT SSI

[15] SSI is used for Social Security Insurance (Sosyal Güvenlik Kurumu). ES is used for Pension Fund (Emekli Sandığı) and The term dependent is used for individuals who are not active insurance holders because according to Social Insurance and Universal Health Insurance Law Act No. 5510, the status of spouses of the insurance holders who are not considered as insurance holders or are not holders of voluntary insurance and who do not receive income or pension due to their own insurances are defined as dependent.

Table 2. (continued)

19	P.T.	48	HIGH SCHOOL	SINGLE	2	SSI
20	M.E.	42	PRIMARY SCHOOL	MARRIED	1	DEPENDENT SSI
21	M.A.	27	HIGH SCHOOL	MARRIED	none	SSI
21	E.K.	39	PRIMARY SCHOOL	SINGLE	2	SSI
22	A.D.	47	PRIMARY SCHOOL	MARRIED	1	DEPENDENT SSI
23	M.K.	36	UNIVERSITY	MARRIED	1	SSI
24	T.Ç.	43	UNIVERSITY	MARRIED	1	SSI
25	A.D.	50	HIGH SCHOOL	MARRIED	4	SSI
26	K.G.	50	PRIMARY SCHOOL	MARRIED	2	SSI
27	T.B.	24	UNIVERSITY	SINGLE	none	SSI

4.3.2.2. Why Are In-depth Interviews Conducted In Ankara?

The second stage of the field is conducted in urban Ankara. There are several reasons why Ankara was selected for this study. First of all, accessibility of the interviewees is important, since I am living in Ankara, for the future steps of the research in order to reach them later again, Ankara is chosen as a research side.

Secondly, Ankara is the capital of Turkey and thus the headquarters of the governmental institutions linked with health are all in Ankara. Viewed from a historical perspective, Ankara is the first city where the government health services started to be restructured during the Early Republican period. To illustrate, in 1924, when Dr. Refik Saylam was the Minister of Health, the first "Numune Hastanesi" (Model Hospital) was established in Ankara. The founding purpose of the model hospitals, was to extend health services all over the country. Ankara Numune Hospital,

which had the most advanced facilities in the era it was constructed, is the oldest health institution in Ankara.[16] Moreover, there is a district in Ankara called Sıhhiye, which literally means health services and which bears the traces of the health reforms made in the Early Republican period. According to Kılınç, Sıhhiye is an urban space where the first health institutions were established in that era and a place which reflects an attempt to create healthy individuals, a healthy society and a healthy city. In Sıhhiye, there are some health institutions such as the building of Health Ministry (it was once called "Hudud ve Sevail-i Sıhhiye Umum Müdüriyeti" and Sıhhiye was named after it), and in the eastern part of the district there are buildings that belong to Ankara Hıfzıssıhha Enstitüsü (Public Health Institution) such as the buildings of Chemistry Laboratory, Bacteriology and Serum (Kılınç, 2002, pp. 129-130). This institute served both as a school which trained its students to become health personnel and a preventive health center that produced vaccines.[17] In the Etimesgut district of Ankara, another health institution called as Etimesgut İçtimai Hıfzıssıhha Numune Dispanseri (Etimesgut Social Healthcare Sample Dispensary) was established in 1933. This institution was established as a model center to enable health services to be extended to villages in Turkey.[18] Furthermore, the city center, Kızılay was named after the Headquarters of the Turkish Red Crescent (Türk Kızılayı-Hilal-i Ahmer), which was built in 1929. Ankara is also the city where the citizens can reach health services most easily as it is the capital. In the past, people living in other cities used to come to Ankara for the treatment of their illnesses or for their operations. Today, it can be said that the number of patients coming to Ankara for an operation has decreased due to the increase in the number of private hospitals but there are still patients coming to Ankara for such a purpose.[19]

[16] Vergili, A.(2011). *Türkiye'de Modern Tıbbın Kurumsallaşması ve Cumhuriyet Dönemi Sağlık Politikaları*, PhD. Dissertation Department of Sociology, Istanbul University (Unpublished,)
[17] Dedeoğlu, N.(2001). Hıfzısıhha Okulu ve Tarihçesi, *Toplum ve Hekim*, 16 (6), 468-469.

[18] Aydın E. (1997). Türkiye'de Taşra ve Kırsal Kesim Örgütlenmesi Tarihi, *Toplum ve Hekim*, 12 (80), 21-44.

Table 3.

Some general demographic indicators of Ankara in 2016

City	Ankara
Total Population	5.346.518
Rural Population Ratio	0,8
Urban Population Ratio	99,2
0-14 Aged Population Ratio	21,2
65 and Over Aged Population Ratio	7,7
Youth Dependency Ratio	29,8
Elderly Dependency Ratio	10,8
Total Dependency Ratio	40,7

Source: MoH, 2016, p. 13, Table 1.3

Ankara is the city with the second highest number of hospitals in all categories (university, public and private) in Turkey. According to the Ministry of Health, in 2016, the population of Ankara was 5.346.518 and the total dependency ratio was 40.7 (MoH, 2016, p. 13). As regards the number of health specialists, Ankara can be said to be the second biggest city in accordance with the number of health personnel in Turkey. According to the Ministry of Health, the number of specialists and physicians is 9.861, the number of general practitioners is 2.278 and the total number of physicians is 16.597 in Ankara (MoH, 2016, p. 227).

[19] This information is grounded on my private e-mails with Funda Şenol Cantek, who is a specialist in the cultural history of Ankara.

4.3.2.3. Why Women Are Chosen As a Unit of Analysis?

When the history of modern medicine was written, and while modern medical knowledge was produced, women were excluded from these processes. However, women have been the primary subjects of the field of health with their labor as caregivers and their healing knowledge (Bozok, 2018, p. 139). By focusing on the women in health, this dissertation aims to recognize and show the existence of women in the field, who are often ignored in this context.

This study focuses on the healthy woman subject as a new formation of the neoliberal discourse in Turkey. First and foremost, this dissertation argues that the issue of women's health is a social issue that should be analyzed from a sociological perspective because it is argued that the concept of women's health is reproduced culturally, politically and economically.

Firstly, women's health as an issue is affected by various cultural aspects. In Turkey, the gender-based and traditional role assigned to women in the family is that of the caregiver for all the members of their families. The Turkish welfare system is also dependent upon these traditional normative roles. To illustrate, women receive healthcare benefits in relation to their husbands or fathers. It is possible to see this situation in many countries, but what makes Turkey exceptional is that "its minimalist corporate structure is maintained through the family ties and the important domestic role played by women" (Dedeoğlu and Eleveren, 2012, p. 11). It could be stated that their traditional roles exclude them from the labor market and make them dependent upon their father or husbands when benefiting from health services. In addition to this, women's role as the caregivers in the family adds to their home-based labor.

> The emphasis upon women as bearing responsibility for the health and welfare of their partners, children and other family members (such as their ageing parents) by ensuring the cleanliness of the home remains strong in contemporary Western societies. Throughout women's lifespans they are encouraged to protect their own health not simply for their own interests but because of their responsibility to others (Petersen and Lupton, 2000, p. 75).

Secondly, this dissertation confirms that women's health is a political issue. As Zola argues, medicine has become an institution of social control not through the political power of the physicians but through the medicalization of daily life and labelling the health and ill relevant to the human existence (Zola, 1972). In this regard, medicalization studies also show that the control of the medical profession over the life of individual mostly targets the life of women because for the medicalization thesis, women's natural life experiences (such as reproduction and birth control, childbirth, infertility and premenstrual syndrome) are more likely to be medicalized than men's life (Conrad, 1992).

> For instance, the contemporary public health discourses frequently position pregnant women as needful of constant self-surveillance to protect the health of their fetus. Pregnant women are advised to monitor their diet closely and are routinely dissuaded from drinking alcohol or smoking throughout their pregnancy (Petersen and Lupton, 2000, p. 76).

If the microphysics of power in Turkey is to be analyzed from a Foucauldian perspective, women's health is a suitable field, for it is known that women's health has been the most important concern of the population policies in Turkey since the first years of the Turkish Republic. In the first years of the Turkish Republic, various official regulations were introduced based on the belief that healthy mothers would raise healthy generations. As stated by Yurttagüler (2004), in the Early Republican era, population was the most important issue and therefore, reproduction became a duty rather than a right of women citizens. Women were assigned the role of mothers and they were natural carriers of the nation, culture and society (Yurttagüler, 2004, p. 91). Today it is also believed that, to promote women's health at the national level means to promote the health of the family first and then the nation. As Foucault claims "the site of the family thus provided a link between the 'private' ethic of good health, as espoused and championed by individual families, and general political objectives regarding the health of the social or public body" (Foucault, 1984f, p. 281, cited in Petersen and Lupton, 2000, p. 74).

Thirdly, this thesis argues that health of the women is an economic issue in this contemporary world. It is seen that women have become the primary target of the commercial health promotion since they are responsible for the health of all of the family members. “Contemporary marketing of health, in public and private spheres, has resulted in the development of an array of health products and ‘lifestyles’ to be promoted and sold” (Bunton and Crawshaw, 2004, p. 188). Women with their traditional roles of the “food supplier” and the “caregiver of the family” are the main consumers of health market involving organic foods, remedies and many other products that are believed to promote health. They are also the primary target groups of the daytime television health shows, in which experts normatively inform them about the benefits of adopting a healthy lifestyle. On the other hand, women are the consumers of the cosmetic sector, which sells beauty as a medical commodity. In the cosmetics and beauty sector, in which there is a blurring line between being healthy and being beautiful. The new formulated desires as to be fit, healthy, young and beautiful. Makes women the consumers of the health sector. In this regard, it can be added that “there is an elision between the ideals of commodity culture and public health, for both promote the slim, attractive, healthy, physically fit, youthful body as that which women should seek to attain” (Petersen and Lupton, 2000, p. 80). In the discourse of healthy living, health is presented as a signifier of social status, success, self-discipline, beauty and happiness. To be healthy and thus to reach these signifiers, women become consumers of health (Bozok, 2011, p. 51).

4.3.2.4. Collecting and Analyzing Data

Before starting the in-depth interviews, I examined the questions asked in the studies that focused on the lay perspective in the field of medical sociology. Then, I formulated my own questions to understand health conceptualization, health behavior, sources of health knowledge. Widely, all these categories will help me to understand the subject position of women in the health field. After framing my questions, I did four pilot interviews. In these pilot interviews, I realized that the interviewees were having difficulty answering some of them and I restated these questions and changed

them into a simpler form using a simpler language. Another thing I realized during the pilot interviews was that when talking about health, women started to mention the health of other members of their families or their children. Therefore, I revised the questions so that women could answer them just by directly mentioning their own health. On the other hand, I left out some other questions which led to a repetition of the answers

Semi-structured in-depth interviews were conducted with 30 women living in Ankara. Following the ethical considerations, before the interviews, the participants were informed about the subject and the aims of the study. Their consent for the recording was obtained and they were told that when the study was published, their personal information would be kept confidential. In compliance with the terms of confidentiality, only the initials of the names and surnames of the interviewees and their ages were used to refer to them.

Some of the in-depth interviews were conducted in the participants' houses and some of them were held in their workplaces. It has been observed that as there were no time constraints, the participants who were interviewed in their houses were more comfortable when answering the questions. The interviews conducted in workplaces, especially the interviews with women who were security staff and salespersons were quite often interrupted. All of the interviews were tape recorded with one exception. A technical problem arose in a recording during an interview, but that interview was noted down. During the interviews I tried to observe the health behaviors of the respondents. I noted down details such as the water on their office desks, if they are at work, the vitamins on the cupboard in the kitchen, the things they ate during the interview or whether they put sugar in their tea, and I tried to understand the extent of their orientation towards a health-conscious lifestyle.

During the interviews, in order to obtain detailed answers, I used some methods and gave some examples from my own experiences. I sometimes mentioned just the opposite cases and asked them to explain their answers. I noticed that the interviewees had difficulty answering the questions especially in the sections related to

reproduction, abortion and birth control. Young respondents were much more comfortable when compared to the middle aged or the elderly group when responding to such questions.

The categories of the questions asked in the in-depth interviews conducted with women living in Ankara are as follows:

- Socio-demographic characteristics
- Social security status
- Definition of health and illness
- Health status
- Health behavior
- Causes of illnesses
- Relationship with medicine
- Sources of medical knowledge
- Perception of health risk and responsibility
- Medicalization

Each interview lasted for about one and a half hours and all the tape-recorded interviews were transcribed. 27 interviews produced nearly 320 pages of transcribed data. The data were transcribed by recording verbal and non-verbal cues to capture the responses, moods and attitudes. Before the process of data analysis, I read the transcribed data several times.

After having collected the data, I analyzed the data in a similar way with the first stage of the field. According to my literature review, I focused on three main concepts of neoliberal governmentality of health, namely medicalization, individualization of health and commodification of health. These concepts become the guiding principles of my data analysis.

4.4. Limitations of the Research

The first limitation of the study is that; the in-depth interviews were only conducted in urban city center of Ankara, therefore the study does not reflect the subject positions of the women in the rural areas as they will have different levels of access to healthcare.

The second limitation is that; most of the women interviewed are middle class women, and women from different economic classes are not included in the study. Economic class position is also a basic determinant in access to healthcare as stated in literature (see also Özen, 2008).

The third limitation is that; in the media analysis section of this study, only the health programs on television are examined, other health content are not covered. Printed media and internet sources were not studied.

The fourth limitation is that; in both the media analysis and the interviews, the local language Turkish is used. The language difference between the field material (in Turkish) and the analysis (in English) inevitably caused semantic differences during the translation process.

CHAPTER 5

NEOLIBERAL TRANSFORMATION OF HEALTH POLICIES IN TURKEY

5.1. Introduction

In this chapter, it is aimed to understand the political background of neoliberalization of health in Turkey. Moreover in order to understand the neoliberal rationality in the political field the Health Transformation Program (HTP) which was launched in 2003 is selected to understand the neoliberal transformation of health policies in Turkey. Here, it is important to add that, for this dissertation, the Health Transformation Program is considered as the governmental practices to fulfil the neoliberal political administrative goals and to constitute the neoliberal form of subjectivities.

5.2. A Brief Overview of the Organization of the Turkish Health Care System

To begin with, it is important to state that, 1961 constitution which has strong clauses on social and economic life, can be seen as an important milestone for the early history of the health care system in Turkey. Mainly, the constitution included a special clause on 'right to health' making the state responsible for universal healthcare provision. In Article 49[20], it is stated that health is a right and state is directly responsible for providing the citizens with physical and mental health and with the necessary health care they require.

Related with the new Constitution adopted in 1961, one of the most important developments of the years between 1960 and 1980s was the Law on the Socialization of Health Care Services (Sağlık Hizmetlerinin Sosyalleştirilmesi Hakkında Kanun -

[20] TBMM 2018

Law Number 224) which was enacted in 1961. This law provided a context for health care policies until 1980s.

As Demirci (2010, p. 164) points out, although they might have different objectives, both Law on the Socialization of Health Care Services and the present Health Transformation Program (HTP) concentrate on the two same axes as financial and organizational aspects of the health care system. Firstly, from the financial aspect, the Law proposes a mixed model in which premiums are paid by the citizens, budget allocations to relevant institutions and out-of-pocket payments all have their share. When citizens apply to the Health Houses (Sağlık Ocakları) that they are registered to, they get health care services for free. Lastly, according to the said Law, if practitioners are not engaged with the socialization program, they are free to work in the private sector.

Secondly, regarding the organizational aspect, the Law declares the adoption of the following issues: Chain of Referral (Kademeli Sevk Zinciri Uygulaması), Full Time (Whole – Day) Practice for health care personnel (Tam Gün Uygulaması), Building the necessary infrastructure, Foundation of higher Boards for Planning and Evaluation (Planlama ve Değerlendirme Üst Kurulları) Integrated Health Care Services (Entegre Sağlık Hizmetleri), Health Services Proportionate to Population (Nüfusa Orantılı Hizmet), Continuous Education for health personnel, Participation, Employment of personnel on Contract- Basis (Sözleşmeli Personel İstihdamı), Inter-sectoral Cooperation.[21]

In this regard, it is important to mention a leading figure of the reform process, Nusret Fişek, professor of public health; he was the designer of the law and had shaped the population and family planning policies of Turkey. Especially his efforts regarding women's health and women's rights in years 1960's are also significant for this

[21] TBMM, 2018

thesis[22]. Following the adoption of the law, the government project titled 'the Socialization of Health Services Program' (Sağlık Hizmetlerinin Sosyalleştirilmesi Hakkında Kanun) was launched. The main aim of this program was to establish a healthcare delivery system which serves the country as a whole, from the smallest villages to the largest cities (Yılmaz, 2017, p. 53).

In this period, three main social security institutions, namely first Social Security Administration (SSK) in 1946, secondly The Retirement Fund (Emekli Sandığı) in 1954 and lastly Social security Institution for self-employed (Bağkur) in 1971, were established.

Historically in the late 1970s, there have been both economic and political crises in Turkey which triggered by the oil crisis in all over the world. With its inward-oriented industrialization structure and national political problems, the coalition government of Turkey didn't succeed against the global economic crisis. Due to its national political problems, it was impossible for Turkey to fully apply IMF prescriptions and stability decisions taken on the 24 January 1980. Then there had been a military coup in 1980 which marked a new period for the Turkish economy for the implementation of the IMF-supported adjustment programs (Buğra, 2015, p. 197). It can be argued that the military coup paved the way to the Turkish economy to integrate into the emergent neoliberal global economy which also means that it was transformed into a proper open market economy of the 1990s (Yeldan, 2001, p. 25 cited in Yılmaz, 2017, p. 62).

Following the military coup, Motherland Party (Anavatan Partisi) ruled the country throughout the 1980s. The years 1980's was the period when Turkey has started to experience neoliberal restructuring in its public sectors, especially in the health care system. Moreover, the 1982 Constitution clearly proved the neoliberal transformation in the healthcare policy of Turkey. As different from 1961 Constitution which defined health as a right within the direct responsibility of the state, the 1981 Constitution declares with Article 56 that state would plan and regulate the provision of health care

[22] For detail information about Prof. Dr. Nusret Fişek see: https://nusret.fisek.org.tr/

services in the country. As Demirci (2012, p. 167) adds that according to the article, the state would perform this duty by making use of the health care institutions functioning both in the public and private sector.

Another important political regulation on health was the Fifth Five-Year Development Plan, covering the period 1985–1989. Yenimahalleli-Yaşar (2010) points out that there are six important steps of the plan, namely: (i) for efficiency public facilities will operate like business enterprises; (ii) private enterprises and hospitals will be subsidized; (iii) prices of services provided by the private health sector will be unregulated; (iv) contracts will be made for private physicians; (v) both public and insurance organizations will no longer provide health services; (vi) a GHI system will be introduced (State Planning Organization, SPO, 1984, cited in Yenimahalleli-Yaşar, 2010, p. 112).

In line with these reforms, the Health Services Basic Act (Number 3359) also adopted in 1987, announced that the public hospitals should be transformed into private health care enterprises, the doctors would be allowed to work at public hospitals privately, and the health care personnel could be employed on a contract basis. Clearly, it can be argued that the act successfully reflects the neoliberal transformation of health policy in its period (Yenimahalleli -Yaşar, 2008, p. 160).

All these regulation triggered the problem of low-income people's access to health care. Mainly, people who are not covered through formal means of health insurance and are unable to pay for health services couldn't access health care services in hospitals. In order to solve this problem, in 1992, Green Card (Yeşil Kart) program established by the coalition government of DYP and SHP. The program also survived through the 1990s and 2000s.[23]

In years 1980's and 1990's Turkish health policy system witnessed many new regulations, significant policy documents can be seen in this regulation process

[23] World Bank, 2013

surrounding the 1982 Constitution, Fifth Five-Year Development Plan, 1987 Basic Health Law and Green Card System of 1992.

Additionally for Yılmaz, in the early 1990's, in accordance with the international trends, various healthcare reforms were made by ANAP governments. For Yılmaz, there are four critical developments in health care policy agenda in this period namely: (1) The commencement of a partnership between the Turkish government and the WB on healthcare issues (2) the publication of a report entitled the Health Sector Master Plan. (3) The revitalization of the medical doctors' movement under the umbrella of the TTB (4) increased the politicians' and bureaucrats' attention to healthcare policy was the emerging income expenses imbalance of the social security institutions (Yılmaz, 2017, p. 67).

Although there are many differences in their problem definitions and solutions proposed, these critical developments clarified that Turkey healthcare system was in need of reform. But in this period since country was ruled by a series of short-lived coalitions, competing for ideas from different political actor's did not lead any significant policy response to the problems, in other words there weren't any large-scale reforms in health care system in that period with the exception of changes towards passive privatization in healthcare delivery and introduction of the Green Card scheme (Yılmaz, 2017, p. 78).

In order to evaluate this period, Ağartan's (2015, p. 981) arguments are essential, in her own words:

> An interesting feature of the reform discourse during the late 1980s and 1990s—which is also seen in the 2003 HTP reform—is the attempt to "balance the requirements of the liberal market economy with the obligations of the "social state" and to strike a new division of labor among the "state and markets whereby the state assumes the responsibility of planning" and regulating the provision of services, establishing and monitoring standards, and focusing on preventive health services (Ozsarı, 1998, cited in Ağartan, 2015a, p. 981).

In line with Ağartan, it can be stated that various transformations in financial, managerial, administrative, people capital components of the health care system have

played a critical role in fostering the transition to neoliberal health policies in Turkey. These developments have also prepared the ground for the most radical transformation attempts as the Health Transformation Program.

5.3. Neoliberal Transformation in Turkish Health Care System

Throughout history, the capitalist system has been transformed through various stages of the world politics and economics. The years 1978–80 were defined as a major turning-point in the world's social and economic history with its significant reconstruction in the state–market relationship and also in financial and labor markets of many countries.

During the capitalist development process, especially the period until the 1980's when there was an expansion of the welfare state, health has become one of the most significant and also most targeted parts of the public sector. Then, during the neoliberal restructuring of the state, the health issue has again gained a popularity; various attempts to transform and also restructure the health care systems took place in the public sector of the almost all countries. In other words, through around world, the repercussions of neoliberal transformation were felt the strongest in relation to the structural changes in healthcare systems. The changes in the health care system mainly lead to various reforms for restructuring the components of the health care systems of the countries.

Although it is known as the global transformation of the political and economic systems of many countries, it can be argued that global neoliberalism has reconstituted the economic and social institutions of capitalism differently in each country and region. Hence, the solution approaches for the transformation varies according to the levels of economic development of each country.

When it comes to the Turkish case, it can be argued that there have been comprehensive reforms in the health care system which can also be read within the context of neoliberal restructuring process since the 1980s. The military coup of these years gave the way to redesign of the political regime and economic orientation in

which welfare state further ignored and the privatization of social services was preferred. This new orientation towards privatization, marketization and deregulation deeply reflected in the health care system of the country. Hence, there had been numerous attempts including certain sets of components such as promoting private sector investment in the health sector and the neoliberal restructuring of the health care system in Turkey. As the latest and substantive chain of the process of neoliberal transformation of the health care system, the Health Transformation Program (HTP) has been launched in the early 2000s. In this section, the transformation in health care system in Turkey with particular emphasis on Health Transformation Program (HTP) introduced in 2003 will be examined.

5.3.1. Before the Health Transformation Program (HTP) (Sağlıkta Dönüşüm Programı)

Before stating the main principles of the Health Transformation Program (HTP), it will be helpful to understand some aspects of the Turkish health system in before HTP period. Thus I will follow the Ağartan's (2012) analysis of the pre-HTP period of Turkish health care system. Following Wendt et al**.** (2005) for health care analysis, Ağartan interprets Turkish health care system before HTP period in terms of three major functions as financing, provision and regulation.

Firstly, under the financing function, it can be argued that social insurance was the dominant feature of the Turkish welfare system. But highly fragmented hierarchical and unequal nature of the social insurance system caused many problems about the social insurance funds, access to public and private facilities and quality of the services in between different social security organizations as ES, BAĞKUR and SGK. There were also problems in the coverage of the social security system to the poor citizens. Although the with the establishment of the Green Card Scheme in 1992 was attempted to expanding the coverage of poor people, it was quite limited since covering only expenses for inpatient care provided by Ministry of Health hospitals and university hospitals upon referral (Ağartan, 2012a, pp. 460-61).

The second problematic issue was the provision function of the Turkish health care system before the HTP period. Historically it was known that the state has been the dominant actor in the provision of healthcare services. Regarding the provision of secondary and tertiary care there were many different actors of the public sector which were responsible as Ministry of Health (MoH) hospitals, the hospitals owned and operated by the Social Insurance Organization (SSK), university hospitals and a small number of hospitals operated by public institutions and municipalities. This segmented structure of the provision schema was highly problematic (Ağartan, 2012a, p. 462).

Lastly, the state assumed to control and regulate many areas in health services and these paved the way for many bureaucratic problems in the area of regulation of health services.

Ranging from certification of the diplomas of newly graduated doctors and planning and regulating the employment conditions and remuneration system of physicians in the MoH hospitals and primary care centers to the monitoring of medical education state was the only responsible actor and this one centered regulation system was very problematic for the quality of the health services. For instance, there was no uniform benefits package; and access of patients to service providers varied depending upon the insurance fund to which they belonged before the HTP period in health policy of Turkey (Ağartan, 2012, p. 462).

To conclude, Ağartan (2012a, p. 463) points out that in the backdrop of Health Transformation Program, the state was a dominant actor in all three dimensions of the health care system and there was a limited role for non-governmental actors, like medical associations and trade unions in all these dimensions. It is very important to note that Ağartan argues that in this period although the role of the markets in healthcare system was limited, the commodification of healthcare was growing as a challenge for the uninsured and the poor. Finally, the inequality was not only emerged between uninsured people and insured ones, there was also inequality in health care services between the different regions and between urban and rural parts of the country. (MoH, 2003; World Bank, 2003, cited in Ağartan, 2012a, p. 463).

Now, what HTP brings about for the organizational and financial set-up within the Turkish health care system will be analyzed.

5.3.2. Health Transformation Program (HTP)

With the general elections of 18 November 2002, the Justice and Development Party (Adalet ve Kalkınma Partisi, AKP) government came into power. The party was committed to improving social welfare and economic growth while simultaneously endorsing "a moral order encompassing agricultural society and its traditional values, mores, and customs, among which religiosity is definitely predominant" (Kalaycıoğlu, 2007, p. 240). Both in the Party Program and the Urgent Action Plan, AKP announced their main targets and policies of the new government and their plans about the transformation of the components of the health care system in Turkey. Hence, the health care reform was assigned such a priority in the AKP's reform package, in December 2003, Transformation in Health (HTP) Program was issued by the Ministry of Health. The HTP booklet defined reforming of the health care system as a major public policy priority (MoH, 2003).

HTP declares its objectives as the "effective, productive and equal organization, finance and provision of health care services" (MoH, 2003, p. 24).

Firstly by efficiency, HTP refers to effective health policies for improving the health level of the population. Rather than treatment of ill people, the main aim of the health policies are the prevention of diseases.

Secondly, what productivity means to HTP is providing more services by using the same sources through reducing the cost of health services. There are many important steps of productivity of the health services for HTP which are listed as rational drug use, management of materials, distribution of human resource and preventive health care.

Thirdly, by equity, HTP means equal access to the health care services for all citizens in Turkey: "The main aim in this objective is to reduce the gap in access to health care

services and health indicators among different social groups in the Turkey" (MoH, 2003, pp. 24-25).

Accordingly, HTP announced its main principles as being human-centered (individual will be addressed in the family health concept), sustainability (continuity of the system), participation (involvement of all components of health sector into the system), negotiating, voluntary and embodying continuous quality improvement, separation of powers, decentralization and competition (MoH, 2003, p. 25).

5.3.2.1. Components of HTP

HTP had announced its eight goals namely:

> (1) to transfer the MoH into a planning and a monitoring body, (2) to unite the existing public health insurance schemes under the umbrella of general health insurance, (3) to make healthcare services more accessible and friendly, (4) to pave the way for health manpower to be equipped with knowledge and to have more motivation, (5) to establish educational and science institutions to support the new model, (6) to introduce quality measures for the healthcare sector, (7) to support the medical institutional structure with rational medicine and equipment and (8) to establish a health information system (MoH, 2003, pp. 26–36).

Firstly, with the vision of HTP, the role of the Ministry of Health would be to develop policies, define standards and making the control and steer the process of source management of the health service system. The organization model of MoH would be structured in accordance with integrated health service delivery. To achieve this aim, it was necessary to redefine MoH's objectives and missions in the fields of strategic planning, organizing human resources, distribution of resources and material management. In order to develop and implement education system, another important point to add on the first component of the program was the following: MoH should control education for training personnel responsible for the planning of health education in various levels of health administrative system.

Secondly, following the requirements of social state justice in the insurance system stated in Article 65 of the Constitution, HTP would gather every citizen under the single insurance system of General Health Insurance. Existing insurance system in

which different institutions were responsible for insurance of different social groups in the country was incapable of reaching the conformity standards since they purchased services in different ways. Hence, there was a considerable number of people without any insurance at all. With the HTP, the level of poverty would be defined with respect to the ones unable to finance health care expenses and to that end, a new evaluation system would be developed. HTP also aimed to separate the health premium pool from other branches of social security systems and a National Health Budget would be set up to recover the system of health financing information in Turkey. With the General Health Insurance, each citizen would have a MERNIS[24] number and the health institutions would not need to check the collection of insurance premiums any more, since the insurance institutions would be responsible for this.

Thirdly, HTP emphasized that the future health service system would be more accessible and widespread in all around the country. Taking into the geographical characteristics of the country, the new plan of health care delivery targets the health house system in the new conditions of the country. According to HTP in order to achieve this goal, it is necessary to create a competitive service environment in which private initiatives, foundations and associations enrolled. Moreover, HTP points out that there is an increasing gap between east and west and also between urban and rural areas of the country; hence HTP focuses on solving this inequality in the distribution of health resources and health services delivery. It is noteworthy that rather than putting private initiatives in the place of the public institutions, it aimed to create a competitive atmosphere between private and public health sectors in the country. Moreover, in the field of primary care, HTP states that family physicians will play an active role since they will be more accessible than other medical professionals. The family physicians will also be responsible for the health education, preventive care and promoting the health by reaching all families in their respective areas. Another important point of the HTP's third component is the staged referral system which aims to strengthen the primary health care system in which family physicians are

[24] The Central Civil Registration System, for details see also: https://www.nvi.gov.tr/ministry-of-the-interior/the-central-civil-registration-system

responsible. In the staged referral system, the first step is the family physicians and then the hospitals follow the line. HTP attempts to prevent overcrowding in the hospitals, to decrease the health care expenses and to improve the quality of the health services especially provided by the hospitals. One of the most important aspects of HTP is the financial and administrative autonomy of health enterprises. According to HTP, all public health institutions are autonomous structures under the control of MoH. It is also possible for companies, foundations, universities and municipalities to set up health institutions.

The fourth component of HTP is related with the improving the knowledge of health human capital and also their motivation. Thus HTP states that there will be new educational programs for health professionals. Especially for the family health area, new educational programs will be planned for family physicians and family health nursing will be also improved to international level. The component also highlights the principle of balance in the distribution of health force among different areas of the country (MoH, 2003, p. 33).

In its fifth component, HTP argues that Turkey is in need of institutions for making sectoral analysis, planning researches, hence the new institutions of public health as a science covering different disciplines including public health, will be established. It is noteworthy that HTP also includes the specialization education of physicians and attempts to improve it under the new structure of health academy or health specialization institutions (MoH, 2003, pp. 33-34).

The sixth component refers to the sustainability of standards in all health units. For this aim, National Quality and Accreditation Institution as an autonomous structure will be established for the organization of automatization, certification and accreditation of services in the health sector (MoH, 2003, p. 34).

Another component of HTP mentions the establishment of two new institutions in the health service system. First one is the National Medicine Institution as an independent structure responsible for the arrangement of policies related to medicine and issues for

medicine marketing. Secondly, in the framework of HTP, the Institution of Medical Devices will be structured for control, quality certificate and calibration for medical supplies and devices according to the international standards (MoH, 2003, pp. 35-36).

Lastly, HTP announces that there will be a new information system in the health decision-making process called the Health Information System. This system will harmonize all the information of different components of HTP. Mainly the system will also keep the medical records of the individuals to provide the information for the decision making process. In this way, it is attempted to improve the productivity of the health services. Moreover, the data gathered by the system will also be used for scientific researches and studies on the determination of health policies of Turkey (MoH, 2003, p. 36).

With the establishment of the new government in 2007, three new topics were added to the HTP: (1) Health promotion for a better future and healthy life programs, (2) Multi-dimensional health responsibility for mobilizing parties and inter-sectoral collaboration, (3) Cross-border health services to increase the country's power in the international arena (MoH, 2009, p. 21).

Now it will be helpful to answer the question of why HTP is evaluated by many scholars as the neoliberal turn in Turkish health care system, in other words what characteristics of HTP can label it as a neoliberal transformation in health care system of Turkey.

5.3.2.2. The Impacts of HTP

Health is an issue which should be analyzed with an examination of the political, economic and also social context of the country. When it comes to health care reforms, it is evident that these transformations have always been critical, since they have many impacts both on the economic and social dimension of the health care systems. From the role of the public and private entrepreneurs in the health sector to the parameters of citizen's access to health, there are always various topics which are open to discussion on the health care reforms. Before examining the impacts of HTP on health

of women in Turkey, it will be helpful to discuss the impacts of HTP which has an influence on both female and male citizens. Now, the question of what have been/would be its effects on the organization and the financing of health care services, health workforce and primary health care services in Turkey will be answered. For suggesting the impacts of the HTP reforms, this study will use some official statistical information.

The HTP has affected many different fields in health care system in Turkey. In this respect, this thesis will focus only five of them. These areas can be ordered as organization of health care services, health workforce, and finance of health care, primary health services and lasly health of the women.

One of the most fundamental changes brought about by the HTP was the transformation of the role of Ministry of Health to a monitoring body, planner and also supervisor of the health provision in Turkey.

There were many attempts towards altering the structure of healthcare delivery as transferring the SSK hospitals to the MoH and then following these legislative changes, establishing the Public Hospital Unions (Kamu Hastane Birlikleri) for granting public hospitals financial and administrative autonomy. Another significant step the government took was to encourage the private investors for opening new private hospitals and SGK would also start purchasing services from them. All these attempts led to a significant increase in the number of private hospitals in Turkey (Yılmaz, 2017, pp. 89-90).

A major step taken by the government is the granting partial financial and administrative autonomy to the public hospitals (MoH, 2003, p. 32). As Demirci (2012) states, the adaptation of managerial principles by the public hospitals caused classification of these hospitals according to their performance and made them to complete each other and also other health service providers in the internal market created within health care system. In this regard, the autonomous service providers

introduced into the health care system, especially the provider/purchaser split, are clearly examined by her as:

> […] creation of internal market and the provider/purchaser split within the health care system together with its autonomous service providers and the competitive environment, adoption of health technology assessment and establishment of pharmaceuticals and medical devices institute, increase in out-of-pocket payments, performance-based payment system and customer-oriented health care services are worth mentioning (Demirci, 2012, p. 251).

Clearly, HTP states that as a result of this automatization, each hospital will be responsible for its administrative decisions, service quality and efficiency. However, it also introduces that those hospitals will be financed for preserving the continuation and quality of services (MoH, 2003, p. 32).

Moreover, it is introduced that all public health care institutions will be autonomous bodies under the supervision of the Ministry of Health. For this aim, first of all, a "unity of service provision" will be established among these hospitals and at the second phase, each institution will be delegated its autonomy separately (MoH, 2003, p. 31).

In this regard, HTP introduces that health care institutions do not necessarily have to be directly linked to the State (i.e. the Ministry of Health), but municipalities, private companies, foundations, provincial administrations and universities can set up health care institutions.

Another important development that HTP states was the adoption of the Public-Private-Partnership (PPP) model. It should be added that following the model, the Public-Private-Partnership Chamber has been established within the Ministry of Health. Moreover, Demirci also states that:

> With this model public investments in health care services have been decreasing while making it more possible and profitable for the private sector to invest in this area, which in the end has been leading to an increase in the number of private investments in health sector (Demirci, 2012, p. 246).

She also points out that the model has originated in the UK and as in UK's practice the project of "health campuses" was developed in Turkey. The health campuses or "integrated health campus" or as generally known by the name of city hospital project should be considered as a typical example of the public-private partnership model that has been adopted in many sectors in Turkey. With integrated health campus, it is said that high technology will be used for the transportation of both doctors and patients. It is also said that besides health, there will be other services that the health campuses will provide to patients with its hotels, restaurants, barbers, markets.

There are several criticisms about the "integrated health campus" since it is believed that these campuses will provide wide opportunities for the private sector to invest in the health sector of Turkey. The most detailed analysis is done by City Hospital Monitoring Group of TTB (Turkish Medical Association). According to the group, the main problems with the city hospitals in Turkey can be summarized as; first, its finance method (high public cost); second, the selection of sites for buildings (especially for agricultural areas); third, the transportation for citizens to the hospitals (both geographical and economic access to health service); fourth, the premises of the former public hospitals (what will be done with the spaces of former hospitals?) and the rights of the health workforce who will start working in city hospitals. Clearly, the criticisms on the city hospital model argue that the city hospitals will lead to the marketization of hospitals and commodification of health in Turkey. Moreover, the health care will no longer be a public service based on social rights of the citizen that would be provided to all on the basis of equality as the city hospitals will be managed by market-oriented principles from now on.

As Tables 3 and 4 indicates that the increase in the number and capacity of private hospitals has also been striking in Turkey. In 2002, the number of private hospitals was 271 and this has risen to 565 in the year 2016 (Ministry of Health of Turkey, 2016, p. 101, Figure 7.1). The numbers, as seen in table 2, indicate that the role of the private sector, in terms of hospital beds, has increased from 5693 in 2002 to 31030 in 2016.

Table 4.

Sectoral distribution of the hospitals

Sector of hospital	2002	2012	2013	2014	2015	2016
Ministry of Health	774	832	854	866	865	876
University	50	65	69	69	70	69
Private	271	541	550	556	562	565
Other	61	45	44	37	36	0
TOTAL	1156	1483	1517	1528	1533	1510

Source: MoH, 2016, p. 101, Figure 7.1

Table 5.

Number of qualified beds in different sectoral hospitals

Sector of hospital	2002	2012	2013	2014	2015	2016
Ministry of Health	6839	41506	45241	50587	55786	62237
University	6402	15473	16921	18651	18975	19899
Private	5693	27149	30380	29283	31518	31030
TOTAL	18934	84128	92542	98521	106279	113166

Source: MoH, 2016, p. 102, Figure 7.3

As it is seen in Tables 4 and 5, the number of public and private hospitals as well as the distribution of hospital beds constitute important indicators for the changing roles of the state and the market in the healthcare sector in Turkey. It can be argued that the

increase in the number of hospitals and beds in the private sector contributed to the rise of the privatization in health sector (Tables 1, 2).

In terms of the health workforce, there are many challenges in the provision of healthcare in Turkey. (WB, 2003) These challenges should be listed as unequal distribution of health professionals, low physician to patient ratio and imbalance in the skills of health professionals and also the quality in the education of health professionals.

In order to address these challenges, HTP encompassed various reforms. The first important step can be regarded as the performance-based payment. Clearly with Performance Based Additional Payment System (Performansa Dayalı Ek Ödeme Sistemi) HTP aims to increase the motivation among health care personnel and also the efficiency of the whole health system.

Clearly performance-based payment is examined by Aran and Roks as:

> Staff was awarded additional pay according to their contribution to measured units of activity. An institutional performance component was later added to the system. Currently, a complex formula integrates the provider's personal performance and the performance of the health care facility. The bonus payment for a health worker in the performance-based pay system is determined through a combination of institutional and individual performance criteria (Aran and Roks, 2014, p. 10).

Although there are some positive impacts, the system is also criticized among many respects. As Demirci (2012) indicates that the performance-based system is highly discussed in various platforms for the increase in unnecessary prescription of services, the waste of resources and also for worsening in the quality of the health care services and lastly for the demolition of solidarity among health care professionals.

Moreover, according to the TTB's report on performance base payment for health professionals, there are some negative effects of the new system on the quality of the health care services since it limits the time that physicians spend per patient. The report also argues that with the performance-based system, primary health services move away from protective health care services. It also emphasized that the system has

negative effects on medical education in educational hospitals, hence it limits the time on education of medical students (TTB, 2009, p. 36).

Another important step has taken by HTP to ban dual employment that allowed publicly employed physicians to work part-time in the private sector. Ministry of Health argues that dual employment of publicly employed doctors caused absenteeism and low productivity in the public hospitals, and defined it as a form of corruption because some of these physicians in the public sector directed their patients to their private practice for the aim of getting additional payments (Ağartan, 2015b, p.5). In January 2015, it is banned to work part-time in privately owned offices, but the physicians are also allowed to work in private health facilities after the end of the official working hours (Elveren and Ağartan, 2017, p. 323).

Additionally, as the progress report of MoH states, "the misconception suggesting the availability of an excessive number of physicians used to be in the agenda" before the HTP. The report also says that in order to solve this problem, YÖK (Higher Board of Education) increased the student quota for medical faculties by 30 % and Nurse Vocational Schools by 15 % in 2008 (MoH, 2009, p. 87).

To address regional disparities in the distribution of health workforce, two policies developed by MOH were expanding contract base employment of health professionals and mandatory service[25]. Mainly, contract-based employment is believed to attract the physicians and nurses by the way of high payments for east and southeast regions of the country. According to Aran and Rocks, the system can be considered as successful with regard to increase in the number of health professionals in deprived regions, however, "it was not successful in achieving new recruitment of general practitioners (GPs) and specialists" (Aran and Rokx, 2014, p. 9).

[25] Mandatory service had been in effect in Turkey between 1981 and 1995. In the first years of the HTP (between 2003 and 2005), compulsory service for health staff was annulled and replaced bycontractual payments in underserved areas (Aran and Rokx 2014, p. 9).

On the other hand, it should be added that mandatory service is another implementation of HTP for the management of health workforce. The system clearly aims to burden the disparities in between the regions of the country. The mandatory service is not new for the Turkish health care system, it is defined by HTP as "compulsory public service for new graduates of public medical schools and for new graduates of medical specialty education for a period varying between 300 and 600 days depending on the residential area to which they were appointed" (Aran and Rokx, 2014, p. 9).

In this regard, it would be quite useful to have a look at the numbers available regarding the number of medical schools and physicians per patients. In the year 2002, there were 44 medical faculties in Turkey which reached 99 in the year 2016. The total number of students enrolled to medical schools were 30.771 in the year 2002 and this number increased to 75.956 in the year 2016 (MoH, 2016, p. 226, Table 10.5).

The figures indicate the increase in the number of medical schools and the number of students enrolled to these schools which can be taken as the complementary policy of the HTP. On the other hand, as Table 3 shows, the number of per capita visits to primary care health centers was 1.1 in the year 2002 and this number has risen to 2.7 in the year 2016. A number of per capita visits to secondary or tertiary level health care centers was 2.0 in the year 2002 and this number has risen to 5.9 in the year 2016. All these this increase both in the number of doctors and medical students were required in order to respond to the growth in the demand fostered towards health care services in Turkey.

Regarding the financing of health service within the framework of HTP, many regulations were put into practice with various laws and policies. The unification of the social security system was one of the most radical reform. Clearly, the problem about health insurance system of Turkey was examined in HTP as: "There is not a general health insurance covering all individuals of our country and current insurance institutions have very different systems."

Table 6.

Total number of per capita visits to a physician in health care facilities by years in all sectors

	2002	**2012**	**2013**	**2014**	**2015**	**2016**
Primary health care	1.1	3.1	2.9	2.8	2.7	2.7
Secondary and tertiary health care	2.0	5.1	5.3	5.5	5.7	5.9
TOTAL	3.1	8.2	8.2	8.3	8.4	8.6

Source: MoH, 2016, p.143, Figure 8.1

It is also pointed out in the HTP that since the number of insured people is not known exactly it is difficult to calculate health expenditure per person and these also prevent making projections for the future (MoH, 2003, p. 17).

In order to integrate all health insurance benefits and cover all citizens, GHI (General Health Insurance) was achieved with the passing of two laws –Act 5502 and Act 5510- in 2006 and 2008. The Social Security Institution (SSI) is also established for the united insurance funds and the Green Card scheme. According to Ağartan and Elveren, GHI as single payer system constitutes important steps against fragmentation of health coverage and it also provides expansion of health coverage. They add that in 2011, 99.5 percent of the population was reported to be covered by public health insurance (OECD, 2013, cited in Elveren and Ağartan, 2017, p. 230).

Despite all these improvements, it is hard to say that the HTP fully eliminate the regressive character of out-of-pocket and informal payments. According to Yılmaz, "despite the unification of all social insurance schemes under the compulsory general health insurance with a broadly defined basic benefit package, healthcare expenditures in Turkey did not increase drastically" (Yilmaz, 2017, p.107). He also adds that with HTP new financing mechanisms as user fees for public health care services,

contributory payments for private healthcare services were introduced in health care system (Yilmaz, 2017, p. 107). For Yılmaz, another HTP implication that increases the patient's out of pocket payment is the basic benefit package for public health insurance. He contends that as SGK became responsible for defining the basic benefit package of public health insurance, the type, amount and duration of diagnostic services, medications and treatment services that are financed by the public health insurance fund were now defined by this institution. This led to the comprehensive character of the package and some changes as the base price for subsidizing medications may have resulted with the increase in patient's out of pocket payments (Yılmaz, 2017, pp. 88-89).

As it was mentioned, with regard to health insurance there are two problematic issues, namely the lack of health coverage and the imbalance in health access for all citizen before the HTP period. Hence, by implementing General Health Insurance, it was aimed to unite all citizens of Turkey under a single Social Security Institution. However, by the end of 2011, there had been some changes in the Green Card system as Green Card holders were subjected to kind of a "revenue test". Accordingly, only those who are detected to have a revenue below a certain threshold, would keep their privileges to access health care services. The revenue tests were said to be repeated regularly to detect whether there occurred any change in the revenue levels of those who have the privilege of reaching health care service under state guarantee. [26]

In this point, it is helpful to have a look at the figures available regarding certain aspects of health care coverage and health care payment as a challenge to equity in the access of health services. It is seen that with the implementation of HTP, the health insurance coverage of the population was raised to 99.2% in 2017 from 69.8 % population in the year 2002 (OECD, 2017). Although health insurance coverage and

[26] See also https://www.haberturk.com/ekonomi/makro-ekonomi/haber/700974-yesil-kartlilar-dikkat# (Accessed on 11.09.18)

access to healthcare services increased with GHI, there still is a considerable rate of people left out of the health coverage.

Table 7.

Percent of government health insurance of total population by years

	2002	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
Government health insurance % of total population	69.8	98.2	98	98.4	98.4	98.2	99.2

Source: OECD, 2017

According to Pala, these people comprise the group of citizens who should pay their own premium and the group of people who have premium debt because of their employment status. Another important point that he adds is the increase in the number of citizens whose fees are paid by state in time so all these indicators clarify that there is a considerable number of people who have no health insurance in Turkey and this also leads to another problem which is the increase of the number of patients who apply the emergency services of the hospitals (Pala, 2017, pp. 60-61).

In line with Pala, Yenimahalleli-Yaşar also states that it is necessary to have public health insurance for the access for health but it is not enough at all. In some cases, due to complementary payments and out of pocket payments, being under the social coverage becomes meaningless for access to health care services (Yaşar, 2017, p. 120).

Concerning the public health expenditure per capita, it is seen that there occurred a serious increase in the last years. While public health expenditure per capita was 740 TL in 2002, there has been a rapid rise in the following years - it reached 1197 TL in 2016. On the other hand, private health expenditure per capita (TL) was 307 in 2002 and reached 328 in 2016 (MoH, 2016, p.237, Figure 11.5). Regarding the out of pocket

expenditure per capital on health was 56 TL in 2002 and it has risen to 249 TL in 2016 (MoH, 2016, p. 239, Figure 11.10).

All the above-mentioned figures indicate that there has been an increase in both public and private health expenditure and also in out of pocket payment in health since the launch of the HTP.

Regarding the primary health care services, HTP states that "there is no well-organized health system approach devoted to performance"(MoH, 2003). According to HTP primary health care services should control and compete with other services hence there are many transformations in primary health care service introduced in the document (2003, p.30). Mainly for the aim of supporting preventive health care service, the health houses continue to provide service but in towns and cities where they have been rather lacking, these services will be undertaken by Public Health Centers (Kamu Sağlığı Merkezleri) (MoH, 2003, p. 30).

HTP introduces the new model in primary health service as the family medicine model which is given the central role in health care system. The model simply relied on the practice of family physicians to be chosen by patients. In this regard, it can be argued that HTP refers to the concept of "patient's choice" in primary level health care and preventive services (HTP, 2003, p. 30).

Additionally, HTP also brought significant changes in the chain of the referral system. By providing patients with the choice of doctors and establishing an effective chain of the referral system, HTP aims at treating the majority of the patients at the primary care level and this gave the way to a decrease in the number of patients in the hospitals at the other levels. Furthermore, it is stated that this would also lead to a decrease in waste of resources, make it possible to provide health services in shorter times and with lesser costs. It is important to note that HTP states that those who do not want to go through the chain of referral will not be forced to do so. (MoH, 2003, p. 31).

The family medicine model aims to individualize the services, to share responsibilities in preventive care and to develop a "single approach" to an individual in primary care (MoH, 2009, p. 64).

In order to understand the model, it will be helpful to state some responsibilities and duties of family physicians which are defined in the HTP Progress Report:

- A family physician is responsible for health, health problems and diseases of all members (from the fetus of pregnant women to the oldest member of the family)
- A family physician is the health consultant of the patients s/he is the one who guides patients and defends patient's right
- A family physician is close to residences of families and is easy to access. The family physicians is the one who knows the best about the health status living conditions of all family members and how preventive health care services and health training could be delivered to them (MoH, 2009, p. 65).

With the adaptation of the Law No.5258, the pilot application of the system came into effect in 24 November 2004 in 11 provinces, and later in 2007, 11 more provinces were added to the list. According to the Law No.5258, the family doctor would be responsible for at least 1000 individuals and at most 4000 individuals respectively. The responsibility of the doctor involves having a close encounter with the registered patients and families, registering and following the health histories of the patients and forming a more personalized contact with the patient so as to create a trusting environment

Transformation in primary health care service with HTP is also criticized by some scholars. Yenimahalleli-Yaşar (2010, p. 121) states that the Socialization Act aimed to organize the primary health care system suitable for population and to adopt integrated services, including preventive and environmental health services. She criticizes this new family medicine system for "fragmenting the integrated services and the multidisciplinary service approach by including only individual health services within the responsibility of family medicine" (2010, p. 121).

Another criticism is based on the uninsured citizen's access to primary health care service. Since the system is based on performance payment, this might force the family

physicians to focus more on those patients who are under the cover of public health insurance. So the people who have no public insurance (because of premium debts or other reasons) will have no chance to access to even primary health care services (Üstündağ and Yoltar, 2007, p. 87).

Furthermore, the right to choose the family physician in this new family medicine model might be problematic for public health issues. Pala indicates that when people from the same geographic area choose different family physicians, it will be hard for these physicians to monitor public health problems as an infectious disease in the same geographic area (Pala, 2017, p. 57).

As an important component of HTP, the family medicine system has done many reforms in primary and preventive health care services. According to Ministry of Health Statistics, first of all, it can be said that there has been an increase in the number of primary level health centers (owned by the Ministry of Health). The number of Family Health Centers (Aile Sağlığı Merkezleri) and medical examination room has risen from 6.076 in 2002 to 24.428 in 2016. (MoH, 2016, p. 127, Figure 7.22).

Accordingly, the number of visits to physicians in primary health care facilities increased from 74.827.588 in 2002 to 215.990.739 in 2016 (MoH, 2016, p.147, Figure 8.5).

Besides all these criticisms, according to the results of patient satisfaction report of MoH, the patient satisfaction with their last primary health care services was 82.8 % in the provinces with the Family Medicine services; 80.1 % in the provinces without the Family Medicine service; and 81.2 % in general in Turkey (MoH, 2010, p. 35).

The reasons behind these rates of patient satisfaction are listed by Elbek as below: Firstly, there were many problems in health care service system of before HTP period. Mainly, because of the economic problems before the HTP period, the public health hospitals had a lack of technical equipment and many physicians in these hospitals lacked appropriate levels of performance. Besides these problems, it was widely

accepted that social networking was an essential way to access the health service in public hospitals. In this period, majority of doctors also had their own private clinics. All these created many challenges for citizens who were trying to access to health care service in public hospitals (Elbek, 2015, pp. 24-25).

In the past ten years, there were many improvements in health care system which have a direct influence on the increase of patient's satisfaction. These can be summarized as; especially in emergency health care service there has been a significant increase in the number of ambulances, snow track ambulance and also air and sea ambulances. This spread the perception among the public that the health care was more accessible. Moreover, easy access to health care services, decrease in the prices of medication, providing green card owners to access service of ambulatory treatment can be seen as improvements that have a direct impact on patient's satisfaction (Elbek, 2015, pp. 24-25).[27]

To conclude, a continuous increase is seen in the numbers of primary care facilities and also visits to the physicians in primary health services in all sectors in the last decade. Women as a vulnerable group vis-à-vis access to health care are also affected more from the above-mentioned impacts of HTP and thus shall be discussed separately.

The Health Transformation Program introduced many changes in health care system of Turkey. The reform initiatives have demonstrated that these changes led many transformations of the domains of the Turkish health care system and have an impact on many different dimensions of the health issue from the workforce to the clinic. In this section, the impact of HTP on women's health will be discussed**.**

It is generally known that having social security for women in Turkey as in many other countries plays a central role in accessing the health service. Yet the majority of women in Turkey are considered to be dependents of men as wife, daughter or mother

[27] For the detailed number see: Ministry of Health of Turkey 2016: 132, Figure 7.26 and Figure 7.27

to enjoy their rights of access to health service. As in the former system, new security system also depends on the employment and occupational status except for general health insurance. In this regard, as Kılıç argues, with the reform there has been a significant gender inequality to get public health service insurance coverage in a country where female labor force participation rate is lower than all EU and OECD countries (Kılıç, 2008).

With HTP, the former social security system which had a segmented institutional structure was replaced by a singular system. The new system has both some negative and positive impacts on the health of women. Firstly, it has eliminated the hierarchical structure between the citizens to access the health service and provides equity in the quality of health services. According to the result of the study that Üstündağ and Yoltar (2007) conducted, there were many problematic areas in the health sector before HTP period. People mostly about bureaucracy, quality of service and exclusion during this time period. One of the important points that the study underlines is that informal payments such as knife payment (bıçak parası), tips or being directed to the doctor's private office were obstacles for low-income citizens to access the health services.

When it comes to the new system, differently from the previous model regardless of their employment status, all citizens are obliged to contribute to the public health insurance fund. But the only exception is those whose income makes them eligible to state subsidy (Yılmaz, 2017, p. 87). There are also additional sources of healthcare financing in HTP, such as patient contributory payments for all hospital visits. On the women's access to health, Ağartan (2012, p. 168) states that reproductive healthcare services are free of charge if women are able to achieve public health service but when it comes to other health services not related with reproductive health there are no exemptions to protect low-income women in Turkey. The out of pocket payments should be regarded as the barrier for low-income women to access the health care service. Ağartan adds that "when women are struggling to make ends to meet as the Health Seeking Behavior Study highlights, they may forego seeking health care in order to purchase food or fuel" (HSBS, 2007, p. 86, cited in Ağartan, 2012, p. 169).

Regarding the primary care, the family medicine system introduced by HTP is also another transformation that might directly affect the health of the women. It can be said that women and children are the main users of the primary care services especially in developing countries like Turkey (Ağartan, 2012, p. 168).

In this regard, Üstündağ and Yontar argue that when health houses of the former system were replaced by the family medicine system, those who are out of the health insurance system had no chance to access primary health care service. As the family physician is paid on the number of registered patients, the chances of those uncovered to be examined would decrease (Üstündağ and Yontar, 2007, p. 87). In this regard, Ağartan indicates that the autonomy of public hospitals introduced by HTP and privatization of health care services should be considered as another barrier for low income women to access to health care service, since public hospitals have been a major provider of uncompensated care for the poor and it is not expected for private hospital to invest health services in remote and poor regions of the country (Ağartan, 2012, p. 170).

Another significant reform that directly influences the women's health condition is the regulations on the gender-neutralization of welfare benefits. The current reform in the healthcare system introduces a further step in ending the former entitlement of dependent daughters of the insured persons to lifelong health insurance. Additionally, the reform that enacted in 2006 aimed to equalize the treatment of women and men in terms of retirement rules.

According to Kılıç when we consider the gender based inequalities in labor force participation "the equalization, however, comes at the expense of certain practical interests, ending an actual provision formerly enjoyed by women; hence, it makes women more vulnerable in the face of present risks." In the same vein, Kılıç (2008) adds that the main reason for early retirement of women is that they are more vulnerable to physical deterioration due to the double shift of domestic and paid labor under difficult conditions. For Kılıç, another significant point for early retirement of women is that female employment is relatively more interrupted because of maternal

and domestic responsibilities, hence it seems unrealistic to have such a high minimum-age threshold (Kılıç, 2008, p. 496).

Lastly, Pala indicates that the HTP the reforms in the financing of public hospitals led to changes in hospital medical care. It should be pointed out that when the medical care is transferred out of the hospital it also led way to the increase in the home-based medical care. In this regard, it can be argued that displacement of medical care to the home means giving more responsibility to the women in the family due to the traditional role of women as a caregiver and healer of the family (Pala, 2017, p. 62).[28]

5.3.4. What Makes HTP a Neoliberal Turn in Turkish Health Care System?

To begin with, a brief account may help us to clarify why the Health Transformation Program (HTP) is considered as the neoliberal transformation of health care system in Turkey.

On the broader level, neoliberal restructuring is a process which can be seen as a response to the cyclical crisis of the capitalist system that started in the early 1970's throughout the world. The process also has many implications on various components of the economic and political structures of the states. Mainly, the reconstructing of the state and the public sector has been one of the most significant end products of the neoliberal transformation. Historically, with the emergence of the modern state, the health care has gained more meaning in the political and economic context. In this point, the health care systems with its public and private dimensions have been one of the most important targets of the neoliberal restructuring.

According to Harvey neoliberalism is a theory of political economic practices that proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets, and free trade. He also adds that in

[28] For detailed information see MoH, 2016, p.157 Table 8.12. on Number of Days Stayed in Hospitals by Years and Sectors, Turkey

neoliberal system, “the role of the state is to create and preserve an institutional framework appropriate to such practices” (2005, p. 2).

In this respect, in order to understand the relation between neoliberalism and healthcare policy Yılmaz asks the following crucial questions: “What does neoliberalism mean for healthcare policy? What are the common dynamics that neoliberal healthcare reforms generate?” For him “neoliberal project aimed to deepen healthcare markets where they already existed and to establish new healthcare markets where there were none before” (2017, p. 30). Yılmaz points out that there are four dynamics on whose combination neoliberalism rely, which are privatization, marketization, commercialization and economization (2017, p. 30).

In this context, privatization means making policy for promoting more reliance on the private sector, to a certain extent for the non-profit sector and less for the state. Next, marketization is another dynamic which aims to redesign the policy domain in the main objective of the market. For marketization, the role of the state should only be the regulation of the market. Another dynamic is commercialization refers to increase the use of market relations in healthcare finance and provision (Mackintosh and Koivusalo, 2005, pp. 3-4, cited in Yılmaz, 2017, p. 31). Lastly, economization as a policy approach is important for neoliberal health care reforms which aim to establish an efficient distribution of limited resources. What Yılmaz emphasizes that “economization in the domain of healthcare generally refers to the introduction of private sector mechanisms targeting cost-containment and/or better allocation of healthcare resources” (Yılmaz, 2017, p. 32).

When it comes to the Turkish case, it is clearly seen that from the 1980s onwards the neoliberal restructuring process has been affecting the Turkish health care system. For Pala (2017, p. 45) the first legal attempt towards the adapting the health care system in Turkey to principles of the market economy is the Basic Law on Health Services (Sağlık Hizmetleri Temel Kanunu) of 1987. According to the law, healthcare institutions serving in the public sector could be turned into health care enterprises working on the basis of market principles. During the 1990s there were many attempts

to realize the neoliberal transformation in the health sector. Following, these reforms, Health Transformation Program (HTP) launched in 2003, may be seen as the most radical chain in the course of neoliberal restructuring of health care system in Turkey.

As it is mentioned before, aims and components of HTP emphasize firstly, the idea of "efficient distribution of limited resources" in healthcare systems both in the financing health services and in the organization of the human capital in health sector. Secondly, HTP clearly opens the health sector to the private enterprises and rather than being an active actor, the role of the state also transformed to the regulation of the health market conditions. In this point, HTP announced that there are new comers in the market as National Medicine Institution and Institution of Medical Devices as a new control and regulation mechanisms. It is very important to note that if anyone tries to consider the phrases that used in HTP booklet as "consumer-oriented organization structure" and "to achieve this goal it is necessary to create competitive service environment" s/he can simply realize the predominance of the spirit of market capitalization in the program. Moreover, the new information system in the health decision-making process may be seen as another result of the neoliberal restructuring of healthcare because Harvey clearly states that:

> Neoliberalism's intense interest in and the pursuit of information technologies leading some to proclaim the emergence of a new kind of 'information society'. These technologies have compressed the rising density of market transactions in both space and time (Harvey, 2005, p.34).

In this respect Demirci, emphasizes that HTP brought a change in conceptualization and philosophy of health care services in Turkey. In her own words:

> With the HTP, health care has started to lose its characteristic of being a right related to citizenship and has become more a commodity that is sold and bought in the internal market that has been created where the state has smaller part to play. In this regard the burden of responsibility is less on the state and more on the individual himself/herself (Demirci, 2012, p. 260).

HTP brought revolutionary changes in regulation, financing and delivery of the health care system and for Ağartan, a major reorganization of health care system occurred with the new division of labor among the private and public sector. For her, this

transformation can be analyzed with what Lars Thorup Larsen and Deborah Stone (2015) call the "two faces of neoliberalism" (2015a, p.968). Clearly in this process, state has been withdrawing from service provision area yet this has not weaken state's position in the system and the state has also gained some degree of leverage over private sector because of its regulatory and rule setting role.

For Ağartan (2012b, p. 466), HTP brought a trend in health policy towards the marketization but all these marketization mechanism were accompanied by the reassertion of the state's regulatory power and maintaining a strong government commitment to healthcare financing. Here how she puts the matter:

> While the public sector remains dominant in financing, the biggest transformation is taking place in the provision and regulation dimensions. Although the role of the private sector is growing slowly in service provision, the trend towards marketization is clear, with greater emphasis placed by the policy elite on the virtues of private provision and growing pressures on public hospitals to become more market-oriented (2012b, p. 467).

Consequently, it is clearly understood that a major theme in HTP has been the strengthening of market mechanisms as a solution to the problems defined. With the pressure to meet rising demand and growing costs, HTP provides a competitive environment for health service provider. At this point, it can be clearly stated that from the perspective of what Yılmaz refers to as the four dynamics of neoliberal health care reforms (privatization, marketization, commercialization and economization), Health Transformation Program highly emphasizes the necessity to inject the idea of neoliberalism into the health care system of Turkey.

Moreover, Pala (2017, p. 46) indicates that HTP is the renamed version of the health reforms of 1983 which was the extension neoliberal political economy of the Turkish governments.

To summarize, within the framework of HTP, health care was redefined as less of a social right and more of a market commodity, the role of state has transformed from active player to controller and rule setter and it can be stated that individuals are becoming more responsible for their own health than the state, health sector has

become open to private enterprises and the new information technologies emerged for the collecting the health data of population. All these reforms lead us to argue that HTP is the latest chain in the course of neoliberal transformation of the healthcare system in Turkey since the 1980s. Although it has been launched in the early 2000s, the program still continues to have serious repercussions on many different aspects of health care system in Turkey.

Following the ideas of above-mentioned scholars, this study considers that with its reforms innovates, Health Transformation Program of 2003 emerged as a part of neoliberalization process in Turkey since the 1980's.

5.4. Chapter Summary

This chapter aims to understand the political background of neoliberal governmentality of health in Turkey by focusing on the Health Transformation Program. In order to understand the political dimension of the neoliberalization of health in Turkey, the chapter provides brief overview of Organization of the Turkish Health Care System. After introducing brief overview of the Turkish Health Care system, the HTP is examined by answering some questions such as: What are the issues that are problematized by HTP? What are the impacts of HTP according to the research objectives? What are the impacts of HTP? Lastly, the features of the Health Transformation Program that makes it as a neoliberal turn for Turkish Health Care Policy are mentioned in this chapter.

It should be added that in this chapter some statistical data are used while the impacts of HTP on different agents in the health care system are analyzed. This chapter demonstrates that the HTP is a significant case for demonstrating how the neoliberal rationality is reflected on the health care polices in Turkey.

CHAPTER 6

MEDIA PERSPECTIVE OF NEOLIBERAL GOVERNMENTALITY OF HEALTH IN TURKEY

6.1. Introduction

Since the early days of mass media, when the newspapers were the only medium to reach the masses, health has been a popular issue because it is an issue of concern both for the ill and the healthy. Health, nowadays, is not only a subject of media content but a genre all by itself as in TV health shows, health magazines, health radio programs, whereas some thematic TV channels like HTV prove how health is distributed throughout a large area in mass media.

In his book *Media and Health*, Seale (2002) emphasizes that health messages in popular mass media are an important influence as a resource of professional and lay health care advice in contemporary life but he adds that health research, in general, does not put enough emphasis on the mass media except health education and health promotion research.

Here it can be argued that as a source of medical knowledge, mass media have a significant influence on people's health consciousness and health behaviour and also on their conceptualization of health. As stated by Giddens, media are a powerful disembedding mechanism to lift people and events out of their local circumstances and media also place them on a world scale. He also adds that the media representations influence behaviours of the audience: "All individuals actively, although by no means always in a conscious way, selectively incorporate many elements of mediated experience into their day-to-day conduct" (Giddens, 1991, p. 188).

This chapter aims to understand the discourse of media as a technology of neoliberal governmentality of health. As governmentality is a system which provides the analysis of discourse and practices together, before analyzing the practices of the women, it is attempted to make an analysis of discourses of television health programs, which play a central role in the constitution of healthy women subject. That is to say, before presenting the result of the discourse analysis of TV health programs in Turkey, firstly the media will be examined from the Foucauldian perspective. Then, the issues of neoliberalism and media in Turkey will be mentioned, and the media and health in Turkey will follow it. Since this thesis argues that Michael Foucault's concept of governmentality is an appropriate analytic tool to be used in understanding the different discourses inherent in the constitution of healthy women subject, in this chapter, I will try to operationalize strategy to analyze the media messages in governmental network.

6.2. Understanding Media from a Foucauldian Perspective

Michael Foucault's notion of power, which is based on the idea that power is not located in the hands of any specific class, has challenged the Marxist view on the role of media in society. Clearly, what Marxist researchers emphasize is that through media messages, there is a reproduction of dominant ideologies as a discursive form. The one-sided model of mass media has been rejected by Foucault's complex theorization of power, which refers to omnipresence and omnidirectional power relations in the society. How can we understand the role of media messages in society from a Foucauldian perspective? According to Stauff (2010), Foucault's notion of governmentality offers an efficient perspective to grasp the complex nature of media messages in the contemporary world. That's to say, depending on the Foucauldian perspective, this study regards the relation between audience and media contents (as between women watching television and television health shows) as a power relation during the mass communication process rather than the linear communication process.

In this regard, it is helpful to note Foucault's account on power relation:

> a power relationship can only be articulated on the basis of two elements which are each indispensable if it is really to be a power relationship: that "the other" (the one over whom power is exercised) be thoroughly recognized and maintained to the very end as a person who acts; and that, faced with a relationship of power, a whole field of responses, reactions, results, and possible inventions may open up (Foucault, 1982, p. 789).

Differently, from the Foucauldian formulation of communication process, the study argues that the mass communication process with its political, social and economic dimensions should be regarded as a form of power relation in the society.

Here, it will be helpful to examine the place of media in Foucault's notion of governmentality by outlining his concepts of discourse and truth. Following Stauff, this study adopts governmentality as a way to understand the discourse of television health programs in Turkey. In this point, media as an institution and discursive field should be considered as "*technologies of government*". For Stauff, from the governmentality perspective, all procedures, institutions, regulated practices and discourse that produce the knowledge about subject and link technologies of self to other regulative practice can be seen as a "*technologies of government*" (Stauff, 2010).

Additionally, as Miller and Rose point out that "governmentality has a discursive character to analyze conceptualization, explanation and calculations that inhabit in the governmental field requires and attention to language" (2008, p. 29). If we consider media as a discursive field and its contents as a *discursive formation* of Foucault's governmentality, it can be argued from his perspective that meaning and meaningful practice is constructed within these discursive formations (Hall, 1997, p. 44). Especially for television programs like reality shows, serials or soap operas etc. it can be argued that they provide the meaning and meaningful practice on the object of governmentality. Dealing with the television health programs, it should be stated that these programs provide the meaning of being healthy and being ill. Moreover, television health programs also suggests the meaningful action on being healthy, what should be done for being healthy, or what should be done for preventing from illness.

However, for Mills, the Foucauldian discourse has also a structure of our sense of reality. To quote from her:

> However, whilst Foucault suggests that discourses structure our sense of reality, he does not see these systems as being abstract or enclosed. He is concerned with the way that discourses inform the extent to which we can think and act only within certain parameters at each historical conjuncture. Thus, although he sees the real as constructed through discursive pressures, he is also well aware of the effect of this 'reality' on thought and behaviour (Mills, 2004, p. 46).

Mills also emphasizes that discourse affects our sense of reality and it also has an influence on the way we think and behave. In this respect, the effects of media contents as discursive formations should be explained as they have a significant influence on our thoughts and our behaviours. Here it can be argued that from a Foucauldian perspective, television health programs have a direct impact on the realities of health and medicine in an individual's mind and what they think about being healthy.

In his archaeological studies, Foucault points out that discourse determines the condition of possibility that defines what can be said, by whom and when. To quote for him:

> Discursive practices are characterized by the delimitation of a field of objects, the definition of a legitimate perspective for the agent of knowledge, and the fixing of norms for the elaboration of concepts and theories. Thus each discursive practice implies a play of prescriptions that its exclusions and choices (Foucault, 1977, p. 199).

During the production process of television program producers decide on the subject matter of the media content, this makes producers define what can be said on the object of governmentality. Moreover, their decision on the guests or the experts in the programs also answers to whom question and the determination of the broadcasting time of the program also important decision as an answer of when question of Foucault's formulation on discourse.

Next, the Foucauldian concept of truth also provides us with a ground to understand the role of the media in the contemporary world. For him, each society has its own truths that are types of discourse made truths and he also points out that there is no separate and independent truth from the power relations as he states:

> The important thing here, I believe, is that truth isn't outside power or lacking in power … truth isn't the reward of free spirits, the child of protracted solitude, nor the privilege of those who have succeeded in liberating themselves. Truth is a thing of this world: it is produced only by virtue of multiple forms of constraint. And it includes regular effects of power (Foucault, 2002, p. 131).

According to Foucault, the political economy of truth is characterized by five characteristics, namely: (1) the centering of truth on scientific discourse, (2) accountability of truth to economic and political forces, (3) the diffusion consumption of truth via societal apparatuses, (4) the control of the distribution of truth by political and economic apparatuses and (5) it is the issue of a whole political debate and social confrontation (Foucault, 2002, p. 131).

On that account, media as a discursive field should be seen as a societal apparatus which enrolled in the diffusion and consumption of truth in the society. For instance, in television health shows, doctors talk about some scientific truths on being healthy, so this can be examined from the Foucauldian perspective as positioning the truth at the centre of the scientific discourse and then diffuse it via television channels for the consumption.

Moreover, from the Foucauldian perspective, when media messages –whether they are television shows, news texts or radio programs– are analyzed as a discursive formation in which many agents enrolled in their production, it is possible to apply his concepts of truth and knowledge to these contents.

The recent discussions on the effects and the role of media in our everyday life, stress on the idea that media has the potential to control to some extent the knowledge, beliefs, opinions, desires of the individuals. Foucault's perspective of governmentality with its radical account on power relation provides a different perspective to these discussions. A notion that is crucial for the Foucauldian perspective is that, his formulation of truth and discourse instead of ideology.

> Foucault's analysis of power indicates that discourses are the arenas in which power-knowledge relations display themselves. Power-knowledge reveals itself through discourses which constitute the mechanisms of control and of normalization process

> operating over individual bodies. Indeed, it is discourses that enable power relations a ground upon which knowledge is produced, because discourses provide regimes of truth, and they maintain and stabilize the criteria of truth (Bilginer, 2006, p. 48).

To sum up, from Foucauldian perspective, it can be argued that medical truths and medical knowledge that are produced in television health programs, are considered as the discourses that function to discipline and normalize the human body and population to secure the power relations in the society.

6.3. Neoliberalism and Media in Turkey

From the perspective of governmentality, neoliberalism should be considered as a political rationality which is diffused in the very sphere of life, from health policy programs to the daily routines of the individuals. Neoliberalism is also a constructivist project with its normative character and reshapes the truth claims of the society. In line with these arguments, mass media can be considered as an arena of discourse formation and orientation which is held in the governmentality network. In this regards, it should be mentioned that the relation between neoliberalism and media should be considered as reciprocal since on one hand, neoliberalism has influenced the media organizations both as a social institution and an economic structure and on the other hand, mass media is an important agent for the formation and the spreading of the neoliberal discourse. Kaya indicates that in concomitant with the neoliberal transformation of the country, there has also been a structural transformation in the media organizations in Turkey between media ownership, power holders and representatives of the capitalist class (Kaya, 2009, p. 257).

Transformation of the Turkish media cannot be abstracted from the global transformation of the information industry. As pointed out by Gülseren Adaklı, the new ownership structure in the world economy has led to a new era in communication industry which becomes the primary aspect of political, economic and cultural fields. These global changes also affected Turkey and the new ownership replaced the traditional companies in media companies. What makes these newcomers of the market different from the former ones is that they are multi-field corporations with

different business branches ranging from the energy to the finance sector (Adaklı, 2001, p. 146).

In order to understand the media structure in Turkey, it is necessary to examine the world's tendency and the current structure very well. Castells and Arsenault have made an important contribution by demonstrating the current ownership structure and relations of the big media conglomerates in the world as:

> The digitization of cultural production and distribution, under the conditions of globalization and deregulation, has ushered in several simultaneous trends. Media content is both diversified and globalized. Media ownership is concentrated and organized around networked forms of production and distribution, the backbone of which is provided by a core of multi-national media corporations that operate through a global network of media networks. In these networks, the global shapes the local but the local also influences the local. The majority of media businesses follow a networking logic so that all nodes of the network are necessary to fulfil the ultimate goals of their program: the commodification of mediated culture and the subordination of all forms of communication to profit-making in the marketplace (Castells and Arsenault, 2008, p. 743).

Beginning with 1980s, deep political changes in state policies came to the stage. Conservative state structure has turned its face to the liberal economy, deregulation policies and then, privatization actions have come into the account. They were holding the great part of the press business, but at the same time, a new type of entrepreneurs has started to emerge. These new entrepreneurs were successful businessmen in the other industry branches such as construction, finance or banking, and they were earning their money from those fields.

When we concentrate on the ownership structure in Turkey's newspapers especially in the 1980s, it is clearly seen that regarding the ownership structure in Turkey's mass media, there was a totally different situation in 1980s than today. This situation depends on the generally known fact that media ownership structure is somehow affected by both the dominant political and existing economic atmosphere of the country.

Moreover, Kaya and Çakmur (2010) also argue on the process transformation of Turkish media in the late 1980s and early 1990, as they detail:

> As a matter of fact, the market-based and outward-oriented strategy for economic development has resulted in taking a shortcut to a more information-based economy and a massive public investment in an advanced communications network. Indeed, the growth in public investment in an advanced communication network generally indicates an expansion of the media infrastructure and an increase in media outlets and products (Kaya and Çakmur, 2010, p. 525).

When we come to the 1990s, the state monopoly on radio and TV broadcasting was abolished and the private sector had already entered the market. Starting with Star 1 channel, in a short period of time, hundreds of new radio and TV stations were established on both local and national scale. "Media policy at this stage was no policy except to allow entrepreneurs and investors a free hand and a general openness to the popular entertainment in the media contents" (Kaya and Çakmur, 2010, p. 527)[29].

In the 2000s, national media accomplished its evolution, which had started at Bab-ı Ali's old apartment buildings and ended in big media plazas in Ikitelli in Istanbul. "The late 1990s and early 2000s witnessed a rapid move from commercialization towards conglomeration, and the media market has come to be dominated by a very few groups through buyouts" (Kaya and Çakmur, 2010, p. 526).

According to the report of TESEV written by Sözeri and Güney in 2010 it is seen "the market shares and concentration shares of the four media groups, namely Doğan Medya, Turkuaz Television Group, Çukurova Group and Doğuş Group [were] dominating 80% of the market in year 2010" (Sözeri and Güney, 2011, p. 55).

In this sense, it is worth stating that the ownership structure of the media atmosphere in Turkey was monopolistic in 2010. From 2010 to 2018, there were many changes in the ownership structure of the media in Turkey but the most significant change which was related to the biggest group of the media sector emerged in the year 2018. In March 2018, it was announced that Doğan media group had been sold to the Demirören Holding in March

[29] As Kaya and Çakmur point out that "initiated its first test broadcasts in March 1990 through the channel baptized as Star 1; declaring itself Turkey's first private television" (2010, p. 527).

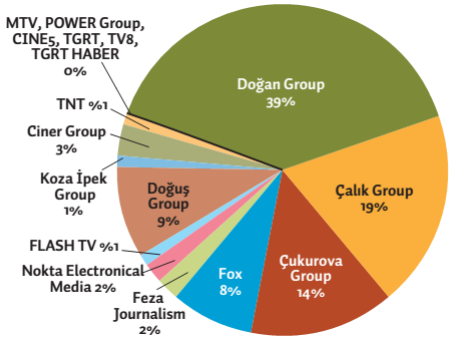

Figure 1. Media Group Sharing in Television Broadcasting in the Year 2010

Source: Sözeri and Güney (2011, p. 55)

To conclude, in the post-1980s era and 1990s there was a neoliberal restructuring of the media ownership structure in Turkey.[30] Concomitant with the global changes in the media industry, it is seen that there was an increasing involvement of capital owners in the media industry in Turkey. Today media ownership structure can be considered as a monopolistic structure or there is a dramatic conglomeration in the media market of Turkey. The monopolistic structure of the media market has many impacts on the content of media, which are one-sided broadcasting, commercialisation and marketization rather than public broadcasting.

6.4. Health and Media in Turkey

Health as an issue in the Turkish mass media first appeared in newspaper columns. Following newspapers, there were many radio programs which covered health-related issues. For instance, in the year 1962, a new part called Doktorun Sohbeti (A Talk by a Doctor) was added to the radio program called Günaydın (Good morning) on TRT radio channel (Oskay, 1971 as cited in Atabek et al., 2013a, p. 117).

Historically until 1990, there were only TRT (Turkish Radio Television Institution) in the Turkish television market. TRT was a publicly-owned autonomous channel with

[30] Competition authority approves sale of Doğan's media assets to Demirören" http://www.hurriyetdailynews.com/competition-authority-approves-sale-of-dogans-media-assets-to-demiroren-131471 (Accessed on 20.01.19)

its legal status, and its functions were defined as being those of a public service broadcasting company. Regarding the health issue there were educational programs starting from the year 1976. İnsan ve Dünyası (Human and His World) should be regarded as the first example of television health programs in Turkey, which presented many health issues ranging from tension to organ transportation or the problems of the elderly. Moreover, a daily television program called Kadın ve Ev (Women and Home) was also an example of daily women programs which informed their audience about some health-related issues. In the program of Kadın ve Ev, there were many parts with different topics and the part with the title Bizim Hastalıklarımız (Our Illnesses) included a doctor as an expert who answered the health-related questions of viewers. It should be noted that the questions of the audience reached the television program by letter so at the final stage of the program, the presenter repeatedly announced the correspondence address of the program. As the only public broadcasting channel, TRT was an important tool for health promotion. The health-related issues as healthy food consumption, healthy baby caring, healthy child feeding, aerobic workouts were the primary issues of the programs on the channel. For instance, in the year 1981 there was a program titled Necmettin Erkan'dan Sağlık Yaşam ve Spor (Healthy Life and Sport from Necmettin Erkan). The program was hosted by Necmettin Erkan as a specialist in sport and healthy life, and during the program, he shared advice about healthy living and sports with viewers[31].

When it aims the promotion of health, television is arguably the most pervasive mass medium with its visual and textual codes, but it can be argued that with the private channels, health issue on television channels transformed from being a subject of education to a subject of attracting more audience. Beginning with STAR 1, television commercial channels began broadcasting their programs in Turkey in the 1990s and health-related subjects were presented in these channels' programs, especially in the daytime programs. Here, it should be added that not only in programs but also in news bulletins, health-related issues were becoming so popular in Turkey that in each news

[31] Researcher has searched the programs internet archive of TRT by using the world "sağlık" (Health) as a keyword from: http://www.trtarsiv.com/

bulletin it was possible to come across news about health. Sometimes information about new medical technology was given and some other times, risks on health were presented. In line with television channels, there was a pervasion of health-related issues in Turkish newspapers, too. Special papers handling health issues started to appear in newspapers. In this regard, the increase in the number of health-related news brought some ethical problems in journalism. The problem is that when the health-related news is reported in an inaccurate, imbalanced or incomplete manner, they become harmful to the health of the individuals. In other words, health-related news as a source of medical knowledge might cause a lot of harm to the health of people. These harms can be summarized as people being misled into placing false hopes in an unproven approach. They may also schedule unnecessary physician visits or they may prefer self-treatment instead of seeing a physician. Many studies in Turkey touch upon such issues. For instance, Hayran and Özdemir (2011) analyzed health-related news in eleven newspapers of the year 2010 and they found in their study that in most news texts, there is an incompatibility between the headline and the content of the news texts and 58% of the news texts which include the name of doctors reflect the medical truths, whereas for the ones which have no doctor's name on them, the accuracy rate decreases to 32%. Another significant research has been done by Sezgin (2011), which analyzes health-related news and other contents. The research concludes that health-related news in the newspaper Hürriyet serves for the 'medicalization of everyday life' and individualization of health in Turkey. Another important point that the study suggests is that with the help of the health-related news, the boundaries between cosmetic and medicine are blurring.

Lastly, Atabek, Atabek and Bilge (2013b) have done another meaningful research by analyzing health-related news that appeared in Hürriyet Newspaper between 1970 and 2010. With their analysis, they point out that the health-related news in Hürriyet reflects the changes in the political paradigm of health transformation policies in Turkey. One of the most important argument that they provide is, throughout the years, health-related news has dramatically changed both in numbers and content. They also argue that between the years 1970 and 2010, because of non-expert sources and hidden

advertisements in the content of news texts, health-related news were problematically commercialized in Turkey.

As it has been mentioned before, the history of the Turkish television broadcasting witnessed many different formats on health-related subjects. Here it should be added that television is the most popular mass media among Turkish people. Clearly, data provided by Radio and Television Supreme Council (RTUK)[32] shows that the average daily time spent watching TV in Turkey in 2008 was three hours a day. Overall, statistics provide that Turkish women are ahead of man in the time they spend watching TV with an average of 4.5 hours per day. Accordingly, it can be argued that television plays a significant role in providing medical knowledge for lay people in Turkey.

Since the 1990s, health-related subjects have become popular for daytime women shows. In these programs, doctors as experts often address different issues and give medical information and healthcare advice to the viewers. Because of the complex broadcasting stream of these programs, doctors were expected to answers medical questions in a limited time. For example, in some of these programs, it was seen that doctors had trouble answering medical questions in five minutes between a song and the recipe of the day (Atabek, Atabek and Bilge, 2013a).

Afterwards, a new genre emerged on Turkish television channels: television health programs. These programs should be seen as the followers of their American versions, especially Dr. Oz Show[33]. These television health programs offer medical information and inspiring stories of lay people in an entertaining format. Supported by different host doctors, these programs use many tools such as medical educational videos or

[32] https://www.rtuk.gov.tr/rtuk-arastirmalari/3726/1984/2009-yili-kamuoyu-arastirmalari.html downloaded in July 27, 2018

[33] The Dr. Oz Show is an American health television show, presented by Mehmet Oz, a cardiothoracic surgeon and also a teaching professor at Columbia University.

graphs, statistics to provide information on different topics, ranging from weight loss, nutrition and staying young to beauty and how to clean houses.

In addition to these, the public service announcements aired on TV cover important health content which allows the meaning transfer between the policy makers and the subjects. For this thesis, 45 public service announcements which have been broadcast on TV over the last three years have been reached on the official website of the Ministry of Health. When examined, public service announcements can be said to cover content related to smoking and the use of tobacco the most. The novelties brought about by the health transformation program such as Cancer Screening, Early Diagnosis and Training Center (abbreviated as KETEM in Turkish), family practice, e-pulse applications and the new city hospitals are some other subjects dealt with in these announcements. The other subjects covered by the public service announcements are the use of antibiotics, obesity and diabetes. Subjects are familiarized with these diseases through these announcements and they are warned against them. What is significant for this thesis is that only two of these 45 public announcements deal with the health issues concerning women and these two were prepared to reach mothers only. That there is no announcement trying to inform women who are not mothers about possible health problems is an important piece of data. [34]

Accordingly, there are many different studies in Turkey which focus on the health-related content on television channels, but here three of them will be mentioned. Firstly, Şahin Kaya's (2011) study on television, women, health and illness is important to show how gender inequalities are reproduced by the media in terms of the definition of health and illness. Kaya's research also provides a perspective for understanding gender inequalities in the relations between media and the health sector in Turkey. Secondly, Koçak and Bulduklu's research on the motives of elderly people in watching television clearly indicates that the primary motive for elderly people to

[34] To see these public service announcements https://sggm.saglik.gov.tr/TR,4282/kamu-spotlari.html (accessed on 22.03.19)

watch health shows is to get medical knowledge. Another research done by Atabek, Atabek and Bilge discursively analyzes two television health shows; namely, Doktorum (My Doctor) (Channel D) and Feridun Kunak Show (Channel 7) in Turkish channels in the year 2012. In this study they conclude that discourses of these television health shows are in parallel with the new liberal-conservative discourse of health and also these shows reflect the political discourse on health in Turkey (Atabek et al., 2013a).

Today, there are many television health shows on both public and private channels in Turkey. These programs feature different kinds of subjects together, ranging from illnesses to recipes or caring for children. Considering their broadcasting time and their contents, it can be argued that these programs mainly address women audience. Doctors as a source of expert knowledge are the central characteristics of these programs. Such programs mostly present a discussion between the presenters and doctors as guest experts in order to give added insight into a selected medical topic.

6.5. The Discourse of Television Health Programs in Turkey

In this section, the discourses produced related to women's health in three programs broadcast on TV will be analyzed. Visual media was chosen in order to understand the discourse on women's health in the media, and the printed press was not included in the sampling. The reasons for this are that television is the most widespread means of mass communication, and it is at the center of all media theories and practices. Moreover, it is known that the target audience of the media content on health in daytime shows is women who are at home when the programs are being broadcast. As a result, health programs on television will provide the necessary data to analyze the discourse on women's health in the media.

Two of the most important public functions of media are to inform the society and to mediate discussions of certain subjects by providing a public sphere. Media also serves as a means of conveying medical knowledge to the public. The health-related media content forms social norms via discourses and establish what is right or wrong related

to the subjects in question, and thus guide people in their everyday actions. Discourses influence perceptions and attitudes through the media, and as a result, they affect behaviors. The discourse analysis of the media content addressing women in health programs on television will reveal how women are positioned in the field of medicine and how medical knowledge and sickness or health behaviors are reproduced via discourses. For data collection, the programs called Doktorum (My Doctor), which is broadcast on Kanal D (Channel D), Dr Feridun Kunak Show on Kanal 7 (Channel 7) and Canım Doktorum (My Dear Doctor) on NTV were chosen with the purposeful sampling technique. While collecting the data, I sought an answer to the question: Which discourses do the health programs on TV addressing women produce related to women's health? Then the collected data was analyzed with reference to the three guiding categories that were obtained from the theoretical framework of the thesis; namely, medicalization, commodification of health and individualization of health. Before mentioning the details of analysis, the contents and the production dynamics of the programs will be mentioned.

6.5.1. The Production Dynamics of the Programs

The discourses produced by the media content are closely related to the features of the media genres. The features such as the parts of the program, presenters, the studio and the set, which could be called as the production dynamics, contribute greatly to the production of the discourses used in programs. Therefore, it will be advantageous to analyze the production dynamics of these programs first in order to be able to comprehend the health discourse aimed at women.

Dr. Feridun Kunak Show is aired live on Channel 7 (Kanal 7) on weekdays except for Friday as a daytime show. The presenters of the program are Dr. Feridun Kunak, a specialist in orthopaedics and traumatology, and his wife Serap Kunak, who is an actor. When analyzed in terms of its genre, this program can be said to include elements from other genres as well. For this reason, although it is claimed to be the health program with the highest rating, the variety of the subjects covered in this program makes its genre unidentifiable. Considering the content of the program, it can

be seen that it is such a different type of health program in which even prizes are distributed to the viewers who watch it keenly and note down the codes during the program. The prizes distributed to the viewers are medical products such as orthopaedic shoes and heating belts and are recommended by the medical expert in the program, who is usually the presenter, and these products are endorsed after the prize contests by repeatedly saying that they are good for health problems like walking difficulties or lumbago.

The program also includes a part in which the viewers are given recipes, which makes the program seem like a cooking show. In each episode, Serap Kunak gives "easy, practical and healthy" recipes and the spectators in the studio always taste the food, which is prepared in the kitchen of the set according to the recipe given. Another component of the program is taken from travel shows, which is another genre. In most of the episodes that were analyzed, Feridun Kunak and his wife visit various cities in Turkey and they not only taste local dishes but also promote historical places there. For example, they go to Bursa and collect recipes of "mantı" (a type of Turkish ravioli made with ground meat and yoghurt) and "lokma" (a desert similar to churros) Unlike travel shows, in this program Feridun Kunak, who is defined as "the doctor who comes over," listens to people's health problems and suggests remedies to them wherever he goes. This content in the program, which in fact aims to entertain the audience while informing them, calls for the use of a hybrid term to refer to a new genre. The term that can be used to refer to it is "infotainment," which was firstly introduced by Neil Postman (1985) in order to criticize the blurring line between information and entertainment in the content of the news. The term has been used recently to refer to such media content, indicating that in such programs entertainment and information are intertwined. This concept has been used since the 1990s to criticize the increasing entertainment and tabloid content used in news programs, for such programs are considered to be straying from their real function of informing the public, which is a public responsibility of news programs. In Turkey, the best examples of infotainment are the videos of animals shown after the main news bulletin, involving serious

political news, is over. Contents such as recipes, contests and music in health programs lead to the tabloidization of health content.

Feridun Kunak Show is aired in a small studio in Ankara with a few spectators in it. The majority of the spectators in the studio are women, but it has been observed that male spectators also watch the show there, though this is rare. These spectators are usually groups of women attending the activities aiming at women organized by municipalities. Members of Kadın Eğitim ve Kültür Merkezi (Women's Center of Education and Culture) and Etimesgut Halk Eğitim ve Kültür Merkezi (Etimesgut Public Educational and Cultural Center) attended the shows which were analyzed. In these programs, the music teachers of such spectator groups sing folk songs and they dance along to the music. This type of content bears the characteristics of entertainment programs. The "health program" Feridun Kunak Show, which involves the qualities of the genres quiz shows, travel shows, cooking shows, and music and entertainment shows, keeps informing the audience with medical knowledge amidst this chaos of genres. The program defines itself at the beginning as "Dr. Feridun Kunak Show, the show that conveys the right information about your health accompanied by an enjoyable chat."

Feridun Kunak and Serap Kunak treat these spectators as if they were their own guests visiting them at home and they frequently hand the microphone to them and ask them questions. The plant whose benefits will be explained in the program is handed around the audience, and they are asked to name it. The treatment of the health problem which is dealt with that day is applied to the audience. The spectators are made to lie on a stretcher so that the creams or the mushes whose recipes are given can be tested on their bodies. In order to convince all the audience that it really becomes effective even in a short time, that particular spectator is made to say that the mush has relieved the pain and the cream has worked its magic. In the program, the doctor, who is also the presenter, examines the spectators as if they were his patients seeing them in his clinic, diagnoses the patient with an illness and even starts the treatment there. Because it is aired live, the program is known to have led to some harsh reactions of the audience

as once the doctor applied massage on the waist of one of the spectators in the studio wearing a headscarf with a toilet pump to treat her lower back pain and her waist was revealed during the application. This instance has been covered on Internet news websites with headlines such as “Feridun Kunak’s treatment causing reactions.”

Feridun Kunak is the only source of medical information in the program. He is an expert in orthopaedics but he tells the audience what to do in all the other areas of expertise. In Feridun Kunak Show, sometimes the subject in question is a symptom such as lumbago, backache or constipation, and sometimes it is foot health or health problems such as heart attack, anemia or osteoporosis.

In Feridun Kunak Show, the doctor first gives the necessary explanations to the audience avoiding the use of medical terminology and then the audience is informed about what they should do in order not to suffer that problem or how they can treat it at home. First, he uses the white board and explains the health problem by drawing it there instead of using visual aids prepared with the latest technology. In many of the analyzed shows, the doctor uses real bones and pumice to tell the audience about osteoporosis, for example, or to explain apoplexy, he makes use of a simple mechanism with a hose through which a red liquid flows or models of certain organs.

While Feridun Kunak gives the audience medical knowledge, the second presenter, Serap Kunak, establishes a much closer connection with women, who are the target audience of the program. Serap Kunak explains how the knowledge given by the doctor can be applied and how the given recipes can be prepared in the kitchen by the audience themselves. Additionally, in this program, a link is often established between health and beauty and Serap Kunak gives beauty recipes that can be prepared at home. She sometimes applies the masks she prepares on the face of one of the spectators in the studio and she keeps repeating how effective it is. Serap Kunak has a book about this subject titled *Beauty Secrets*. This book is endorsed in the contest part as it is given as a prize to the audience. She tells the audience about how to do the laundry healthily, how to cook chestnuts or gives them recipes for breakfast for healthy slimming. Moreover, she convinces the audience that these recipes are reliable ones that they use

at home by uttering sentences like “I assure you that we will never tell you about anything that we do not try ourselves” (FK, 15.02.17).[35]

In each program, Feridun Kunak wears a tracksuit and training shoes as if he were a sports trainer. At the beginning of each show, he gets the spectators in the studio to do morning sports. Not even once has he been observed to wear any other type of clothing such as a white coat or a green scrub, both of which are usually worn by doctors. The other presenter, Serap Kunak does not wear a medical clothing item, either.

Feridun Kunak addresses not only the audience in the studio but also the on-air callers as “dear sisters”, “fellow sisters”, “(my) elder sisters” or “(my) dear sisters” as these words connote the sincerity in everyday conversations. In the program, the message that is supposed to be given to the audience is written in subtitles in the form of a fixed sentence pattern. For this reason, subtitles will also be taken into consideration when the program’s discourse is analyzed.

The program called My Doctor, which is aired on Kanal D, is a daytime show broadcast on all weekdays. The duration of the program is nearly one and a half hours. The presenters of the program are Dr. Murat Aksoy, a vascular surgeon, and Hilal Ergenekon. The most distinguishing feature of the program is that the diseases that are dealt with are presented in the form of patients’ stories. In this part of the program, in which the documentary language is used, patients and the relatives of patients share their experiences with the audience.

Through this program, the audience witnesses the experiences of the patient suffering from the disease, his or her communication with his or her doctor and the doctor’s diagnosis as well as the treatment. This program bears the quality of real-time as the documentary language is used and real-life experiences are told. The approach which is defined as unacceptable in terms of medical sociology as it focuses on the

[35] When mentioning the programs, I used the abbreviations of FK for the Feridun Kunak Show, D for the program called My Doctor and C for the program My Dear Doctor together with their broadcast dates.

experiences of an ordinary patient is the approach that can clearly be seen in the program My Doctor. Similar to Feridun Kunak Show, recipes are given in this program, too, but this time by guest dieticians. Another similarity is that in addition to medical knowledge, entertaining content is a component of this program, which brings about the tabloidization of the health content via other media contents.

Animations are used in this program when health subjects are presented. When the voice-over defines the disease, these animations convey the medical information related to the disease to the audience. The program is shot outdoors. The presenters present the program in the streets, at the street markets or shopping malls. These outdoor places can vary as sometimes they can be houses of the patients, where patients talk about their past experiences or sometimes doctors' clinics. Another significant feature of the show is that sometimes operations are recorded and shown to the audience by changing the operating room almost into a studio by installing cameras.

The subjects handled in the program are explained by doctors who are experts in those fields. Guest doctors and the presenter always wear a medical clothing item. In addition to expert doctors, yoga trainers, beauty experts, sports trainers and dieticians are also consulted as sources of information. The content of the program is defined in its teaser as "Everything ranging from what is necessary to maintain your health to the important information on the secrets of a happy life or useful tips for your health." The program is not solely concerned about diseases and the essential things to do to be healthy. Beauty is also a subject that is quite often dealt with. In a part of the program, facial mask recipes are given by beauty experts, who are not doctors, or these experts inform the audience about how to rejuvenate the skin. These parts of the program, which are about beauty and aesthetics, are in parallel with the discourse of the aestheticization of health.

My Dear Doctor (Canım Doktor) was a program presented by Prof. Dr Cihan Aksoy, who is a physical therapist, and was broadcast on NTV on Saturday mornings. It is no longer aired. When compared to the other two programs which are analyzed, the

duration of this program is shorter than the others with 30 minutes. Unlike the other two, because of its airing time and day, My Dear Doctor is not a program targeting women only. Therefore, the wording used when addressing women is different in this program. Women are rarely addressed the way they are in other programs. The program is unlike the other two programs with respect to the subjects that are handled, as well. To illustrate, there is a more frequent coverage of mental illnesses and illnesses especially affecting working women and men, who are the target audience of the program. There is observable attention paid to specialization. Information on health issues are provided by specialists in their fields and even academicians working and teaching at hospitals or presidents of health associations, who are also specialists in a particular branch, are consulted. In a nutshell, it can be stated that the most competent specialists in their own fields are selected and they are invited to the program as reliable sources of medical knowledge.

The presenter of the program My Dear Doctor, Prof. Dr. Cihan Aksoy, presents the program alone with his casual clothes on rather than a white coat. At the beginning of each program, Mert Güler, a yoga and Pilates trainer, teaches the audience physical exercises that can be done within a very short time. While teaching them these exercises, Güler repeatedly utters the phrase "movements that can be done at the office," again highlighting that the target audience is working people.

It has been observed that some shows are aired not in the studio but the conference halls of universities with university students as spectators. The content of the program is comprised of the dialogues between the presenter of the program and the doctor who is an expert in his field, who keeps answering the presenter's questions. It has been noticed that even though the presenter tries to avoid the medical terminology and asks the questions with the wording used by the audience, the experts use a great deal of that terminology. At the end of each episode, the presenter sums up the medical content of the program which is conveyed to the audience starting with the phrase "We have learned that…"

In the program, My Dear Doctor, animations about the subject that is being dealt with in the program are frequently shown on the screens in the studio. It has been observed that in some programs, the tables related to the symptoms or the treatments of the diseases are displayed on these screens. The experts' sentences are repeatedly quoted in the subtitles. For this reason, as it is the case in the other programs, the subtitles are included in the discourse analysis as they are outstanding and highlighted parts of the discourse. The following table indicates the broadcasting date and the contents of the three television health programs which have been selected as a sample for this thesis.

Table 8.

The broadcasting dates and contents of the television programs to be analyzed

DOKTOR FERIDUN KUNAK SHOW – Channel 7	
BROADCAST DATE	**CONTENT**
02.01.17	Alzheimer's disease, menopause
15.02.17	Obesity
06. 02.17	Cancer, foot health
29.12.16	Urinary tract infection
05.01.17	Neck pain and backaches
06.12.17	Lumbago
08.12.17	Menopause
12.01.17	Hemorrhage
15.02.17	Slimming
20.04.17	Anemia
19.01.17	Bilharziasis, bone curvature in children
20.02.17	Meniscus
9.03.17	Sleep disorders
6.04.17	Brain health

Table 8. (continued)

16.03.17	Herniated disc
27.03.17	Heart attack
27.04.17	Radiation
09.05.17	Neck pain
22.05.17	Osteoporosis
18.05.17	Slimming
23.05.17	Foot health
DOKTORUM (MY DOCTOR) - Channel D	
BROADCAST DATE	**CONTENT**
11.07.16	Obesity, breast cancer
12.07.16	Diabetes, knee pain
13.07.16	Thyroid gland dysfunctions, bypass
14.07.16	Obesity operation, vertigo
15.07.16	Neck pain, lumbago and scoliosis
18.07.16	Hypoglycemia, reflux
19.07.16	Amnesia
20.07.16	Urinary incontinence, anemia
21.07.16	Burning calories doing household chores, heart attack
22.07.16	Kidney stone, snoring
25.07.16	Menopause
26.07.16	Colonoscopy
27.07.16	Healthy slimming
28.07.16	Nevi, respiratory diseases

Table 8. (continued)

29.07.16	Cough, dyspnea
01.08.16	Constipation
02.08.16	Endoscopy, breast reduction
03.08.16	Lumbago
04.08.16	Osteoporosis
05.08.16	Preservation of food, latent diabetes
CANIM DOKTOR (MY DEAR DOCTOR) - NTV	
BROADCAST DATE	**CONTENT**
21.01.17	Scoliosis
14.01.17	Jealousy in siblings
07.01.17	Psoriasis
24.12.17	Postnatal depression
10.12.16	Rheumatic diseases
26.10.16	Amnesia
30.04.16	Alzheimer's
06.11.16	Organ transplantation
30.10.16	Aesthetic operations
22.10.16	Depression in children
17.09.16	Social trauma
10.09.16	Nutrition during the Sacrifice Holiday
25.09.16	Children's success at school
02.10.16	Healthy ageing
04.06.16	Pimples and nevi

Table 8. (continued)

11.06.16	Fasting and nutrition
07.05.16	Oedema and tympanites
13.09.16	Circulatory disorders and cellulitis
20.02.16	Attention deficit disorder and hyperactivity in children
02.04.16	Hepatitis, jaundice

6.5.2. Health Discourse Aiming at Women in the Television Health Programs

This dissertation argues that neoliberal governmentality of health is made possible through three strategies, which are medicalization, commodification of health and individualization of health. In this section, the discourses produced in three television health programs aired on three different television channels are analyzed according to these three strategies. It must be noted here that the strategies medicalization, commodification and individualization are strategies that cannot be completely separated from each other and thus complement each other. It can be said that during the analysis, it is likely to identify more than one strategy within the same discursive formation. The reason for this analysis is to seek an answer to the question: Do the health discourses produced in these three programs as the selected sampling support the strategies of medicalization, individualization and commodification or are they against them.

6.5.2.1. Medicalization

In this section, the discourse of the selected three television health programs is analyzed with reference to the medicalization strategy of the neoliberal governmentality of health. The main question in this section is: Are the discourses produced in these television programs in line with the medicalization strategy of the neoliberal health discourse or do they produce counter-discourses contradicting the medicalization strategy

First, as seen in Table 8, the analyzed television programs aim to inform the audience about a particular illness in each episode. If diabetes is to be covered, an expert in diabetes is invited to the program. The guest doctors in the program talk about what to do to protect oneself from a particular illness or how to live with that illness if one is already afflicted with it. It can be stated here that all the analyzed programs defined health in relation to illness. In these television health programs, health is defined as the state of not being ill, being protected against it or avoiding it. The main theme used by the experts in the television programs is healthy living. Audience are constantly told that they can protect themselves from illnesses by changing their lifestyles and adopting a healthy living style. The discourse of the healthy living style may in fact be considered as the medicalization of everyday life, that is, the inclusion of many acts in the daily life within the scope of medicine.

Medicalization of everyday life is a radical criticism expressed by Illich leveling at health system. Medicalization is dealing with a subject or a case either within the scope of medicine or by making it open to medical intervention.

In addition, it has been noted that activities such as healthy cooking, healthy sleeping and healthy cleaning have been medicalized. It becomes quite obvious that the domain of the medical intervention has expanded considerably with the discourse used in the media. Health tips concerning everyday life, especially on nutrition, affect all our daily activities ranging from doing the housework to getting up in the morning or walking in the street, and through this discourse, all areas of women's lives are noticed to have been medicalized. The following examples illustrate how various elements of the daily life are medicalized in these programs.

> Healthy curtain cleaning with Serap Kunak. (FK.19.01.17)
>
> How to make cleaning vinegar (We're going to make cleaning vinegar, ladies. Why did I say ladies? Because generally, women do the cleaning. (FK.19.01.17)
>
> We're going to tell you how to walk on the streets on a winter's day dear sisters. (FK. 29.12.16)
>
> How should glasses be used? (FK. 19.01.17)

What are the points to be considered when getting out of bed? (FK. 19.01.17)

Make sure you put another pillowcase on your pillow! (FK. 09.03.17)

Methods of drying vegetables and fruit. (FK. 16.03.17)

Be careful with these when hanging curtains. (D. 11.07.16)

Which mistakes do you make when doing the kitchen work? (D. 11.07.16)

Plastic shopping bags may disable you. (D. 11.07.16)

A healthy "gold day" menu. (D. 13.07.16)[36]

Do you carry your bag properly? (D. 15.07.16)

Do you suffer from a backache when doing the ironing? (D. 21.07.16)

What should you consider when doing the housework? (D. 21.07.16)

In the program My Dear Doctor, because of the time limitations of the program and the lack of guests other than the expert doctors, the medicalization of everyday life is very rarely seen. The most typical example is when tips on how to prepare and consume the meat of the sacrificed animal are given. (C. 10.9.16)

Medicalization spreads through all areas of life, and the natural processes in life such as birth, death and menopause become medicalized as they are described as medical conditions, and they become open to medical intervention. In the analyzed programs, it has been observed that subjects such as birth, menopause, motherhood and childcare are covered very often.

It has been observed that in the analyzed programs menopause is also quite frequently dealt with and this phase is medicalized. To illustrate, in the program called Dear Doctor, the question "One who enters a bathhouse sweats. What happens to those who enter menopause?" is asked (D. 25.07.16) when handling the menopause phase and then a recipe for an herbal cure to relieve the effects of menopause is given. In another episode of the same program which was aired on 04.08.16, it is said that "osteoporosis

[36] Gold Day means a women's gathering in which women come together once a month and bring gold to the host to save their money

is a reality every women will face even if to a small extent especially in the menopause phase" and the audience are warned about the possible health problems stemming from menopause. Similarly, it is seen that recipes for herbal cures for the menopause period are also quite often given in Feridun Kunak Show. The following sentences exemplify the discourse produced on menopause in this program:

> Make this tea both to postpone menopause and to get rid of the disturbances it causes. (FK. 8.12.17)
>
> Menopause is a troublesome situation for our sisters. Chamomile reduces the stress resulting from menopause. (FK. 02.01.17)

Other subjects which are quite often covered in these programs are motherhood, another important phase in women's lives, and healthy child raising. A cook who appears on the program My Doctor gives mothers a recipe for healthy baby food. (D.05.08.16) In his program, Feridun Kunak constantly advises mothers to breastfeed their babies. Here it can be noted that the motherhood phase of women and the issue of child-raising are also medicalized through the discourses used in these programs.

In the same program, it is claimed that the reason why mothers do not lose weight after giving birth is that they do not breastfeed and the mothers who do not do so are criticized. The effects of breastfeeding on women's health are also highlighted. "Breastfeeding is such a blessing of God. When mothers breastfeed, they lose weight but unfortunately, they don't [and they say] 'He doesn't suck, mister brother doctor.'[37]He will. To suck milk is in his nature but what are you doing? You're making the biggest mistake by immediately starting to feed him with the feeding bottle" (FK. 27.03.17).

In an episode of My Dear Doctor, the subject dealt with is postnatal depression and the time after birth is explained by the medicalization of that period. When the subject post-natal depression is handled, motherhood is defined by saying, "Motherhood is

[37] Breasfeeding is such a blessing granted by God. When the mother breastfeeds the baby, she loses weight but unfortunately, they don't do it, saying 'It doesn't suck, brother doctor.' It will! Sucking is in its nature. But what are you doing? You are making the biggest mistake! You give it the feeding bottle.(FK. 27.03.17)

not a concept to be defined on its own. An egg yolk can't exist without its white and neither can motherhood be defined without the child. There is the unity of the mother and the child" (C. 24.12.16). In this way, motherhood as a concept is medicalized.

A typical example which shows how women's body is defined in connection with motherhood is seen in Feridun Kunak Show, where the presenter of the program draws the body of a woman on a board and says, "This is the womanhood organ, this is through which we defecate and this is the part with which we give birth," and thus defines the woman body with the function of childbearing. This discourse reminds us of the fact that the presence of women in public service announcements only with their roles as mothers.

In addition to all these, the discourses in the programs show that many experts and new subfields of specialization have emerged. Mert Güler, a yoga and pilates experts who often appears in the program My Dear Doctor, teaches women how to breathe right and the physical exercises that could be done in their daily lives. In the program My Doctor, meat expert Cüneyt Hasan tells spectators how to choose the right meat and in the same program a variety of specialists such as a face yoga expert or a beauty expert are hosted. It is noteworthy to mention that unlike the other two programs, My Dear Doctor hosts only doctors as experts in certain fields, so it has been noticed that no other types of specialists are invited to the program. However, it should also be noted that another feature of this program is that some doctors make comments on the areas other than their field of specialization. For example, Feridun Kunak, who is the presenter of the Feridun Kunak Show, is an orthopedist but imparts the audience information about all the medical fields. The situation is no different in the other two programs which have been analyzed. The presenter of the program My Doctor, Dr. Murat Aksoy, is a vascular surgeon but he gives the audience information about all the medical areas of expertise. The presenter of the program Dear Doctor, Cihan Aksoy, is a physical therapist but he also comments on whatever subject a particular episode deals with. It is possible to state that new experts other than doctors and new areas of expertise have emerged but in these programs the doctors are presented as

knowledgeable people in even outside their areas of interest and as authority figures. These two situations clearly reveal that the neoliberal discourse has created new experts and that it has caused the medicalization of everyday life, which paved the way for the medical authority extending to the every sphere of the life.

In this dissertation, individuals' self-healing practices, which means their efforts to recover by refraining from drugs and preparing home-made mixtures and food, are considered as a reflection of medicalization in the subjects' everyday lives. In the analyzed programs, especially in Feridun Kunak Show and My Doctor, it has been observed that a healthy recipe for a dish, tea, vinegar, etc. is definitely given in each episode. Examples to these discourses are as follows: A vinegar that is good for constipation (FK. 20.04.17), home-made cures for the treatment of hameorrhage (FK. 16.03.17), natural cough paste (D.13.07.16), and "Today we are going to make a cataplasm that you can prepare at home and will be good for your backaches or your neck aches" (FK. 05.01.17).

This thesis argues that another indication of medicalization is the individuals' dietary choices being under the control of medicine. In the analyzed programs, there is a frequent link between dietary choices and health. To illustrate, in Feridun Kunak Show, the presenters often give recipes for dishes. The guest dieticians appearing in the program My Doctor also give healthy recipes quite often. Although rarely covered, dietary choice is also an issue to be handled in My Dear Doctor. The following are some examples to such discourses:

> The best pharmacy is your fridge. (D. 18.07.16)
>
> In order to prevent menopausal hot flush, you should eat a spoonful of flaxseed and three walnut kernels every day. (D. 25.07.16)
>
> Super food fighting osteoporosis. (D. 04.08.16)
>
> We can say farewell to anaemia with natural black grape wine. (FK. 20. 04. 17)
>
> The benefits of thyme 19.01.17. (FK. 19.01.17)
>
> Which foods should we consume for a healthy brain development? (FK. 06.04.17)

> Your brain does not work when you drink little water. Drink water please. (FK. 06.04.17)
>
> The benefits of hash for health. A recipe for a cake with hash. (FK. 16.03.17)
>
> Sweet basil helps the body to get rid of the toxins. Use it abundantly in your dishes. (FK. 16.03 17)

Healthy nutrition in Ramadan. Types of desserts recommended to be consumed. Stay away from desserts made with pastry when breaking your fast. (C. 11.06.16)

All in all, it can be stated that in the discourses used in the three analyzed programs the phases of menopause and motherhood in women's life cycle are medicalized. Many of the areas of women's lives are medicalized and everything in women's lives becomes the subjects of medicine. In other words, women's everyday lives are medicalized through the special mixtures they prepare for self-healing and their dietary choices. In the discourses used in these programs, women are told to be active citizen-consumers in order to heal themselves and to spend most of their daily lives trying to prepare this healthy food to the other members of their families.

6.5.2.2. Commodification of Health

In this thesis, the health has been approached as a commodity as a consequence of neoliberal governmentality of health, both in the sense of the transformation of health care services and in the consumption motives of women (See Chapter 4.)

In the analyzed programs, especially women are encouraged to consume healthy products through preparing the cures, teas and mixtures. Women are told to make some teas with the herbs they will buy from herbalists or to spread some oil mixtures on their bodies to relieve their pains or to recover from their illnesses. All these discourses lead women to consume natural products rather than pharmaceuticals in order to be healthy. The emphasis on "naturalness" is a commonly observed discourse formation in the analyzed programs. It can be concluded that this discourse of "naturalness" in these programs has turned health into a commodity.

In Feridun Kunak Show, cures, mush recipes or recipes for mixtures such as vinegar are given for spectators so that they can avoid illnesses or can treat themselves at home. When the information on such practices is conveyed to the audience, it is underlined that these are "natural." It is claimed that these recipes, which can all be prepared with the ingredients that can be found in any kitchen, are good for the treatment of hemorrhage, urinary tract infection and also disturbances and pains stemming from menopause. For example, preparing mush recipes, cure recipes and recipes for vinegar are presented to women as effective health behaviors that they should show in order to be healthy. Discourse examples from the analyzed television programs that can be added to this category are listed below:

> A recipe for a natural mush to treat hemorrhage (FK. 12.01.17)
>
> Natural health recipes and cures to overcome obesity (FK. 15.02.17)
>
> Natural treatment methods to get rid of urinary tract infection (FK. 29.12.16)

In the program My Doctor, a natural cream for chapped skin, a natural formula that relieves menopausal symptoms, natural recipes for purifiers by Erkan Şamcı a natural formula for hair and nails, in the program Feridun Kunak Show, a natural cataplasm for knees, a natural treatment for urinary tract infection, and in the program called Dear Doctor, the natural and unnatural results of aesthetic surgery, and "What is a natural breast."

Furthermore, through the connection made between beauty and health and the discourses produced in these programs, women are told to consume certain products in order to be beautiful and healthy. Here it should be mentioned that, this thesis argues that aestheticization of health also leads health to become a commodity.

In the analyzed television programs, it has been observed that subjects in the domains of beauty and aesthetics are quite frequently covered. In Feridun Kunak Show, mask recipes for skin beauty and shiny hair are given, PRP system is introduced and it is explained that women's own blood is collected and separated in machines and this separated blood is mixed with a cream for a good skin. In the program My Doctor,

beauty is covered as a subject in relation to both surgical operations such as breast reduction and botox and also alternative methods to be applied at home such as such as facial masks or face yoga, which contribute to the rejuvenation of the skin. In the program My Dear Doctor, on the other hand, the guest doctor, who is a cosmetic surgeon, gives detailed information about rhinoplasty and surgical operations performed on the face.

In the program called My Doctor, cosmetic applications are introduced by paying visits to the clinics of the guest beauty experts. For example, expressions used such as "Rejuvenate with Şems Aslan's recipes", "Strawberry peeling with the basic ingredients you can find at home" (18.07.16), "All ladies, all of us, want to have a youthful, firm and glowing skin" (14.07.16), "You can always stay young with face yoga" (14.07.16) and "Secrets of youth and beauty after the age of 40 with Suman Dumankaya" exemplify how beauty and health are dealt with as two interconnected subjects.

In an episode of My Dear Doctor, which was broadcast on 30.10.16 on NTV, aesthetics is covered as a subject in a detailed way and topics like natural and unnatural results in cosmetic applications, mammoplasty, natural breasts and undesirable botox results are discussed.

In the program called Doctor Feridun Kunak Show, aired on Kanal 7 (Channel 7), on the other hand, Serap Kunak often gives recipes for hair and facial masks. Serap Kunak's book, which is full of these recipes, is also mentioned quite frequently throughout the program and sometimes given as a prize to call-in callers.

6.5.2.3. Individualization of Health

In the analyzed programs, the discourses supporting the idea that health is one's own responsibility is seen in three aspects. The first one is that individuals are continuously told to be their own doctors and to check their bodies. For instance, they are frequently told to check their nevi, their fingernails or the color of their urine. In these programs,

women are constantly advised to have a blood count, mammography and colonoscopy and thus have their health checked regularly.

The following illustrate the discourses holding women responsible for their own health:

> Vitamins that should definitely be taken at old age (C. 2.10.16)
>
> Things that should be done to age psychologically healthy (C. 2.10.16)
>
> Ways to lessen oedama… Stay away from carbohydrates! (C. 07.05.16)
>
> Simple tips for those suffering from indigestion during the holiday (C. 10.09.17)

"A single vitamin or a single substance doesn't have the ability to stop or prevent the Alzheimer's. Only integral approaches or life-style [change] approaches can have such an effect. Take the Mediterranean diet, for example." (C. 30.04.16)[38]

The health discourse in the media is given to women with the message "Be your own doctor." Pill and Stott (1982) mention the fact that there is an inclination towards preventive medicine rather than curative medicine in the UK and in the process in which this is supported by the official policy, the aspect of individual health behavior is highlighted. They also emphasize that the official policy supports changes in individuals' behaviors and attitudes as they are expected to take on the responsibility for their own health and to be healthier (Pill and Stott (1982) cited in Özen, 2017, p. 158).

To present health as an individual domain of responsibility and to distance it from its social context by holding the individual's behaviors or lifestyle responsible for his or her diseases is an indication of the effects of neoliberal discourse on health, which occurred after the 1980s.

[38] Tek bir vitamin tek bir maddenin alzeimer hastalığını durdurma ya da önleme gibi gibi bir kabiliyeti yok ancak entegral yaklaşımların hayat tarzı yaklaşımlarının böyle bir etkisi var mesela Akdeniz tarzı beslenme (30.04.26)

Today, the discourse of being healthy can be said to be spreading fast and to include all members of society whether they are ill or not, and the place of seeking health, which is normally a clinic, is replaced by home. The discourse claiming that individuals can do certain things to improve their health with cheap things they can find at home is becoming more and more widespread and it has started to become generally accepted by people from all classes that good health is an issue that should be considered as people's own responsibility.

The media has a prominent role in health's becoming an individual issue, which has been socially constructed (Sezgin, 2011, pp. 172-173). It has been noted that in the contents of all the three programs analyzed, the health discourse addressed at women frequently dictates that health is the individual responsibility of women. The following examples illustrate that in these programs women are motivated to protect their own health and also heal themselves.

> Methods to get rid of urinary tract infection, which is especially seen in women. (FK. 29.12.16)
>
> Banana mush to relieve your pains. (FK. 20.02.17)
>
> Practical knowledge on how to lessen the effects of menopause. (FK. 8.12.17)
>
> Make these types of tea both to postpone menopause and to get rid of the disturbances it causes. (FK. 8.12.17)
>
> Natural recipes to get rid of arthritis forming in joints. (FK. 20.02.17)
>
> Golden tips for healthy slimming (FK. 15.02.17)
>
> A recipe for a mixture to cure parasites (FK. 19.01.17)
>
> Sisters, to avoid varicosis, you should definitely apply cold water on your feet after each bath, especially below your knees. (FK. 22.05.17)[39]
>
> An oil mixture to soothe knee pains. (FK. 31.01.16)
>
> Relieve your backache with the miracle orange mush. (FK. 16.03.17)

[39] Hanım kardeşlerim her banyodan sonra ayaklarınıza dizden aşağıya bilhassa muhakkak soğuk su tutunuz varis olmamak için.

A cure for stomach parasites. (FK. 19.01.17)

Sisters, when we drink little water, our brains do not work as well, so please drink water. (FK. 06.04.17)[40]

In the program, one of the most striking examples of the discourse addressed at women asserting that women are their own doctors is saying to the audience that a doctor defeated cancer with the mixture whose recipe is given. Without giving the name of that doctor or any details related to that study, the presenter says, “Dear sisters, now I’m going to make a very nice mixture. A Turkish doctor defeated cancer with it and spread it out to the world. What is this boon? It’s turmeric.” (FK. 06. 02.17)[41]

Furthermore, in the program, the guest doctor criticizes patients for seeking help from recommended vitamins and medicines rather than changing their lifestyles and for not taking the responsibility for their own health by saying: “Of course, this is the public expectation. [They prefer to say] ‘I’d prefer the doctor to give me a pill so that I can do it and avoid [the illness] rather than taking the burden on my shoulders’ [but] there’s no such thing!” (C. 30.04.16)

In the analyzed programs, it has been observed that the discourse claiming that in addition to preventing illnesses or relieving their pains on their own with health behaviors that they can show at home, women must also be careful about the symptoms of their illnesses and about what kind of diseases they may result from is quite frequently used. Discourse examples from the analyzed television programs can be added to this category as listed below.

[40] Az su içtiğimiz zaman beynimiz de çalışmıyor bacılar bu yüzden lütfen su içiniz.(29.40 - 6.04.17)

[41] Sevgili Kardeşlerim şimdi çok güzel bir karışım yapacağım bununla bir Türk doktoru akciğer kanserini yendi bütün dünyaya yaydı ne bu nimet zerdeçal. (FK. 06. 02.17)

> Puerperae must be careful about their health, both their mental and physical health. (C. 24.12.16)

> Make sure you look at the color of your urine. It can tell you about many diseases. (FK. 29.12.16)[42]

Sisters, I will tell you something important. All women may have some vaginal discharges at certain times. What you should be careful about is that if it is transparent and odorless, you don't have to be alarmed about it much, but if it has an odor, it goes yellow and it causes itchiness, you should definitely see your doctors. (FK. 08.12.17)[43]

> If I were to make one thousand programs and teach only one thing, it would be this: You should be conscious about your vitamin D [levels]. Ladies, what do you think you should know? You should know your vitamin D by heart. You should also know [your vitamin] B [levels], as in Bursa and also iron. If you lack these, make sure that you get them back. If you don't, your bodies will collapse. (FK. 22.05.17)

You may have headaches for no reason, for example. Why? Because you lack oxygen. Because the level of hemoglobin that will carry, the oxygen is low in your body. (FK. 20.04.17)[44]

> How will we know if there is something wrong in our brains or not? We'll tell you about it. When a relative of yours has something wrong with him/her, you will know whether it has anything to do with the brain. You'll know whether it's bleeding and how it happens. (FK. 06.04.17)[45]

[42] İdrarınızın rengine muhakkak bakınız idrarın rengi size birçok hastalığı haber verecektir (FK. 29.12.16)

[43] Kardeşlerim size önemli bir şey söyleyeceğim her hanım belirli zamanlarda kadınlık bölgesinde akıntılar olabilir burada dikkat etmeniz gereken husus vardır eğer bu akıntı berraksa kokusuzsa o kadar telaşlanmayınız ama hem koku var hem renginde sararma var hem kaşıntı varsa muhakkak muhakkak doktorlarınızla temasa geçmeniz lazım. (FK. 8.12.17)

[44] Lüzumsuz baş ağrılarınız olur mesela neden çünkü sizde oksijen yok sizde oksijeni taşıyacak hemoglobin düşük sizde. (20.04.17)

[45] Beynimizde bir şey var mı yok mu nasıl anlayacağız size onu belirteceğiz bir yakınızda bir şey oldu acaba bunun beyinle ilgili bir kanama mı değil mi nasıl olduğunu anlayacaksınız. (06.04.17)

In the program My Doctor, the discourse on which symptoms in the body might belong to which ailments is conveyed quite frequently. The audience are told to learn them and to do the most rational action in line with this knowledge about their health.

> Deformities in one's fingernails [and toes] may be precursors of some underlying diseases. (D. 18.07.16)
>
> Anaemia is seen more commonly in women. (D. 20.07.16)
>
> Anaemia often strikes especially children and women. For this reason, if you have your blood counts checked, you can prevent serious health problems. (D. 20.07.16)
>
> In the event that the urine is not transparent, you should definitely consult a doctor. (D. 21.07.16)
>
> Stomachache and inflammation are precursors of what? (D. 02.08.16)
>
> Your potbelly may be a symptom of latent diabetes. (D. 05.08.17)
>
> Don't downplay your stomachache! (D.12.07.16)
>
> The underlying reasons of dizziness. (D. 14.07.16)

In the program My Dear Doctor, the discourse addressed at women claiming that they should observe their bodies and diagnose their ailments is used less than the other two programs. The program with such discourse is the one in which not only women but men are advised to observe the changes in their nevi and consult a doctor when they see an increase in the number of nevi on their bodies. As it is seen in the example: "Tips on how to control the dangerous nevi on our bodies" (D. 04.06.16)

Furthermore, when the subject is how to detect scoliosis in children, mothers are told to check their children's bodies and if they ever encounter a suspicious case, they are told to take them to a doctor. "How can we detect scoliosis in our children when they wear a swimsuit?" (FK. 21.01.17) [46]

Another discourse supporting individualization of health is the discourse related to the necessity of individuals' awareness of their own risks and taking the essential precautions. It has been noted that the discourses of fear and risk are quite often used

[46] "Skolyozu mayoyla çocuk geldiği zaman nasıl anlayacağız?" (FK. 21.01.17)

in the programs. In this discourse, audience are told that even though they are healthy at the moment, many illnesses await them in the future and therefore, they should see them as potential patients. In such programs, it is aimed to make the audience perceive the disease that is dealt with in the episode as a risk for them. The audience are afraid of such risk discourse and put the precautions given in the program into practice. In these programs, via the subtitles with exclamations or the words uttered either by the presenter or the guest doctor, the audience are warned in a frightening way that even though they are healthy for the time being, they may be suffering from an illness in the near future. Here, there is a situation in which Beck's definition of "risk society" does not cover because according to him, risks first emerge in a particular geographical location but then spread out to other parts of the world and become universal. Risks that become widespread in complex ways do so in unpredictable ways (through pesticides, breast milk, babies, etc.) (Beck, 1992). In the television programs, on the other hand, risk is a notion that is used in order to manipulate people to show a particular health behavior. The idea is that if the individuals are not cautious enough and they do not strengthen their immune systems or take good care of themselves, they might contract a disease at any moment.

For example, in Feridun Kunak Show, the presenter tells the audience that when they do not care about themselves when doing the cleaning, they may develop diseases that they will suffer for the rest of their lives. "Don't carry buckets! Don't carry nylon bags! Don't ruin yourself! You only live once! You won't get your hands back. Look, today is almost over. You will never come back to live this moment again. Do not harm any parts of your bodies, or else you'll be busy with them all the time! You'll suffer throughout your lives." (FK. 20.02.17)

Or the presenter Feridun Kunak says that unless women do the suggested exercises, they may suffer from varicosis. "If you don't want to suffer from varicosis, do these exercises a lot!" (FK. 29.12.16)

In the same program, it is said that insomnia affects the whole bodily health of women and it stems from psychological problems.

> Unfortunately, in Turkey, mostly our mothers and our sisters suffer from the problem of insomnia. Can it be because they worry about everything too much? Or think over things too much? Do these things affect them? Because one of the most important factors leading to insomnia is worrying too much. If you are stuck in a thought, you can never go to sleep and when you can't sleep, your bodies can't be healthy in any way (FK. 09.03.17).

Also, women are given the message that they should be careful about the colors of their urine and vaginal discharges and if these are not the way they are supposed to be, they could be ill. "As regards liver… There is jaundice, which we call hepatitis. Please be very very careful when the color of your urine is like tea." (FK. 29.12.16)

> Bags are women's indispensable accessories but did you know that heavy bags could make you ill? (D. 15.07.16)
>
> Your doctor, together with Murat Aksoy, will tell you how you transform the house where you live into a poisonous house. (D. 29.07.16)
>
> Breast cancer is the greatest and the most serious risk threatening women in their lives. One out of every eight women runs the risk of developing this cancer throughout her life. (D. 11.07.16)
>
> Be careful about the chemicals you use at your homes. (D.29.07.16)
>
> Be careful about the desire to eat sweets and to sleep. You may be suffering from hypoglycemia. (D.19.07.16)
>
> Diabetes patients, pay attention! (D.10.09.16)
>
> If you have such nevi, pay attention to its signals! (C. 04.06.16)
>
> If you stay there for too long, the air that is breathed in may mix with blood and create harmful toxic effects on the bone marrow. As the name suggests, it's an occupational disease. It may even cause much worse diseases. May God forbid! (C. 28.01.17)
>
> If you have such symptoms in your children, beware! (C. 24.12.16)
>
> Mothers, you've heard it, right? Direct your attention to your children. If they have swellings on their joints, take them to a hospital immediately but the children may not say that their joints are aching. (C. 24.12.16)
>
> Oedema and tympanites… If you are suffering from these two, beware! (C. 07.05.16)
>
> Beware of obesity! (C. 07.05.16) [47]

[47] It should be noted that programs are coded with the first letter of of the original names as for Feridun Kunak Show, FK, for Doktorum D and for Canım Doktor C is used as a code.

In this thesis, another aspect of individualization of health is operationalized with regard to the relationship the subject constructs with her/his health. Is it individual or social construction of health that affects the health perception and behavior of the subject? In this regard, it is argued in this thesis that, perception of health as a social construct entails the adoption of the social roles.

In most of the analyzed programs, it has been noted that women's health is defined in relation to their roles as mothers. For the discourse structures in the health programs on television, women's health is a socially constructed issue rather than an individual one. Especially in the programs Feridun Kunak Show and My Doctor, it is often emphasized that women are responsible for the health of the other members of their families and they are the caregivers in their families.

In Feridun Kunak Show, as regards the discourse on women, it has been observed that women are addressed in relation to their roles as mothers. Women are given health advice with the wordings such as "Get your children to drink it," or "Do it for your husband," making it obvious that women are expected to take on the role of motherhood. Accordingly, it can be said that according to the program makers, women's health is important as they are the caregivers in the family who manage the health problems of the family members and if they are healthy, they can take care of them, which makes women's health a socially important issue for them.

The presenter of the program summarizes why women's health is important as quoted below:

> If you aren't well, if you aren't strong, if you aren't healthy, you can't be of use to anyone. You are the pillars of your homes. You are the pillars of society. My sisters, my elder sisters, be healthy! Be strong! (FK. 15.02.17) [48]

[48] Sen iyi olmazsan sen güçlü olmazsan sen sağlıklı olmazsan kimseye faydan olmaz siz evin direğisiniz siz toplumun direğisiniz bacılarım, kardeşlerim, ablalarım sağlıklı olun güçlü olun"(FK. 15.02.17)

In the same program, it is stated that the reason why mothers do not lose weight after giving birth is that they do not breastfeed and the mothers who do not do so are criticized. The effects of breastfeeding on women's health are also highlighted.

> Breastfeeding is such a blessing of God. When mother's breastfeed, they lose weight but unfortunately, they don't [and they say] 'He doesn't suck, mister brother doctor.'[49] He will. To suck milk is in his nature but what are you doing? You're making the biggest mistake by immediately starting to feed him with the feeding bottle. (FK. 27.03.17)[50]

When children's ailments are dealt with in the program My Dear Doctor, it is remembered that the target audience is not made up of women only and they are addressed as "mothers, fathers." However, the responsible party is again identified as women. For instance, when the subject is scoliosis, the guest doctor says "Mothers will ask why girls suffer from scoliosis more," and the host doctor says, "Mothers should observe it and then immediately see a doctor," (C. 21.01.17) and thus they advise women certain health behaviors by laying the responsibility for observing children's diseases and seeing the doctor on women because of their roles as mothers. In another episode about rheumatic diseases, the presenter addresses women again based on women's roles as mothers by saying, "Mothers, you heard it, didn't you? Focus your attention on your children. If there are swellings on their joints, take them to us but the children may not say 'My joints are aching."(C. 24.12.16). In the same program, when the subject post-natal depression is handled, motherhood is defined by saying, "Motherhood is not a concept to be defined on its own. An egg yolk can't exist without its white and neither can motherhood be defined without the child. There is the unity of the mother and the child." (C. 24.12.16). In this way, motherhood as a concept is medicalized. The body of the woman is present in the medical sphere as she is the one responsible for the health of the child. In general, in these programs, mothers

[49] Emzirmeyi Allah öyle bir nasip kılmış ki anne emzirirken kilo gidiyor ama gel gör ki yapmıyorlar emmiyor doktor bey kardeşim emer onun tabiatında var emmek ama siz ne yapıyorsunuz en büyük hata çocuklara hemen biberonu dayıyorsunuz" (27.03.17)

[50] It should be mentioned that this example is also used to illustrate the medicalization aspect.

are given the responsibility to recognize their children's diseases and take them to the doctor and thus to learn medical knowledge.

In brief, the discourses in the analyzed TV programs urge women to take responsibility for their own health and be their own doctors by constantly having their bodies checked through some medical screenings and tests and women are warned that health risks should be managed by themselves.

In addition, in these programs, women's health is not defined as their individual health but as the health of their social roles as wives or mothers, which is an important principle of the neoliberal rationality. All these data denote that the discourses in the television programs are in line with individualization of health strategy of neoliberal governmentality.

6.6. Concluding Remarks

The basic functions of the mass media can be listed as forming a public sphere, to present correct and unbiased information to the public and to provide a negotiation space. Media has an active role in forming social norms through discourses. Media is an important source of information that produces public knowledge, determines what is normal or abnormal and legitimizes certain opinions and actions. Media ascribes meanings to people themselves and to those around them. These meanings enable people to make sense of the world and to act accordingly. Certain opinions and behaviors are regarded as socially acceptable and normal due to discourses used in the media, while some others are not, and are labelled as "abnormal" or "deviation." From the governmentality perspective, television health programs produce discursive formations which put political rationality into practice. This thesis argues that with its discursive characteristic, media can be regarded as the technologies of neoliberal governmentality.

Several points can be made regarding the result of the discourse analysis of television health programs. To begin with, from the Foucauldian account on power, knowledge and truth, it can be argued that by producing discourse on health, these television

programs define what is normal and what is pathological for health, and which body is desirable and which is not.

Here, various features of the discursive formation which is produced by television health programs can be analyzed according to techniques of neoliberal governmentality of health; namely, medicalization, commodification of health and individualization of health. The analysis of discourse of television health programs as technologies of the government reveals the relations of neoliberal health discourse on particular conditions of practices of government (which is examined in the policy background chapter of this thesis) and the practices of self-formation, which will be examined in the next chapter.

The discourse of television health programs shows that new forms of expertise and fields of specifications have been formed in relation to governing the production of medical knowledge and truth regimes for the health of women. Furthermore, television health programs concern to spread out medical control to every domain of women's life. It has been found in the analysis that medicalization of health in women's lives is actualized through self-healing and controlling dietary habits rather than as a pharmaceutical invasion. In these programs, the discourse of 'naturalness' is quite often emphasized and women are told to seek remedies in natural forms rather than using medicines. All of these findings reveal that women are considered as active consumers via the discourse of naturalness. All in all, these programs commodify health with the discourses they produce.

They supervise women's responsibility for their health by identifying certain risks and promoting fear. They also neutralize women's responsibility of managing their own health risks. Moreover, they seek to promote the various aspects such as controlling, monitoring and screening, which are encapsulated in the notion of 'illness awareness'. In this way, women become active subjects in the neoliberal governmentality of health network. In so far as active subjects are obliged to agree to consume, to protect and also to seek for their health, this makes them 'enterprising selves' who invest on their own human capital.

However, what is significant at this point is that television health programs problematize the health of women as a social issue rather than an individual matter. This data will be presented in the following chapter on the interviews conducted with women. The discourses used in the programs show us that the issue of women's health is handled in connection with women's social roles. A woman's health is presented as the mother's, the wife's, or the caregiver's health, rather than her own health.

To conclude, even though these programs, whose numbers are multiplying on Turkish TV channels, produce different discourses according to the broadcast policies and target audience of the channel, the discourse that they use related to women's health share certain common qualities. These discourses influence women's perception of health, their illness and health behaviors and they manipulate them. It can be stated that the discourses addressing women in the programs My Doctor, Feridun Kunak Show and My Dear Doctor, the programs aired on NTV, Kanal 7 (Channel 7) and Kanal D (Channel D) between 2016 and 2017, are mostly in accordance with the neoliberal discourse and in parallel with the transformations experienced in health and medicine. According to the findings of the first phase of field research it can be said that the strategies of neoliberal governmentality of health as medicalization, commodification of health and individualization of health play an important role in constitution of healthy woman subject from the media perspective. The findings of the first phase of the field research also suggest that neoliberal implication for health is embodied in the ways that health related discourse is produced by the analyzed television health programs.

CHAPTER 7

SUBJECT PERSPECTIVE OF NEOLIBERAL GOVERNMENTALITY OF HEALTH

7.1. Introduction

The purpose of this study is to explore how healthy women are constructed as a subject by the neoliberal discourse. Adopting the governmentality perspective as a methodological tool, this study tries to investigate different discursive mechanisms such as media and subject in the network of neoliberal governmentality of health. In this chapter, in order to understand subject perspective of neoliberal governmentality of health, women's account on health and illness is analyzed with reference to the categories of medicalization, commodification of health and individualization of health. As the second phase of the field study, in this chapter, it is aimed to understand women's positioning as a subject in the neoliberal health realm. Hence, this section aims to analyze women's own interaction with the neoliberal health discourse.

7.2. Description of the Respondents

There were a total of 27 interviewees living in urban Ankara. The major districts in which the interviewees lived were Çayyolu, Etimesgut, Bağlıca, Sincan, Yaşamkent, Keçiören, Batıkent and Bahçelievler. In all of them, female city dwellers were interviewed.

A look at the age distribution of the interviewees reveals that the majority of the respondents are aged over 20 and the average age of the interviewees is 45. Regarding the educational level of the interviewees, it can be said that there are ten women with a primary school degree, ten with a high school degree and seven women with a university degree in the respondent group. It is important to add that none of these

women graduated from a medical school or any other health education school. A look at the employment status of the interviewees reveals that only two of them are retired, nine women are housewives who are not actively involved in the labor market, and the remaining 16 are actively working in different professions.

When it comes to the social security positions of the respondents, all the respondents are under the social security coverage. Specifically, 19 of them have their own social security coverage, whereas eight of them are in a dependent position. The labor market attachments of the respondents with their social security status are given in the table below.

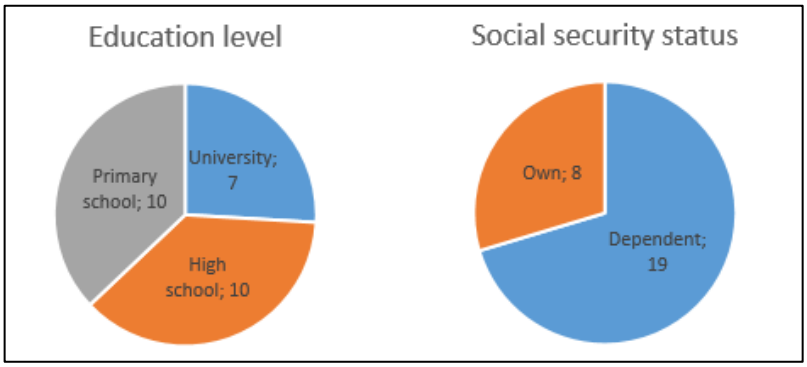

Figure 2. The Percentage of the Respondents with Regard to Their Educational Level and Social Security Status

When we look at the marital status of the interviewees, it is seen that the majority of the women are married. 22 of them are married and five of them are single women. Moreover, the majority of the respondents (23) are also mothers.

It can also be added that the majority of the respondents are living in an apartment and consume natural gas for heating. It is important to note that according to the household income level, most of the respondents are middle-class women. Only three of them have a household income of less than 2000 Turkish liras.

7.3. Understanding the Subject Perspective of Neoliberal Governmentality of Health: Women's Account on Health and Illness

In this section, I am going to present and discuss the findings of the second phase of the field research. As it was mentioned before, I analyzed the literature on governmentality and neoliberalism and health issues, and then I elaborated on some strategies of the neoliberal governmentality of health, namely, medicalization, individualization of health and commodification of health. In order to understand how women conduct of themselves and the other in the process of being a healthy subject, I analyzed the data obtained from the in-depth interviews with women living in Ankara with reference to the categories of medicalization, commodification of health and individualization of health.

7.3.1. Medicalization

As it has been discussed before, Irving K. Zola (1972) examines the concept of medicalization as a process in which medicine has become the major institution of social control. According to Zola, medicalization can be seen in "the expansion of what in life is deemed relevant to the good practice of medicine which implied increased intervention" and also "expansion of what in medicine is deemed relevant to the good practice of life, which refers to use of medical rhetoric" (1972, p. 487). Moreover, Peter Conrad contends that "medicalization describes a process by which nonmedical problems become defined as medical problems, usually in terms of illness and disorders." (2007, p. 4) For Conrad, the "natural life events" such as childbirth, menstruation, menopause and andropause, aspects of aging such as baldness, and even death and dying and "problems in everyday living" are the conditions and problems that get medicalized in the modern era (Conrad, 2013, p. 197).

In this thesis, two basic phases of medicalization is attempted to be operationalized as emphasized in the theoretical framework. These two stages are: medicalization of the natural cycles of the female body like menstruation, giving birth, motherhood, menopause, etc. and medicalization of everyday life.

Firstly in order to understand the extent of medical control over the biological life cycles of women, I asked them some questions about issues of menstruation, menopause and pregnancy. I sought an answer to the question of "Have the lives of the respondents been medicalized?" In other words, "Are such phases as delivery, menstruation and menopause perceived by the respondents as medical processes?" Secondly, in order to understand the process of medicalization of respondents' everyday life, I tried to find an answer to the question "To what extent are the daily lives of the respondents under medical control?" First of all, it can be stated that the extent to which the respondents' pregnancy and delivery processes were medicalized vary depending on their ages. For example, the respondents over the age of 40 have not experienced the pregnancy process as a medical phase. They have maintained their normal daily lives just by seeing the doctor regularly for the tests. Moreover, these respondents state that they have had normal deliveries.

For instance, D.A., who is 56 and has two children, talks about her pregnancy periods as follows:

> We weren't that conscious. I didn't even go to a doctor. Believe it or not, I didn't see a doctor. For the second, we didn't do anything again. We had some financial problems at that time. We ate whatever we could find. But if I had it now, I would act more consciously. Sometimes I tell my daughter-in-law about it. The new generation is exaggerating it, though D.A. (56, primary school, married, mother of two, and housewife).

The majority of the respondents who are below the age of 40 assert that they have gone through their pregnancy by implementing their doctors' recommendations. They state that they have used folic acid, iron supplement and various vitamins prescribed by the doctor. Apart from these, one of them says that she did prenatal yoga. In this age group, most of them have had a cesarean delivery. While sharing this information, they have been observed to give an explanation regarding the reasons leading to it. Many of the respondents can be said to justify it by starting the sentence with the phrase "I had a cesarean but..." As a mother of two children, D.G's, answer is illustrative.

Hamilelikte mutlaka yumurta işte doktorun önerdiği işte balık vs onlara dikkat ettim bir de işte vitamin aldım. Doktor söyledi işte Elevit aldım bir multi vitamin ihtiyaç olduğunda da tahliller sonucunda demir hapı kullandım balık yağı kullanmıştım. Hamlelik yogasına gittim benim kadın doğumcumun kendisi benim yoga hocamdı benim aslında denk geldi. D.G

When I was pregnant, I especially ate eggs. I ate whatever the doctor recommended me like fish and so on... I was careful about it. And I also took vitamins. The doctor told me and I took Elevit. When I needed a multivitamin pill, after some tests, I took iron supplements. I also consumed fish oil. I did prenatal yoga. My own gynecologist was my yoga instructor. In fact, it just coincided that way D.G. (40, university, married, mother of two, and lawyer).

When talking about their cesarean deliveries, A.Ü., aged 37, and M.K., aged 36, felt the need to explain the reasons why.

Rahim darlığından dolayı normal doğum yapamadım. Zaten şey günüm de 10 gün geçmişti10 gün bekledikten sonrasında alttan gelmediğinden dolayı sezaryenle hemen alınması gerekiyordu ve aldılar A.Ü.

Because of cervical stenosis, I couldn't have a normal delivery. I was ten days past [my due date]. After waiting for ten days, because it didn't come from below, it was necessary to take it by a cesarean and they did it A.Ü. (37, high school, single, mother of one, security).

Benim sağlık problemlerim vardı. İşte kan sulandırıcı iğne falan kullandım hani düşük tehlikesine vesaireye. O yüzden de hematoji ve nöroloji doktorum sezaryen yapılmasını, yani kadın doğum doktorumda sezaryen olmasında daha sağlıklı olacağını benim açımdan. Yani bebekten önce anneyi düşündükleri için .M.K.

I was suffering from some health problems. I had blood-thinning injections as there was the risk of a miscarriage, so my hemotogist [hematologist] and neurologist [recommended] a cesarean. My gynecologist also told me that a cesarean would be better for my health. I mean, because they think about the mother first, rather than the baby M.K. (42, primary school, mother of one, housewife).

When the respondents' attitude to the medicalization of menopause is analyzed, it has been observed that respondents can be categorized under two groups. The first group has experienced menopause, whereas the other group has not gone through it yet. Those who have not entered it yet have been asked what they think about seeing a doctor and receiving medical help in the process. Most of them abstain from any hormones or supplements even though they see doctors. The majority of the respondents state that they try to go through this period with the herbal teas they make themselves. For example, N.E is aged 65, graduated high school, married and mother of two, and utters the following words:

R: Menopoz döneminde doktora gittiniz mi?

N.E: Tabi doktora da gittim. Vitamin verdi. Vitaminlerimi kullandım.

R: Hormon verdi mi doktor size? Hormon tedavisi verdi mi?

N.E: Hormon tedavisine ben de yanaşmadım doktorda şey yapmadı. Hormon vermedi.

R: When you entered menopause, did you see a doctor?

N.E: Of course I went to the doctor, too. He gave me vitamins. I took my vitamins.

R: Did the doctor give you hormones? Did he prescribe a hormone treatment?

N.E: I didn't want any hormone treatment and neither did the doctor... The doctor didn't give me hormones.

On the other hand, D.İ, aged 31, teacher, married, non-mother has not experienced the menopause, and she defines menopause as a point where womanhood ends. She thinks that during this period, a woman needs to see a doctor and the process has to be delayed via the use of drugs.

As regards the processes of pregnancy and delivery, it is possible to state that the interviewed women's tendency to have a medical intervention differs depending on their ages. For women below the age of 40, those two phases of life are medical processes and they require medical intervention. Most respondents over the age of 40 state that they maintained their normal daily routines during their pregnancy, but they also say that they were careful about their diets even though they did not take any iron or folic acid supplements. Their lives during these periods can be said to have been regulated through their eating and drinking practices. To conclude, if medicalization is considered as the perception of natural processes as medical processes rather than just a set of medical methods, most of the respondents' lives could be described as medicalized.

As it was stated in Chapter Six, an analysis of the television health programs reveals that the phases of motherhood, raising a baby and menopause are medicalized through the discourses used in the programs. For example, in Feridun Kunak Show, mothers are urged to breastfeed their babies and in the program My Doctor, a chef gives a

recipe for a healthy baby food.[51] In addition, menopause is very often covered in all the television programs in question. In these programs, recipes for various mixtures and teas are given so that the symptoms of menopause are reduced. Women are told that they can get rid of the disturbances stemming from menopause with the recipes they can prepare at home.

Furthermore, self-care replacing medical treatment is also considered a kind of medicalization in this study, for it is argued in this thesis that in the self-care process, individuals take active steps to become healthy: They seek advice from other experts, they make their own remedies and they use certain ingredients for preparing these remedies.

During the in-depth interviews, I asked two questions: "What do you first do when you feel that something is wrong with your health?" and "Do you administer the treatment prescribed by the doctor exactly?" Most of the interviewed women prefer to treat themselves at home rather than get professional help when they first feel that there is something wrong with their health. For example, N.C, who is 48 and a mother of two, graduated from high school, married and works as an office worker states that when she feels ill, she first washes her face with cold water and then consumes lemon juice and yoghurt. 36 year-old M.K., who has one child, says that whenever she has a problem with her health, she immediately goes to the kitchen and makes linden tea for herself and takes vitamin C as a supplement. K.G., aged 50 and a mother of two, underlines that she has some self-healing methods that she uses at home when she feels sick.

[51] On the one hand, the capability of women to bear and breast-feed children and the changes in their bodies associated with menstruation, pregnancy and menopause have been valorized as constitutive of femininity, as evidence of women's specialness and power, as experiences to be enjoyed and welcomed as essential to femininity. On the other hand, concern about the ways in which such phenomena have historically been defined by patriarchy as the basis for women's inferiority and their exclusion from the public and economic spheres has led some feminist writers to deny women's embodiment, to seek to reduce differences between the sexes and to view women's physical experiences as purely social constructions constituted by medical and scientific discourses(Lupton, 2003, p.142).

Evde iyileşme yöntemlerim var. Kalkarım kahvaltımı yaparım, çok keyfim yoksa bir tane çok düşük bir şey ağrı kesici içerim. Ondan sonra yavaş yavaş evdeyken dolanırken eğer çok şiddetli ağrım bir şeyim olursa, dayanamayacak gibi olursam öyle giderim doktora. Öbür türlü kolay kolay gitmem. K.G

I have my own methods of recovery at home. I get up and eat my breakfast. If I'm out of sorts, I take something light, a light painkiller and then if gradually the pain increases as I walk around the house and it becomes too intense, if I can't bear it, then I see a doctor. Otherwise, I don't see a doctor straightaway K.G. (50, primary school, married, mother of two, and babysitter).

A.Y., aged 45 and a mother of four, on the other hands, states that when she does not feel well, she has a rest and does nothing else to heal herself. She says that she resists using pills at home. It is evident when she says, "I don't give in to pills immediately."

Sabah kalktığımda kırgınlık varsa kendimi dinlenmeye çekerim, yatarım, sessizlik isterim. Hani bi ilaç yapayım da geçsin hani şunu yapayım demem. Kendimi fena hissettiğim zaman ağrımı yenebileceksem ilaç kullanmam, yenemediğim zaman son deme gelince ağrı kesici kullanırım. Kendimi hemen teslim etmem hapa. A.Y

If I feel malaise when I get up in the morning, I have a rest. I lie down and seek silence. I don't say, 'Let me prepare a remedy for it and get rid of it.' If I feel that I can relieve the pain, I don't take any pills. If I can't do this, at its most intense, I take a pill. I don't give in to pills at once A.Y. (45, primary school, married, mother of four, domestic cleaner).

Similar to most of the participants, N.K. employs her own methods at home when she feels sick and postpones seeing a doctor. N.K. goes to a doctor when the effects of the symptoms intensify.

Beni çok rahatsız edecek ve kendime göre de bir çare bulamamışsam, beni rahatlatacak bir çare yoksa doktora giderim. Yumurta kapıya gelecek ya ben o cinstenim. Yani kansızlığı bile anca saçlarım dökülüp kel kalmaya başlayınca gittim. Baktım bütün belirtiler de var kansızlıkla ilgili ancak o zaman doktora gittim. Önce teşhisi ben koyacağım. N.K

If it really disturbs me and if I can't find a remedy for it myself, if there is nothing to relieve it, then I go see a doctor. I am one of those who do something at the eleventh hour. I mean, I saw a doctor for the treatment of anemia when I started to lose my hair and almost went bald. First I realized that I had all the symptoms of anemia and then I saw a doctor. I must diagnose the illness myself first N.K. (48, university, single, non-mother, officer).

Based on the respondents' answers, such a pattern emerges: When the majority of the respondents feel that they are sick, they first try to heal themselves at home using their own methods. They decide to see a doctor or get professional help only after the

symptom or the pain intensifies. Some of the respondents prefer to have a rest and take some pills or vitamins at home, whereas some others try to heal themselves by consuming some teas and mixtures they prepare themselves.

As Rose and Novas (2005) consider that there has been new form of political subjectivities as biological citizenship with their consumer identity, these individuals are directed to develop an active alliance with experts to develop their ability to self-care. Here it can be stated that they try to heal themselves using home-based remedies. In the self-care process, the individuals take active steps to become healthy: They seek advice from other experts; they make their own remedies and they consume certain ingredients for preparing these remedies. All of these make them active health consumers whose lives are medicalized in the network of neoliberal governmentality of health.

For instance, Z.A., who, unlike the other respondents, has experienced a cancer treatment, says that after the treatment, she started to develop illnesses very fast and as a result of the tests, she has learned that her body lacks some of the essential vitamins. When she becomes ill, she takes these vitamins first through the consumption of apricots and wheat. Then, she has vitamin vials and get injections shot. Z. A. describes this process as a self-healing process.

> *Tahlil yapıldı D3'ün çok düşük dediler bana. Sonra anladım ki kanser rahatsızlığı aşırı üzüntü stres ve yorgunlukla beraber vücudun immun sisteminin düşmesi ve vücutta bu esnada B12'ler düşüyor, D3'ler düşüyor, bunun düşmesi kansere sebebiyet veriyor.Ondan sonra benim bütün tedavi şeyim değişti. Nasıl değişti, demek ki benim B12'lerimi yükseltmem lazım, D3'lerime dikkat etmem lazım. Bunun için ne yapmam lazım, hemen B12 hangi gıdada var. Buğdayda var kayısı çekirdeğinde var. Onlarla ilgili kürler… Tabi ampullerle iğnelerle o şeyi toparlamaya çalıştım, gerçekten onlar bana iyi geldi. Z.A*
>
> I had a test and they told me the level of my D3 was extremely low. I later realized that it was because of cancer. Because of extreme sorrow, stress and fatigue, the body's immune system collapses. In the meantime, B12 level decreases, D3 decreases and when they decrease, it results in cancer. Then all my treatment changed. How did it change? [I said to myself] 'This means that I need to increase the level of my B12, I must be careful about my D3. What should I do for it?' I learned which foods have them. Which foods have B12? Wheat does, apricot seeds do. Cures including them… Of course, with vials and injections I tried to [increase them]. They really worked for me. Z.A. (48, university, married, mother of two, officer)

Another important point is traditional healing methods that need to be added to the discussion of the process of medicalization. Certainly, some traditional healing methods applied by ordinary people are most of the time outside the scope of the modern medicine. Especially the use of prayers for healing can be considered as the demedicalization of the health-related practices in the literature. In line with this operationalization, the respondents have been asked the question "Have you ever sought help from anyone other than a doctor so that your illness can be treated?" Some interviewees explain that they employ traditional healing methods which can be formulated as demedicalization. For instance, for SD., her mother can heal people with skin illnesses such as eczema by reciting prayers without earning any money. She says that patients diagnosed with eczema have seen her mother, and she has treated them.

> *Annem okuyup üflüyor. Sadece oraya üflüyor yani. İşte orayı çiziyor. Sonra orayı okuyup üflüyor. 1 hafta içinde falan soğan falan yeme diyor. Soğan, sarımsak yeme diyor. 1 hafta içinde annemin eli deydiyse eli deysin şifası geçiyor, ve o yara iyileşiyor.S.D.*
>
> My mother says prayers and blows. She blows upon only that part, I mean. She draws a critical there. She tells them not to eat onions or the like for a week. She says 'Don't eat any onions or garlic.' Within one week, if my mother touches that organ, when she touches that, her healing power is transmitted and then the scars heal. S.D (35, primary school, married, mother of two, domestic cleaner).

Similarly, M.E. also recounts that she has recovered with the power of prayers. M.E. says that the lesions on her body have healed thanks to the prayers her husband recited and his breath. Considering the responses of these respondents, it could be stated that religion is a factor affecting people's health behavior. Moreover, both respondents believe that the people who heal others by saying prayers are gifted by God for curing those specific illnesses. S.D. adds that her mother was bequeathed with this gift when she was a child and has healed so many people so far. During the in-depth interviews, the respondents have also been asked whether one's health can be affected negatively by the evil eye. All the respondents are of the opinion that health is affected by it. When asked what they do to protect themselves from it, most of them say they pray a lot and maintain their health in this way. The following expressions uttered by K.G. (50, primary school, married, mother of two, and babysitter) during the interview illustrate this pattern well:

R: Hiç başınıza geldi mi çok sağlıklıyken birinin nazarı deyip kendinizi kötü hissettiğiniz?

K.G: Eşimin arkadaşı vardı, hep onlarla buluşalım bir yere gidelim pikniğe gidelim, oradan geldim mi benim deli gibi baş ağrım olurdu.

R: Ne yapıyordunuz peki o zamanlarda siz?

K.G: Arkadaşım vardı alt komşum, "kız Fatma oku derdim" o okurdu da masaj falan yapardı.

R: Have you ever experienced it? Have you ever felt healthy and then felt the effect of evil eye on you and fell ill?

K.G.: My husband had a friend. Whenever we met, whenever we had a picnic together, for example, I had a terrible headache after I came back home.

D: What did you do then?

K.G: I had a friend. She was my neighbor downstairs. I used to tell her "Say prayers to me, Fatma." She did so and then she gave me a massage, too.

Similar to K.G., A.D. (50, high school, married, mother of four, and market owner) used traditional healing methods by herself which could be understood as a demedicalization process with respect to operationalization of the concept of medicalization in this thesis. She says the doctor has diagnosed her with muscle tear and prescribed her injections. When she feels the symptoms again, rather than seeing the doctor again, she tries to recover using the traditional method that is called cupping. According to her, this alternative method does not completely work but neither do the prescribed medications.

Geçen sene gittim doktora kas yırtılması var dedi. İğne falan verdi biraz geçti, şimdi yine var. Şimdi ben de napıyorum bardak vurduruyorum. O geçiriyor ama gerçekten. Samimi söylüyorum. Vuruyorum bir iki hafta gidiyor, tamamen gitmiyor. İlaç da tamamen hastalığı bitirmiyor ki! A.D.

Last year I saw a doctor and the doctor told me I had a muscle tear. I was prescribed injections and they relieved the pains a bit but now I'm suffering from it again. What am I doing now? I'm having cupping. That really works. I mean it. I have it and then its effects last for two weeks, but it doesn't completely treat it. But nor does the drug treat it altogether, anyway! A.D. (50, high school, married, mother of four, market owner).

One can say that everyday routines of the subjects are controlled by the medicalization as the impact area of the latter expand with the articulation of the concepts like healthism and/or healthy lifestyle. The dietary choices need to be focused on in the context of the subjects' relationship with health and medicalization of everyday life.

When asked questions about their pregnancy or their everyday health behaviors, many respondents mention their eating and drinking habits in their answers. The questions related to what they do to become healthy are answered in relation to their dietary habits. It is possible to conclude that for the respondents, health behaviors are only behaviors related to food such as eating vegetables in season, eating additive-free products, and consuming organic food. It is possible to conclude that for the respondents, health behaviors are only behaviors related to food such as eating vegetables in season, eating additive-free products, and consuming organic food. Moreover, they maintain that they take precautions for the future risks through their nutrition. As it is clearly seen from the following answers, they think that with specific dietary choice, they can be healthy.

> *Hmmmm sağlıklı olmak için sağlıklı beslenmeye çalışıyorum. Elimden geldiğince yani şey bal, zencefil karıştırırım mesela. Kestane balı, zerdeçal, zencefil, çörek otu böyle karışım yapar sabahları bir kaşık mutlaka atarım. Aldığım ekmeğin bile içinde ne olduğuna falan bakıyorum. Yumurtanın organik olmasına dikkat ediyorum. Serbest gezen tavuk olsun diye" N.E.*
>
> Um, to be healthy, I've been trying to have a healthy diet. I mix honey and ginger as much as I can, for example. I make a mixture of chestnut honey, turmeric, ginger, black cumin seeds and take one spoonful of it every morning. I even have a look at the ingredients of the bread I buy. I'm careful to buy organic eggs. I pay attention to them being eggs of free-range chickens. I mean we eat few [eggs]. I've been trying to buy them from decent places, from the places I know so that they are really organic but we don't consume them a lot. N.E. (65, high school, married, mother of two, retired).
>
> *Kuşburnunu içeriz, bazen bizim şimdi evde çocuklar hasta olur ceviz kabuğuyla elmanın kabuğu, nane, limon bunların üçünü kaynatırım çok güzel geliyor R K.*
>
> We drink rose hip tea. Sometimes our children get sick and I boil walnut skins, apple skins, mint and lemon. I boil these three and they really help them recover. R.K. (53, primary school, married, mother of six, housewife).

S.D. also adds that:

> *Hani bu kelle paça onlar hastalığa kemik erimesine geliyor diyorlar mesela. Onları aslında yapıp içmeyi düşünüyorum kendim. Eşim içmezdi. Kanser hastasına iyi geliyor diyorlar mesela. Ceviz iyi geliyor diyor ablam. Ceviz ye diyor. Bana sürekli diyor ceviz ye ceviz sen alzhemir olacaksın erken yaşta diye. Beyine iyi geliyor diye ceviz ye diyor. Cevizde tüketmeye çalışıyorum. S.D*
>
> They say this sheep's head and feet are good for illnesses, for osteoporosis, for instance. In fact, I'm planning to make them myself and eat it. My husband didn't use to eat it. They say it's good for cancer patients, for example. My elder sister says walnuts help. She tells me to eat walnuts. She constantly tells me, 'Eat walnuts, or you will get the Alzheimer's at an early

> age.' 'They're good for the brain. Eat them,' she says. I also try to consume walnuts. S.D. *(35, primary school, married, mother of two, domestic cleaner).*

As can be inferred from the examples above, the respondents mention what they eat and drink when asked to describe their health seeking behaviors or health promoting behaviors. In parallel to this, most of them prefer to heal themselves by consuming certain foods and using some recipes rather than taking drugs, which is called as self-healing. In addition, they believe that they are safe from illnesses by consuming certain healthy foods. This pattern indicates that medicalization as a lifestyle has become a part of these women's everyday lives. Lupton (1996) argues that it is important to understand the changes in the symbolic meaning of food and patterns of food consumption habits and also the individual's raised awareness of health implication of dietary habits. To her, "the assumption is made that as long as the correct diet is followed faithfully, the longevity and good health is guaranteed" (1996, p. 74). Dietary habits are an activity one must do regularly in order to continue one's life. Individuals' diet being under a constant control means the individual's being under control. This is exactly what Foucault calls the "technology of self." During the construction of the subject, the knowledge of which foods are healthy is presented to the subject as a truth regime. Moreover, Lupton argues that "although it is clocked in apparently neutral discourse, […the] language of contemporary nutritional science draws upon moral subtexts around bodily discipline and the importance of self-control" (1996, p. 74). In accordance with it, a social control is maintained covering most spheres of the everyday life. Therefore, it could be concluded that the everyday lives of the respondents are being medicalized through their dietary habits.

The media analysis made in the first phase of the field research reveals that the discourses used in health programs on TV are in line with the respondents' answers as they have similar qualities. As mentioned before, health problems on TV often highlight the link between dietary habits and health. It has been observed that most of the programs include recipes for good health and information about healthy nutrition. The common discourse used in the analyzed programs underline that it is necessary

for women to acquire healthy dietary habits to be healthy. The foods and drinks whose recipes are given in these programs are presented as both healing and health protective.

To illustrate, T.B. (24, university, single, non-mother, engineer) talks about a health problem that she overcame thanks to a mixture whose recipe was given in a television program. She says, "I heard it on TV. Yogurt and red pepper are not only good for losing weight but they also settle the stomach. I also suffer from postnasal drip. It's also good for it. I use it for that, too."[52]

Similar to T.B, R.K. states that she always watches her favorite health program on television and follows the doctor's advice in the program. She says that she puts the information that she receives from such program into practice to heal herself.

> *TV'de Feridun Kunak Show var, Onu hiç kaçırmam. Bunlar olmasa hiç kaçırmam onu sürekli izlerim. Hatta bazen onun yaptığı sirkelerini falan yapıyorum. R.K.*
>
> There is Feridun Kunak Show on TV. I never miss it. If there is nobody, I never miss it. I always watch it. I sometimes even make vinegars that he makes and the like. R.K. (53, primary school, married, mother of six, housewife).

In fact, this situation could be explained in this way: Experts have to address women using the everyday language so that women receive the knowledge that they want to convey. Foods provide a common language that experts and women share. For instance, talking about vegetables and fruits instead of presenting health knowledge using medical terminology enables the flow of information from the experts to the lay people, which leads to some discussions termed as the popularization of medicine and even medicalization of everyday life. In fact, people's determining their dietary habits based on the criterion of healthfulness shows their dependence on experts. Here it can be noted that medicine as a field is being popularized in addition to being professionalized. Lastly, the role of providing food to the family belongs to women in the Turkish society. Women hold the responsibility for feeding other members of the family. As regards healthy nutrition, it could be said that women now hold the

[52] Televizyonda duydum yoğurt limon ve kırmızıbiber hem kilo verdiriyor hem de mideyi rahatlıtıyor hem de geniz akıntım var ona da iyi geldi uyguluyorum (TB)

responsibility for the healthy diet of their family members, as well. They now fulfil new duties such as buying healthy food (hormone-free, natural, organic, etc.) and cooking them using healthy methods. That is why the women who were interviewed frequently stated that they preserved food by freezing them, conserving them and by making yogurt in order to have a healthy nutrition.

To sum up, this state of expressing health behaviors in connection with dietary habits enables us to understand social control of subjects' everyday life through dietary habits, which is an aspect of medicalization. This is due to the fact that dietary habits cover a major part of everyday life and the social control imposed in this way proliferates. Healing through dietary habits instead of using medication also entails the medicalization of everyday life as these individuals take active action to become healthy.

7.3.2. Commodification of Health

According to Henderson and Petersen,

> significant changes in the health care in many contemporary societies, involving the deregulation and privatization of services and an emphasis on cost-effectiveness, 'user-pays', 'self-care', 'community-based care', and so on, pose important challenges for policy-makers, health care workers and recipients of health care (2004, p.2).

They also add that from welfare to neoliberal politics of health care, health has become a 'commodity' and individuals are also identified as health care 'consumers' (2004, p. 2). In this thesis, health has been approached as a commodity as a consequence of neoliberal governmentality of health, both in the sense of the transformation of health care services and a new mentality of health, which constructs the neoliberal healthy women subject.

In connection to this, the respondents were asked whether they went to a private hospital or a state hospital when they got sick. Most of them said that they preferred private hospitals.

For example N.E. says:

> *Ben genellikle özel hastaneyi tercih ediyorum, sıra beklememek ve daha iyi olduğunu düşündüğüm için. Devlet hastanelerinden şimdi bütün profesörler ayrıldı. Profesöre gidebilmek için özel hastaneler artık şart oldu bu nedenle özele gidiyorum. N.E.*
>
> I generally prefer private hospitals so I don't have to wait in line and I also think they are better. All professors have quit their jobs at state hospitals. If you want to see a professor, going to a private hospital is a must. That's why I go to private hospitals N.E. (65, high school, married, and mother of two, retired).

D. G. recounts similar experiences:

> *Çok şükür imkanımız var özel hastaneye gidiyorum, çünkü devlet hastaneleri çok yoğun. Sıkıntı ne? Bugün hastayım o anda hastayım telefon ediyorum. Asla randevu alamıyorum. Araya birini sokmam gerekiyor. 1 hafta sonra gel diyor. 3 gün sonra gel diyor. Ama ben o anda hastayım, gidene kadar iyileşirsin ya da daha ağır hasta olursun. İstediğin doktora gidemiyorsun. Sağlık ocaklarının kesinlikle yeterli olduğunu düşünmüyorum. Aile hekimleri insiyatif almıyor ben mesela uzman doktora gitmek istiyorum. D.G.*
>
> Thank God we can afford it and I can go to private hospitals because state hospitals are very busy. What's the problem? [Suppose that] today I'm ill. I'm ill at that moment and I call [the hospital]. I can never make an appointment. I need to pull strings. They tell me to come one week later… or three days later. But I'm ill at that moment. Till you go there, you may recover or you may get extremely sick. You can't see whichever doctor you want. I definitely think that community health centers are insufficient. Family practitioners cannot take the initiative. For example, I want to see a specialist [but I can't] D.G (40, university, married, mother of two, lawyer).

Similar to D.G., V.İ also said that she preferred private hospitals.

> *Ben artık özelleri tercih ediyorum. Arada ki fark varsa ödüyorum. Ama hiç olmazsa saat verdi mi saatinde muayene oluyorum. Tamam çok pahalıya patlıyor hatta şeyleri tahliller falan ama en azından bir neticeye varabiliyorsun.Çünkü devlet hastanesinde sıra beklemekten ve bir türlü ulaşamadığın için doktorlara bu Bodrumda yaşadım. Eşim parmağını kırmıştı devlet hastanesinde kaldı bütün gün. Bir eşimin parmağına baktırmak için. Onun için devlet hastanesinde sıra beklemektense özele gidiyorum. V.İ.*
>
> Now I prefer the private ones. If there's any difference in the cost, I pay it whatever it but at least I can get examined on time when they give me an appointment. Yes, it costs me an arm and a leg. Especially the tests and the like but at least you can get a result. Because at a state hospital you just wait in a line and you can't reach the doctors. I had such an experience in Bodrum. My husband had broken his finger. He had to spend all his day at the hospital. Just to get his finger examined… That's why I go to a private one rather than waiting in a queue at a state hospital V.İ (59, high school, married, mother of two, housewife).

In addition to this, V.İ. also says that she sees a family practitioner even when she suffers from a minor health problem:

> *Bazen ufak tefek hastalıklar için sağlık hekimine gidiyorum. Mesela dün gittim raporumu çıkarttım. Bir tek rapor için hastaneye gitmiyorsun. Ya da ne bileyim ufak bir rahatsızlığın oldu mu sağlık ocaklarında olan doktorlarda çok iyi yani onu da söyleyeyim. Benim oturduğum semtteki sağlık ocağı kan ölçüyorlar. Şekeri ölçüyorlar. Her şeyi yapıyorlar. Tahlillerinizi yapıyorlar. Onun için Hastaneye gitmenize gerek yok. V.İ.*
>
> Sometimes I see a health doctor[53] for unimportant diseases. For example, I went there and got my report. You don't go to a hospital just for a report. Or when you have a trivial health problem, the doctors in community health centers are also very good. I must also say that. At the community health center in my neighborhood, they measure blood. They measure blood sugar. They do everything. They do their tests. You don't have to go to a hospital for these V.İ (59, high school, married, mother of two, and housewife).

Different from V.İ., T.B. says that when she has an unimportant health problem, she prefers a private hospital as she thinks that she will not be taken seriously at a state hospital.

> *Devlet hastanesine de gidiyoruz ama mesela bu ameliyat için özel hastaneye gittim, neden, devlet şey yapmayabilirdi. Çok ufak bir şeydi bu. Dikkatlerini çekmeyebilirdi onlar daha büyük hastalıklarla daha iyi ilgileniyorlar ya bu sefer özel hastaneye gittim*. T.B.
>
> We also go to state hospitals but for example, I went to a private hospital for this operation. Why? The state [hospital] would possibly not have taken it [seriously]. It was a trivial thing. They might not have paid attention to it. You know, they deal with more serious illnesses. So I went to a private hospital T.B (24, university, single, non-mother, engineer).

In addition to it, T.B. says that she has a private health insurance in order to be able to go to private hospitals and thus she always prefers private ones.

Unlike all these respondents, some of them say that they prefer state hospitals over private hospitals because they do not trust private hospitals. For instance, I.K. says:

> *Devlet hastanesini daha çok seviyorum. Çünkü özel hastanelere güvenemiyorum. Acaba para için çok faza mı tahlil yapıyorlar. Para için gereksiz tahlil mi yapıyorlar. Şimdi benim kafamda hep o var. Bir de benim teyzem geçen sene rahatsızlanmıştı. Şimdi özel hastanelere bakış açım o kadar çok değişti. Artık onlara hiç inanmıyorum. Beyninde tümör vardı. 2 tane devlet hastanesine gitti. Hacettepe ve Ankara Hastanesine gitti ameliyat ettirmeyin dedi. Özel hastaneye gittiler. Orada bir doktor yok canım ne tümörü hiç bir şeyi yok dedi. Hiç bir şeyi*

[53] Here, she means a family practitioner.

> *yok dedi biz ameliyat ederiz dedi. Doktor ameliyat etti teyzemi 4 gün sonra öldü teyzem. Ayakta duran teyzem öldü. Onun için özel hastanelere güvenmiyorum. I.K*
>
> I like state hospitals better because I don't trust private hospitals. "Can they be doing these tests just for more money? Can they be doing them unnecessarily?" These questions always preoccupy my mind. Another thing is that, my aunt got sick last year. Later, my opinion about private hospitals greatly changed. Now I don't trust them any more. She had a brain tumor. She went to two state hospitals. She went to Hacettepe and Ankara Hospitals and she didn't want an operation. They went to a private hospital. One of the doctors there told her What tumor? There's no tumor. There's nothing wrong. The doctor said she wasn't sick and that they could perform the operation. The doctor did the operation and my aunt died four days later. My aunt, who was on her feet, died. That's why I don't trust private hospitals I.K. (48, high school, married, mother of two, and housewife).

As it was discussed in Chapter 5, with the impact of neoliberal policies, Turkey's health care system has started to undergo a substantial reform. As argued by Ağartan, the marketization of healthcare is clearly seen especially in the provisional aspect in Turkey as an implication of the Health Transformation Program in 2003. She also adds that "marketization is closely related to another trend, namely commodification, which can be defined as the extent to which a country's provision of healthcare services relies on the market and prices are determined by markets" (2012, p. 459).

Based on the interviewees' answers, it is possible to conclude that most of them prefer private hospitals to receive a much better care. These respondents believe that they can be healthy by paying the price for a high quality health service, which suggests that health has become a commodity. That is to say, in the new health care system, citizens have become consumers and health has become a commodity rather than a right. [54]

Moreover, as Henderson Petersen puts it:

> Consumerism is often presented in terms of personal empowerment and freedom of choice. However, behind the rhetoric of 'freedom of choice', 'right to know', and 'entitlement to participate', that has recently come to dominate discussions in health

[54] As Richard Hugman puts it, "Common ground in the political and philosophical language of 'citizenship' appears to be occupied by these two approaches to consumerism in health and welfare, in which service users are to be seen as citizens with rights to standards of service, involvement in decision-making about their lives and control over their own use of the services" (Taylor, 1989, cited in Hugman, 2005, p. 194).

> care, lie compulsions surrounding the exercise of choice and an array of predefined and limited options for action (2004, p. 3).

Accordingly, the respondents state that they prefer private hospitals using their "freedom of choice". As maintained by Rose (2004), it can be said that with neoliberal governmentality, there is a new conceptualization of freedom because the respondents perceive going to a private hospital as a "freedom of choice".

Moreover, Ağartan also contends that in the new healthcare system of Turkey, "patients have been assigned new responsibilities as shoppers in the marketplace who can 'choose' among public and private facilities" (2012, p. 467). As regards this point, it can be argued that commodification of health is closely linked to health's being an individual responsibility, which will be discussed later.

Secondly, this thesis argues that commodification of health is also observed in the individuals' consumption habits of health products which are not only limited to pharmaceuticals but also include organic food, supplements, healthy cleaning products, organic clothes, etc. Individuals, who are held responsible for their own health, have been made to believe that they have to "consume" these products to be healthy.

For instance, N.E. said:

> *Hmmmm sağlıklı olmak için sağlıklı beslenmeye çalışıyorum. Elimden geldiğince yani şey bal, zencefil karıştırırım mesela. Kestane balı, zerdeçal, zencefil, çörek otu böyle karışım yapar sabahları bir kaşık mutlaka atarım. Aldığım ekmeğin bile içinde ne olduğuna falan bakıyorum. Yumurtanın organik olmasına dikkat ediyorum. Serbest gezen tavuk olsun diye. N.E. (65).*
>
> Um, to be healthy, I've been trying to have a healthy diet. I mix honey and ginger as much as I can, for example. I make a mixture of chestnut honey, turmeric, ginger, black cumin seeds and take one spoonful of it every morning. I even have a look at the ingredients of the bread I buy. I'm careful to buy organic eggs. I pay attention to their being eggs of free-range chickens. I mean we eat few [eggs]. I've been trying to buy them from decent places, from the places I know so that they are really organic, but we don't consume them a lot N.E. (65, high school, married, and mother of two, retired).

In parallel to this, N.E., R.K. also mention consuming some food products, teas and herbs for their health.

Kuşburnunu içeriz, bazen bizim şimdi evde çocuklar hasta olur ceviz kabuğuyla elmanın kabuğu, nane, limon bunların üçünü kaynatırım çok güzel geliyor R. K. (53).

We drink rose hip tea. Sometimes our children get sick and I boil walnut skins, apple skins, mint and lemon. I boil these three and they really help them recover R. K. (53, primary school, married, mother of six, and housewife).

In this context, Henderson and Petersen also state that "the consumption of particular health-related goods and services is shaped not simply by perceived health benefits (improved health), but also by their associations with particular images, lifestyles, and tastes" (2004, p. 3). Here, it can be argued that the healthy living discourse used in television programs mobilize the consumption of health products. The popular discourse of healthy living suggests some behaviors to people so that they can adopt a healthy lifestyle (Featurestone, 2005, p.146). Individuals must consume the products of the healthy living industry in order to have a healthy lifestyle. Consumption society targets healthy individuals rather than the unhealthy ones. In accordance with this, the respondents think that in order to adopt a healthy lifestyle, they must consume healthy products. It can be argued that this case show us the implication of how health become the object of consumption.

It is of significant importance to mention "naturalness" discourse, which is commonly seen in the health programs on TV. As mentioned before, in health programs, there is a promotion of naturalness. The audience are advised to consume natural products instead of taking medicines through the discourse emphasizing the importance of natural life, natural foods, and natural remedies for diseases. In this respect, it can be argued that the discourse of naturalness is in line with anti-pharmaceutical approach. As Illich (1976) puts it in his book entitled *Medical Nemesis*, individuals' being against the pharmatization of society leads them to other areas of consumption. In relation to this, the answers of respondents' reveal that many respondents refrain from both seeing a doctor and taking medicines. Respondents seek ways to recover at home even though they see a doctor. They believe that drugs will be addictive and they have side effects. In their answers, they generally emphasize this belief: While medicines heal a part of the body, they do harm to some other parts. These respondents think that

while medicines treat their illnesses, they damage another part of their bodies. This pattern, which is evident in the respondents' replies, indicates that they prefer to try treating themselves at home in a natural way.

For example, M.K. says:

> *Bu konuda televizyonları da dinliyorum, internetten de bakıyorum mesela diyorum işte grip için şu bitki çayları iyi gelir… onlara… öncelikli antibiyotikten çok böyle doğal yollarla geçirmeye çalışıyoruz. İşte el yıkaması, hani kendime çocuğuma da aynı şekilde onu söylüyorum. Onun haricinde işte böyle ıhlamurdu, kış çayları, sonra ne bileyim balık yağı, D vitamini… Hani bunlar, bu tip şeyler gribi önleyen şeyler.M.K.*
>
> Related to this subject, I listen to the television, I search it on the Internet and for example I say, 'these herbal teas will work…for them… Rather than antibiotics, we try to heal them in natural ways. Washing hands… I tell my own child the same thing. Except for this, linden tea, winter teas…What else? Fish oil, vitamin D… These are the things preventing the flu M.K. (36, university, married, mother of two, responsible).

This pattern is even more evident in the answer of H.V., who contracted cancer but rejected the treatment of chemotherapy, believing that chemotherapy will do harm to her other organs. H.V. says:

> *Yani mesela kemoterapiyi ben istemedim, kanser ilaçlarını ben istemedim. Benim bir arkadaşım vardı, çok samimi değilim ama aynı apartmanda oturuyorduk onun kızı 36 yaşında rahim kanserinden öldü. Ben kemoterapinin insanlara iyi gelmediğine inananlardanım. Onun için istemedim ve gerek de yoktu yani. Neden öbür organlarımı kaybedeyim ki? Herkes aynı şeyi söylüyor tümörü küçülteceğim diye başka yerler iyi yerleri de hasar veriyor. İstemiyorum, istemedim de yani.H. V.*
>
> I mean, for example, I didn't want chemotherapy. I didn't want cancer drugs. I had a friend. Not a close friend of mine, though, but we were living in the same apartment building. Her daughter died of uterine cancer at the age of 36. I am one of those who believe that chemotherapy doesn't treat people. That's why I didn't want it. And in fact, it wasn't necessary. Why would I lose my other organs? Everybody says the same thing. They want to shrink the tumor but they do damage to the healthy parts. I mean, I don't want it and I didn't, either H.V. 61, high school, married, mother of two, housewife)

In addition to this, the respondents try healing by consuming some foods instead of taking medication. For example, D.İ., aged 31, who was diagnosed with anemia by the doctor, says that the doctor prescribed her anemia drugs but she drinks grapes

molasses, instead. D.İ. states that she does not like taking any medications as she believes that using drugs is addictive.

> *Vücudun buna bağışıklık kazanacağını düşünüyorum. O yüzden ilaç kullanmak istemiyorum çok fazla ve ilaçlarının yan etkilerinden dolayı her ilacın farklı bir yan etkisi olabilir. Bir tarafı düzeltmek isterken başka bir tarafları bozmaktan korktuğum için açıkçası ilaç kullanmak istemiyorum .D İ.*
>
> I think the body will develop immunity to it. That's why I don't want to use any drugs a lot. And also, because of the side effects of medicines, every drug may have a different side effect. Frankly, as I don't want to do any harm while trying to fix some other parts, I don't want to use any medicines D. İ. (31, university, married, non-mother, and teacher).

In line with D.İ., D.A says:

> *İçmem yok yani çok önemli bir bu hastalığımla ilgili bir ilaç değilse içmem, sevmiyorum ilaç içmeyi. Onun yerine bir limon koyuyorum bir su koyuyorum bir bal koyuyorum ama ilaç içmeyi sevmem. Ne bileyim hoşlanmıyorum, bir tarafını yaparken bir tarafını bozacağına inanıyorum. D. A.*
>
> I don't take it. If it isn't crucial, if it isn't a drug which is directly related to my illness, I don't take it. I don't like taking [any medicine]. Instead of that, I add some lemon [juice], some water, some honey…but I don't like taking drugs. I don't know. I believe it will damage something as it repairs another D.A. (56, primary school, married, mother of two, and housewife).

It is clearly understood from D.A.'s answer that she prefers to heal through her dietary habits. The rationale for the anti-pharmaceutical stance of the interviewees is their belief that drugs will do harm to other organs of their bodies with their side effects. Based on the expressions of the interviewees quoted above, it is possible to draw the following conclusions:

The respondents perceive themselves as health consumers who consume things in order to be healthy. In that case, paying for a high quality health service is a freedom of choice for them. Furthermore, they believe that they can acquire a healthy lifestyle by consuming the healthy products presented to them by technologies of neoliberal governmentality. Many respondents prefer to consume healthy products rather than using medications in order to recover in natural ways. These patterns indicate that they are active consumers in the network of neoliberal governmentality. In conclusion, the

participants' underlying motivation of consumption can be said to be healthy, which shows us that health has become a commodity.

7.3.3. Individualization of Health

According to Polzer and Power (2016), the construction of health as an individual responsibility has become dominant in biomedical worldview in capitalist societies. When it comes to neoliberal societies, it is seen that maintaining of health as an individual issue is a prevailing ideology in healthcare policies. They also emphasize that rather than WHO's definition of health as a "state of complete physical, mental and social well-being" (WHO, 1946), which reflects the idealized post-World War II conceptualization of health, the health in neoliberal societies has become an obligatory and lifelong pursuit of the individual (Polzer and Power, 2016). It is observed that most of the respondents reiterated similar qualities in the interviews.

The respondents have been asked whether they think health is a responsibility that falls on the state or the individual. Most of the respondents are of the opinion that health is an issue which should be considered as the individual's responsibility. These women have also emphasized in their definitions of health that it is essential that one take good care of oneself in order to be healthy and be his or her own doctor. According to I.K. and A.Ü., health is the individual's responsibility and if individuals do not look after themselves well, they will become ill and in such a case, no responsibility lies with the state.

I.K. says:

> *Bireyin sorumluluğu olduğunu düşünüyorum. Ben dikkat edeceğim ki daha sonra gidip onlardan şifa ve tedavi bulacağım. Önce ben kendime dikkat etmeliyim. Diyorum ya ben kendi kendimin doktoru şöyle oldum. Biraz evvelde dedim. Midem gerçekten geç saatte yediğim yemeği istemiyor. Almıyor. Bir de çok affedersiniz kabızlık sorunu yaşıyorum. Kabız olacağımı düşündüğüm şeyleri yememem gerektiğini düşünüyorum. I.K.*
>
> I think it is the individual's responsibility. First I'll take care of it and then I'll go and seek a remedy and demand a treatment from them. First, I must take care of myself. As I've already said, I've become my own doctor. I've just said it. My stomach rejects the food that I eat at a late hour. It doesn't take it. Excuse me for saying it but I've had constipation. I think I should

> avoid eating the foods that will make me constipated I.K. (48, high school, married, mother of two, and housewife)

Similar to I.K, A.Ü. says:

> *Sağlık bireyin sorumluluğudur. Birey kendine iyi bakarsa sağlıklı bir şekilde hayatına devam eder. Bunun devletle bir alakası yok ki. Sen kendine bakacaksın, ayaklarının üzerinde durmayı bileceksin. Yapamadığın yerde devlet zaten sana yardım eder, destek çıkar. A.Ü.*
>
> Health is a personal responsibility. If a person takes good care of herself, she leads a healthy life. It has nothing to do with the government. You will take care of yourself. You will know how to be back on your feet. In cases where you can't do it, the state will help you and support you anyway A.Ü. (37, high school, single, mother of one, security).

Even the respondents who state that health is a responsibility falling on the state say that this responsibility must be fulfilled through providing citizens with treatment at hospitals and through educating them and raising their awareness about this issue. In this regard, it can be argued that raising the awareness of the active citizens is rooted in the concepts of the health promotion and health education, which are formulated by Lupton and Petersen as the strategies of the "new public health". They also add that from the perspective of neoliberalism, the discourse of new public health seeks to transform the awareness of individuals in such a way that they become more self-regulating and productive both in serving their own interests and those of society at large. Following Petersen and Lupton (2000)[55], it can be argued that neoliberal rationality persuades ordinary citizens to raise their self-awareness on medical knowledge. That is to say, a neoliberal healthy subject is an active citizen who seeks medical knowledge to achieve good health and manage her/his illness and health risks.

In parallel to these arguments, it has been observed that most of the respondents have made an effort to gain medical knowledge and to this end, they have derived their medical knowledge from a variety of different sources.

[55] According to Petersen and Lupton, "this is a crucial feature of the concept of neo-liberalism: the recognition that in modern societies the state is positioned as not domineering, repressive or authoritarian, but rather as part of a set of institutions and agencies that are directed at enhancing personal freedoms and individual development. Therefore self-government—or the regulation and discipline of the self as an autonomous individual—partly takes place through external imperatives" (2000, p. 12).

To illustrate, T.B. uses the Internet for searching about some information about the nevi on her body and went even further by examining them first by herself using an application that analyzes them. Due to the information she obtained from this application, she visited a doctor.

> *İnternet benim bilgi kaynağı tabi doğru bilgilendiren doktor ama sürekli gitmediğimiz için, benlerimden ameliyat olmadan önce internetten araştırdım. Hatta bir uygulama vardı onunla benimin fotoğrafını çektim uygulama bana tehlikeli dedi sonra doktora gittim ve ameliyat oldum T.B. (24).*
>
> Internet is my source of information. Yes, in fact, a doctor can inform us appropriately but because we don't see doctors regularly, before having a nevus removal surgery, I did some search on the Internet. In fact, there was an application and I uploaded a photo of it. The application told me it was dangerous, so I went to a doctor and I had surgery T.B. (24, university, single, non-mother, engineer).

For some other respondents, the people around them with a special interest in health issues are an important source of information even though they have not had any formal health-related education. It has been noted that these respondents consult a pharmacist that they can contact about health issues or a relative of theirs whom they consider knowledgeable and interested in doing research about health problems. For those, an oral source is important when accessing health knowledge. For example, N.K. (48) has obtained information about the drugs she has been prescribed for her blood pressure by consulting a friend of hers, who is a pharmacist.

An important point that should also be noted here in relation to the sources of health knowledge of respondents is the exchange of information between daily house cleaners and carers and their employers, who are also women. For example, A.Y. (45) says "I only trust my house cleaner. As regards health, I talk to her and I share [my health problems] with her. I ask her what to do in certain situations. I don't get any information from any other person." A.D., on the other hand, mentions that the woman whose house she cleans gives her vitamins and tells her that she has to drink water for good health. K.G. is 50 years old and she is a babysitter. During the interview, she asked the person at whose house she was working which vitamins she gave her. Similar to A.D., S.D. has also learned a lot from the women whose houses she cleaned.

Moreover, it is observed from the respondent's answers that they use television as a source of medical knowledge. For instance, I.K. (48) watches health programs on television. She has a notebook in which she notes down the recommendations given by the doctors in such programs. In this notebook, there are some recipes given in some programs in order to defeat certain illnesses or not to develop them. Some respondents like I.K. state that they watch the health programs on television and the news related to health in news programs. Expressing that they put the information that they receive from such programs into practice, these respondents say that they consume some natural teas and mixtures at home as they believe that they cannot be harmful. R.K. (35) always watches her favorite health program on television and follows the doctor's advice given in the program.

> *TV'de Feridun Kunak Show var, Onu hiç kaçırmam. Bunlar olmasa hiç kaçırmam onu sürekli izlerim. Hatta bazen onun yaptığı sirkelerini falan yapıyorum. R.K.*
>
> There is Feridun Kunak Show on TV. I never miss it. If there is nobody, I never miss it. I always watch it. I sometimes even make vinegars that he makes and the like R.K. (53, primary school, married, mother of six, and housewife).

In the group of respondents who view television as a source of medical knowledge, some respondents watch television programs on health, while for some others, what is significant is the health expert in the program. There are some experts whom they trust and they watch these experts in whichever program they appear. As the respondents absolutely trust them, they follow the books and social media accounts of these experts.

For instance D.G. says:

> *İşte şeyden internet, sosyal medyadan işte bu konuda uzman olan kişileri takip ederim. Yazı, makale, okur sonra doktoruma sorarım. Televizyonda belki de algıda seçicilik hani bunlara hep yöneldim. Televizyonda da bu konu ile ilgili bir şey olduğunda ben seyrederdim. Kimi başka bir şey seyreder ben bunları seyretmeyi tercih ederdim. mesela ben son dönemlerde Ayşegül Çoruhlu'yu takip ediyorum. Bire bir uygulamasam da sonra medyada Yeşim Erbil var. Onları takip ediyorum. Karatay'ı takip ediyorum. Hepsini işte şeyin kitaplarını okudum. Ahmet Ahmet Hoca. Şey ıuıu soyadını hatırlamıyorum ama Taş Devri Diyetinin yazarı o da vefat etti. O'da bu konularda beslenme konusunda uzman bir doktor D.G.*

> Well, I follow the experts in their fields on the internet...Umm, on social media. I ask my doctor after reading some essays, articles. Maybe because of perceptual selectivity... I have a tendency to watch these on TV. I've always watched anything related to health. Some others prefer different programs, but I've always preferred to watch these. Recently, I've been following Ayşegül Çoruhlu. Even though I don't put them into practice exactly... There is also Yeşim Erbil on the media. I follow them. I follow Karatay. All of them I mean. I've read his books. What was his name? Ahmet, Professor Ahmet. Umm, I can't remember his surname but he is the writer of the book *The Stone Age Diet*. He died too, actually. He was a doctor whose expertise was in such issues, in nutrition...D.G. (40, university, married, mother of two, lawyer).

On the other hand, H.V., aged 61, contends that she does not follow any social media content or television programs as she does not trust the information given in these sources. However, for her Canan Karatay[56] is an important source of medical information as an expert.

> *Sadece bir tek Canan Karatay'ın sitesin, kendisini değil de, sağlıklı yaşıyoruz, bir o var. Başka yok. Ondan çok şey öğrendim tabii. En azından yani şekersiz yaşamayı öğreniyorsun. Beslenmenin bu güne kadar yanlış olduğunu öğreniyorsun. Ben inanıyorum Canan hanımın söylediklerine, mesela senelerdir insanlara kırmızı et yemeyin, yağ yemeyin, yumurta yemeyin yani zaten ben bunların yani insanlar manyak ettiler bir şey yemez oldular.) Rejim yapacaksan zayıflayacaksan sıfır yağ, sıfır şeker, sıfır tuz hale getirdiler. Ben onun için kendimi bildim bileli o televizyon programları seyretmem. H.V.*

> [I follow] only Canan Karatay's website, We Live Healthy, not herself. Only this... No exceptions. I've learned a lot from her, for sure. At least you learn how to live without sugar. You learn that your nutrition so far has been unhealthy. I believe in whatever Mrs. Canan says. For example, we've been told for years not to eat red meat, fat or eggs. I mean people have gone crazy. They've started to eat nothing in the end. If you want to go on a diet, if you want to lose weight, [you'll use] zero fat, zero sugar, zero salt. It's become like that. That's why I've always stayed away from that sort of television programs H.V. (61, high school, married, mother of two, housewife).

Ö.O, on the other hand, says she looks up more than one source in order to reach reliable medical knowledge.

> *Neydi bir adam vardı ismi. Feridun Kunak eşiyle birlikte olan onu izlerim. Yani ben öyle tek bir yere bakmam kaç tane site varsa hepsine bakarım tek birine güvenmem. Çok güvenilir ya*

[56] Professor Canan Karatay is an internal diseases and cardiology specialist. "Karatay and her aptly named 'Karatay Diet' have become household names in Turkey. Karatay's diet proposes a number of controversial tips such as eating all types of protein regardless of calories and consuming healthy fats." Ergil, Y.L. (2017, 25 January). Turkey's diet gurus and their healthy living tips. Daily Sabah. Retrieved from https://www.dailysabah.com/expat-corner/2017/01/25/turkeys-diet-gurus-and-their-healthy-living-tips

da güvenmez değil aslında en son her zaman doktorun dediği en güvenilirdir diye çok da kaya almam ama okurum yani bilgi adına okurum çok güvenip inandığım için değil. Ö.O.

What was the name of that man? Feridun Kunak. The one in which he appears [on TV] with his wife. I watch it. I mean, I don't look at just one of them. I have a look at all such websites. I don't trust only one of them. They are neither trustworthy nor unreliable. In fact, thinking that what matters most is what the doctor says, I read them just to be informed. Not because I have full trust in them Ö.O. (48, primary school, married, mother of one, secretary).

As these examples suggest, most of the respondents feel themselves responsible for obtaining medical knowledge. In addition to this, it has been understood that the majority of them use various sources to reach reliable medical knowledge. It has been noticed that in the analyzed health programs on TV, it is constantly repeated that their aim is to inform the audience and to raise their consciousness. For instance, in the program My Doctor, Murat Aksoy, the presenter, goes to a shopping mall to raise awareness on public health and asks the people there questions about health. If the people give him a wrong answer, he conveys them the right medical information like a teacher (D. 12.07.16).

Another aspect of individualization of health is operationalized in this thesis with regard to the topics of risk assessment and risk management. According to Dean (1999, p. 132), risk is a calculative rationality with its techniques of shaping and managing the human conduct in the service of some effects. For him, the individualization of risk is a major way for drawing back from socialized risk management techniques of the welfare state, so it creates new forms of governing in contemporary democratic liberal states (1999, p. 133). Dean also points out that individualization of risk "is a link to a form of governing that seeks to govern not through society but through responsible and prudential choices of action of individual on behalf of themselves" (1999, p.133).

It is clearly seen that all of the women who have been interviewed can assess their health risks. Most of them believe that they have genetically inherited some diseases from their families and in order to protect themselves from these, they try to take some measures in their lifestyles. The risk assessment of these women, who think that they

may also develop the illnesses that their mothers and fathers have been suffering from, is linked to their understanding that taking care of one's health is an individual responsibility. With respect to this point, it could be maintained that neoliberalism as a political rationality makes people responsible for being aware of their own future health risks and also managing these risks with their lifestyle choices.

For example, D.G. (40, university, married, mother of two, and lawyer) is most worried about developing diabetes in the future because her family members are suffering from it. As a health risk management strategy, D.G. says that she sees a doctor every year and has the essential medical checks.

> *D.G: Şeker. Yani çünkü ona şahit olduğum için şekerden korkuyorum. Annemde, teyzemde olduğu için. Ondan dolayı.*
>
> *R: Bu riski önlemek için ne yapıyorsunuz?*
>
> *D.G: Ben yılda 1 kere endokrolojiye giderim. Kan değerlerime bakılır şekerime de. Gerekli gördüğü takdirde doktor beni işte şu bölüme bu bölüme git der. Biraz kan eksikliğim falan oluyordu. D vitamini eksikliğim varsa bunları tamamlar doktor. O şekilde vitamin kullanırım.*
>
> D.G.:Diabetes. I mean, I'm afraid of it as I've been witnessing it. Because my mother and my aunt suffer from it. That's why.
>
> R: What do you do to eliminate the risk?
>
> D.G.: I go to endocrology [She means endocrinology] once a year. My blood values are checked. So are my blood glucose levels. If the doctor thinks it's necessary, s/he tells me 'Go to this service or that service.' I used to have blood deficiency. If I have a vitamin D deficiency, the doctor supplements it. I use vitamins for it.

A.Ü.'s (37) mother has suffered from joint rheumatism and because of it, she is most scared of this illness. As a risk management strategy, she consumes the foods recommended to her mother by the doctor.

> *A.Ü: Şu andaki tek düşüncem; annem gözümün önünde olduğu için iltihaplı eklem romatizması. Yani şöyle söyleyeyim… Ya şu yemek kaşığı ya… Annem bunu kaldırıp da yemek yiyemiyor. Hareketleri çok kısıtlandı. Ben ondan çok korkuyorum. Öyle olmaktan da çok korkuyorum.*
>
> *R: Peki bu hastalığa yakalanmamak için bir şey yapıyor musunuz?*

A.Ü Doktor anneme şey söyledi; mümkün olduğu kadar süt ve süt ürünlerini çok tüket dedi. Günlük süt. Onlardan alıyorum. Doktora annemle beraber doktora gidiyoruz. Yani onlardan duyduğum, doktordan duyduğum, anneme tavsiyelerin hepsini ben de kendime, oğluma yapmaya çalışıyorum.

A.Ü.: My main concern at the moment is the joint rheumatism, as I witness what's happening to my mother first hand. Let me say is this way... Suppose that this is a spoon. My mother can't even lift it and eat her own meals. Her movements are highly limited. That's why I'm very scared of it. I'm really scared of being just like her.

R: Do you do anything not to develop this illness?

A.Ü.: The doctor told my mother to consume milk and dairy products as much as possible. Daily milk... I buy them. I go to the doctor together with my mom. I mean, whatever I hear from them, from doctors, whatever they recommend to my mother, I try to do them for myself and my son.

S.D. and G.K. are worried about developing hypertension in the future although their family members do not suffer from them. They take their own precautions in order not to develop them. S.D. mentions a precaution she learned from a program on TV. The risk management strategies of S.D., aged 35, and G.K, aged 54, are related to their food consumption preferences. G.K. says that she is most worried about developing hypertension in the future and in order to protect herself, she watches her diet, she tries not to add extra salt to her dishes and she does physical exercise. S.D's response, on the other hand, is as follows:

Kanser tabi ki. İşte şu iyi gelir. Kelle paçaya mesela o kansere bile iyi geliyor. Kemik suyu mesela bayanın biri kendi kansermiş geçen yine televizyonda gösterdi. O ağır ateşte kaynayınca bir şey çıkarıyormuş.. Kadın şimdi onu yapıp satıyormuş. Kendi de kanser hastasıymış. Kadın doğal elma sirkesi yapıyor. Bir sürü bir şeyden sirke yapıyormuş . S.D

Of course, it is cancer. Things like, 'It's good for it...' Take sheep's head and foot, for example. It even treats cancer. Take bone broth, for example. The other day, they showed a woman suffering from cancer on TV again. The woman simmered bones. When it is boiled that way, it produces something. Now the woman takes it and sells it. She is a cancer patient herself, too. The woman makes natural apple vinegar. She makes a vinegar of lots of things S.D. (35, primary school, married, mother of two, domestic cleaner).

Here it becomes evident that, as pointed out by Dean (1999), health risks have become individualized. It can be inferred from the respondents' replies that individuals not only take their own health risks but they also develop numerous strategies to manage

them. It should be noted that in the first phase of the field research, the results of the media analysis also indicate that risk discourse is frequently used in the health programs on television. In the analyzed programs, it is seen that diseases are defined and the audience are warned about the risks and dangers to the body. It is also observed that the risk discourse promoted by television health programs urges women to be aware of the risks, check their health condition and monitor themselves.

To illustrate, in the analyzed television health programs, women are warned about the necessity of monitoring one's nevi often and are also warned against the risk of cancer. In parallel to this, T. B., an engineer aged 24, says that she searched the nevi on her body on the Internet and went even further by examining them first by herself using an application that analyzes them. T.B. has monitored her nevi by herself with the help of a mobile phone application because she thinks that nevi are a risk factor for cancer.

Another aspect of individualization of health that is operationalized in this thesis is the level of the individual's relationship with one's own health. It is aimed to answer the questions of: Does the individual answer the health related questions as an individual or under the influence of her own role in the family? Does the individual perceive health as an extension of his/her individuality or as a social construct? Under the category of individualization health, the analysis of the respondent's answers aims to understand whether women's perception of health is socially constructed or an individual issue. As mentioned before, the perception of health as a social construct entails the adoption of the social roles and discourse on health is formulated through such roles by the individual. On this matter, the use of illness as social labeling and attaching other meanings when defining a person ill shows that health is perceived as a social construct rather than an individual condition.

When defining health, most of the respondents defined it as a tool that is necessary for them to lead their everyday lives. To them, health is necessary for them so that they can perform their daily activities. Actually when referring to their daily activities, women mention their responsibilities in the family. In relation to this, Bozok argues that:

> In patriarchal ideology, the housework is presented as the women's duty. Regardless of whether they worked or not, the women are generally forced to do the housework, while the men detest doing that and claim to commit themselves to the laboring in which they earn money. This gendered division still continues in the contemporary neoliberal capitalist patriarchy (Bozok, 2013, p. 155).

In Turkey, women have a lot of domestic responsibilities that are expected to be fulfilled by them. As responsibilities such as keeping the house clean, childcare, preparing food and cooking meals for the family members require physical activity, women define being healthy as being functional and being able to fulfil their household responsibilities. Women's defining health as a notion connected with functionality indicates that they make a connection between being healthy and being "capable of fulfilling household responsibilities."

As is obvious from the responses of the majority of the respondents, the things that women want to cope with by being healthy are their household responsibilities that are attributed to them within the family. For example, when defining health, Z.A. (48), who has two children, mentions being helpful for others.

> *Sağlık zinde yaşamak, ihtiyaçlarını görüp ayrıyeten başkalarını faydalı olabilecek kadar vücudunun dirençli halde olması ve bu pozisyonda gününü geçirebilmek yani ağrısız sızısız günü tamamlayabilmek. Yani enerjik bir şekilde günü tamamlayabilmek, sağlık benim için bu. Z.A.*

> Health is to live energetically, to meet your needs and also to have a resistant body so that you can be helpful for others, to spend the day in this way and to finish the day without any aches or pains. I mean, to finish the day energetically... This is what health is for me Z.A. (48, university, married, mother of two, and officer).

R.K., who has six children, mentions feeling safe and knowledgeable when describing being healthy and says that she can take better care of her children when healthy. R.K.'s definition makes it clear that to her, being healthy is the equivalent of being knowledgeable and feeling safe.

> *Sağlık bence daha yani kendini garanti hissedersin, daha bilgili hissedersin. Benim okumam yazmam da yok da çok öyle bilgim olmuyor ya. Sağlıklı kendin yani kendin doktora gidip sağlıklı olman daha güvenli olur. Çoluğuna çocuğuna daha güvenli bakarsın, sağlıklı bakarsın. R.K.*

> I think health is… I mean you feel yourself guaranteed, more knowledgeable. I can't read or write and I'm not much knowledgeable. Being healthy, I mean if you see a doctor on your own and be healthy that way, it is safer. You can take care of your children more safely, more healthily R.K. (53, primary school, married, mother of six, and housewife).

In addition to this, the majority of the respondents who defined health as a tool see it as being fit enough to function. These respondents consider being healthy as being physically healthy. It is clear from their definitions when they frequently underline the importance of "not needing anyone else" or "being able-bodied."

> *Sağlık, benim için çok önemlidir. İlk önce sağlık, sonra sıhhat, huzur mutluluk hani derler ya. Sonrasında istediklerimizi isteriz evimiz olsun arabamız olsun. Kesinlikle. Yani çok şükür elim ayağım tutuyor, gözlerim görüyor, nefes alabiliyorum. Yani bütün vücudumu kullanabiliyorum çok şükür. Çok önemli bence sağlık D.S.*
>
> Health is very important for me. Health comes first, then wellness, peace, happiness, as they say. Then we desire what we want to own like a house or a car. Definitely! I mean, thank God I am able-bodied, I can see, I can breathe. I mean, thank God I can use all of my body. I think health is really important D.S. (35, primary school, single, mother of two, office cleaner).

These responses, which reflect common opinions, present the fundamentality of family and women's family-based roles within the conceptualization of health. It is seen that rather than perceiving themselves as individuals, they answer the questions of the interview as wives and mothers in the family. It is generally argued that the Turkish welfare state depends on a normative model of the family in which men are breadwinners and the women are care providers in the family. In her analysis of the characteristics of the former and recent welfare regimes of Turkey, Buğra (2012) points out that the new social policy has brought a new form of familialism. That is to say, the familiastic characteristics of Turkish former welfare regime should be understood as the state's indirect contribution to protect the traditional family structure in its economic significance (Buğra, 2012, p. 21). According to Buğra, AKP's social reform program includes significant social policy efforts directed to the disabled. With these reform implications, as well as in the realm of child protection and elderly care services, the preferred policy option was to financially support the family and minimize the role of institutional care seen to be clearly an inferior care provided within the family (Yazıcı, 2008, cited in Buğra, 2012, p.27). "Positioning the family

as the primary unit of care the new system, reinforced of women as a care provider" (p. 27).

It is generally argued that the Turkish welfare state depends on a normative model of family in which men are breadwinners and the women are care providers in the family. As a result of this division of labour in family, women receive the health insurance and other social benefits as dependents of the father or the husband. As Dedeoğlu and Elveren point out that dependency status of women is widely seen in many countries but what differs Turkish welfare system from other countries is that its "minimalist corporatist structure is maintained through strong family ties and the important domestic role played by women" (Dedeoğlu and Elveren, 2012, p. 11). At this point, it can be argued that Turkish welfare regime has managed to address many economic crisis and poverty due to social exclusion by its familiastic structure.

In this regard, it can be stated that women's gendered roles of care givers for the elderly, the disabled and children also lead to her role as the family healer. In the frame of the caregiving role, women are also responsible for the long-term patient care in the family. Women have to manage multiple roles as care givers and healers and tend to many other unpaid domestic chores.

In relation to this, the majority of responses centering on the issues of family responsibilities of women and dominance of patriarchal discourses is clearly observed in the second phase of the field research.

For instance, I.K., a housewife and a mother of two, talks about how important health is for her when defining health and she describes it as if it were an object to be cared about or protected. In her definition of health, I.K. uses the expressions "not needing anyone" and "doing one's own chores". For I.K., health is essential in terms of its role in fulfilling her household responsibilities and her own role in the family. This is evident when she says, "We must always stand erect in front of our husbands and children and be healthy." I.K. says that she can give support to her family members only if she is healthy.

Sağlık hele de günümüzde insanın dikkat etmesi gereken en önemli şey hani derler ya Allah hayırlısını versin. Sağlık versin derler ya para pul sağlığım olmayınca ne yapayım parayı, pulu, zenginliği derler ya dikkat etmeliyiz. Çocuklarımızın yanında eşimizin yanında bilmiyorum dimdik sağlıklı ayakta durmalıyız. Elin ayağım tutuyor. Hiç kimseye minnet muhtaç olmadan yaşıyorsam benim için en büyük sağlık kendi işimi kendim görmek. Kimseye muhtaç olmadan ve oram ağrıyor buram ağrıyor dememek. I.K.

Especially today, health is the most important thing one should care about. May God give us the most auspicious of everything, as they say, May God give us health, as they say. When it comes to money… As they say, what am I supposed to do with money or wealth if I am unhealthy? We must be careful. We must manage our own well-being. I don't know… We must stand erect in front of our children and our husbands and be healthy. I am able-bodied. If I live my life without being indebted to anyone or needing anyone, for me the best indicator of my healthfulness is doing my own chores. Not needing anyone and not whining about my aches and pains I.K. (48, high school, married, mother of two, and housewife).

It is known that chronic patients and those who suffered from serious illnesses in the past are affected by these experiences and these experiences influence their viewpoint on health. D.A. (58), who suffered from a serious health problem with her pancreas, spent twenty days in the intensive care unit and survived a life-threatening condition. Later, she could not take care of her own needs as she got a treatment in the hospital many times and did nothing but rest and try to recover at home, which had a deep impact on the meaning she attributed to health. As a result of the hard experience she has been through as a chronic patient, D.A. describes health as follows:

Ben hasta olduğumda bir ayağa kalksam diyorum başka hiçbir şey… Sağlık olunca hiçbir şeyi gözün görmüyor diyorsun ki şunu da yapayım aslında hepsi boş sağlığın senden gittiği an her şey bitiyor. İnsanın elinin ayağının tutması çok önemli. Ben diyordum ki ya şu kalkıp da bir su içecek miyim diyordum kalkamadığım günler çok oldu. Ağlıyordum kalkamıyordum gücüm yoktu çünkü eşim de çalışmak zorundaydı. Sağlık çok önemli benim için elin ayağının tutması çok önemli. Kendi ihtiyaçlarını karşılamak çok önemli yoksa yatalak çok zor. Bilmiyorum ben bu konuları çok çektiğim için. D.A.

When I suffer from an illness, I say nothing but 'I wish I could stand up.' When you are healthy, you aren't aware of anything. You just say I want to do this and that. In fact, all is empty. The moment you lose your health, everything comes to an end. To be able-bodied is very important. [When I was sick] I kept saying, I wonder if I can get up and drink water by myself. There were so many days when I couldn't. I would cry, I wouldn't stand up. I wasn't strong enough and my husband was also working. Health is so important to me. To be able-bodied is so important. To meet your own needs is so important. Being confined to bed is so hard. I don't know. Maybe it's because I suffered a lot D.A. (56, primary school, married, mother of two, and housewife).

When defining health, 48 years old Z.A., who has been through a cancer treatment, says that to her, health is a means of spending her life and helping others.

> *Sağlık zinde yaşamak, ihtiyaçlarını görüp ayrıyeten başkalarını faydalı olabilecek kadar vücudunun dirençli halde olması ve bu pozisyonda gününü geçirebilmek yani ağrısız sızısız günü tamamlayabilmek. Yani enerjik bir şekilde günü tamamlayabilmek, sağlık benim için bu Z.A .*
>
> Health is being energetic, being able to meet your own needs and also the body's being resistant enough to help others, and to spend the day in this way. I mean to finish the day without any pains or aches. That is, to finish the day energetically. This is what health is for me Z.A. (48).

In this context, Petersen and Lupton state that:

> The emphasis upon women as bearing responsibility for the health and welfare of their partners, children and other family members (such as their ageing parents) by ensuring the cleanliness of the home remains strong in contemporary Western societies. Throughout women's lifespans they are encouraged to protect their own health not simply for their own interests but because of their responsibility to others (Petersen and Lupton, 2000, p. 75).

When the respondents were asked whether they found themselves healthy at the moment they were being interviewed, it was observed that despite the health problems they said they had been suffering from, they said that they were healthy. In this context, the emphasis on the socially constructed roles of women in Turkey is clearly observed because being ill is culturally labeled as vulnerability. The respondents think that their illness affect the well-being of the other family members and for this reason, they define their health status as healthy.

The respondents' answers are similar to the overall conservative and patriarchal scheme of gender relations in Turkey. The similar case was seen in the media analysis phase of the field research. For instance, in Feridun Kunak[57] Show, the presenter says:

> If you aren't well, if you aren't strong, if you aren't healthy, you won't be of use to anyone. You are the pillars of your houses; you are the pillars of the society, sisters. Be healthy and strong (F.K. 15.02.17).

[57] *Sen iyi olmazsan sen güçlü olmazsan sen sağlıklı olmazsan kimseye faydan olmaz siz evin direğisiniz siz toplumun direğisiniz bacılarım, kardeşlerim, ablalarım sağlıklı olun güçlü olun (F.K. 15.02.17).*

Many of the women who were interviewed reported that despite the chronic diseases they had such as diabetes, high blood pressure, or coronary diseases, they felt themselves good and that they were healthy. These women, who are defined as medically ill, do not regard themselves as sick. It is possible to see the cultural factors here. They avoid being referred to as unhealthy as there is a stigma attached to the sick, so they prefer not to say that they are ill and are afraid of being talked about as a sick person. To them, if they become ill, the order of the household will be disrupted and they must not show vulnerability.

For instance, H.V., who has diabetes, has had a cancer treatment and has difficulty seeing says that she is healthy.

> *A çok şükür şekerim o kadar kötü değil, kanserim de o kadar kötü değil, çok küçük yani ilaç tedavisi de yapmıyorum şu kanser tedavisini de yapıyorlar ya kemoterapi de görmedim. Bir de şeye girdim radyoo… eskiden şua derlerdi bir tek o yani yaktılar birazcık orayı hepsi bu kadar. Doktora gidiyorum herhangi bir şuan da bir şeyim yok zaten çok küçüktü, koltuk altımda falan lenflerde hiç yoktu, iyim yani zaten o zaman da hiç kafama takmadım ben onu hiç öyle kanser hastası gibi hissetmedim kendimi H.V. (61).*
>
> Thank God, my diabetes is not that bad. Neither is my cancer. It is something trivial. I mean, I don't take any medications. You know, when they treat cancer…I haven't had chemotherapy, either. But I had radio… They used to call it rays. They burned that area a bit and that was all. I see a doctor and there is nothing bad at the moment. It was already a small one. There was none in my armpits or my lymph. I am fine already. I didn't take it seriously even then. I am fine, I mean. I never felt like a cancer patient H.V. (61, high school, married, mother of two, housewife).

Similarly, D.A., who suffers from a pancreatic disease and hypertension, and Ö.O, who has a thyroid disease, define themselves as healthy.

> *Şu anda iyiyim Allah'a şükürler olsun. İyiyim yani bir problemim yok. Kanallarımdan dolayı sıkıntı yaşıyorum, pankreas iltihabı oldu. Ameliyat oldum sonra bir dönem daha sıkıntı oldu ama bi iki üç yıldır çok çok rahatım. Herhangi bir problemim yok D.A. (56).*
>
> Thank God, I am well at the moment. I'm fine… I mean I don't have any problems. I've been suffering from a difficulty because of my vessels. I contracted pancreatic inflammation. I had an operation and then I suffered from it for some time but for the last two or three years I've been so fine. I don't have any problems D.A. (56, primary school, married, mother of two, housewife).

Evet, kendimi sağlıklı hissediyorum. Ben aslında tiroit hastasıyım ama çok önemsem de. Tiroitlerim çalışmıyor. Çalışmadığı için kilo aldım. Gerçi ondört kilo da verdim. Ö.O.

Yes, I feel myself healthy. In fact, I am a thyroid patient but I don't care that much about it. My thyroids are not working. As they don't work, I've put on weight. I've also lost 14 kilos, though Ö.O. (48, primary school, married, mother of one, secretary).

Evet çok sağlıklı hissediyorum. Hâlbuki hastayım ama sağlıklı hissediyorum. Ama şu anda kalbim rahatsız ama kalp ilacı kullanmıyorum. Mide kanaması geçirdiğim için hepsi mide ilacı. İşte koruma, gaz giderici ama daha çok midemi korumak. V.İ.

Yes, I feel myself very healthy. In fact, I am sick but I feel healthy. I have a coronary disease now but I don't take any cardiac. As I've had a gastric bleeding, I take only gastric medications. [The purpose is] to protect [myself] and to get rid of the gas but mostly to protect my stomach V.İ. (59, high school, married, mother of two, housewife).

Moreover, during the interview, the respondents were asked to think of a person they know who was constantly ill and to say why this person was always ill. The aim was to understand their opinions on illness and causes of illness. The answers given to this question reveals an interesting pattern. The respondents said that these people in their families, in their neighborhood or their friend circles, who are known to be constantly ill were not ill in fact but they were trying to attract attention using their illnesses. According to the respondents, there was not a cause for becoming constantly ill, either biologically, structurally or genetically. To them, there was only one reason why these people were always ill and that was their being hypochondriac. The use of the term "hypochondria" to describe an illness can be considered as a metaphor the respondents used to refer to these people without defining them in a negative way. Most of the respondents refrain from describing these people as abnormal or inadaptable but prefer the term "hypochondriac"[58]. The following quotations exemplify this:

Ben bunun biraz da psikolojik olduğunu düşünüyorum. Durmadan yutkunamıyorum. Midem ağrıyor. Başım ağrıyor. Hatta geçen endeskopi, kolonoskopi de yaptırdı. Hiç bir şey çıkmıyor. Ama psikolojik olduğuna inanıyorum ben. Yemeği yer hastayım. Otururken başım ağrıyor. Nedir bu hastalık hastası derler ya gerçekten de teyzemin kızı hastalık hastası. Bu yüzden eşinden de ayrıldı. Çünkü sürekli hastayım diyor. Yaptırıyor tetkiklerini ama hiç bir şey çıkmıyor. Bizde inanamıyoruz. İnandırıcı olmuyor o zaman. I.K

[58] The term hypochondriac is used for the Turkish concept 'hastalık hastası'.

I think this is a bit psychological. [She always says] 'I can't swallow. I have a stomachache. I have a headache.' The other day, she had an endoscopy and a colonoscopy. Nothing has been detected. But I believe it's psychological. After she eats her meals, she says 'I'm sick.' While sitting, she says 'I have a headache.' What is this illness? You know, they say hypochondria. My aunt's daughter is really hypochondriac. That's why she got divorced. Because she constantly says that she's sick. She has her health checked but nothing is detected. And we can't believe her. She is not credible in that case I. K. (48, high school, married, mother of two, and housewife).

İşte söyledim en sağlıklı işte kayınvalidem ama sürekli hastayım diyor. Bence psikolojik. Evet psikolojikmen. O yerleştirdi kafaya hastayım demeyi. Soruyorsun nasılsın dediğinde, kollarım ağıyor, sırtım ağrıyor, şuram ağrıyor… Aslında hiçbir şeyi yok. Adana'da oğlu götürür zaten, checkuptan geçiyor, kesinlikle böyle 18 yaşındaki kızlar gibi maşallah, kendisi eski topraklardan. D.S. (35).

In fact, I've already mentioned her as the healthiest person but she always says she is sick. I think it is psychological. Yes, it is psychological. She automatically says that she is ill. When you ask her how she is, she says, "My arms are aching, I have a backache, there is an ache here, an ache there… In fact, she doesn't have any of them. Her son in Adana takes her to the doctor and makes her have a checkup but she is definitely like young girls at the age of 18. She is hale and hearty D.S. (35, primary school, single, mother of two, office cleaner).

Kayınvalidem her dakika doktora gitmek isteyen bir hanımdı. Doktora gidiyor geliyor… Kafa hastalığı kafa. Ondan çok yıldık zaten, eşim artık parayı verirdi hadi özel hastaneye… Doktor gittiğimizde teyze hasta değil dedi. Teyze kafadan hasta dedi. Doktora gidiyor üç ay ilaçlar içiliyor. Ne vermiş işte mide ilacı vermiş kalp ilacı vermis. G.E.

My mother-in-law was a woman who wanted to see a doctor all the time. She saw a doctor and [when] she came back home… Her illness was in the head. That's why we got sick and tired of it. My husband used to give money to us and we went to a private hospital. When we went to the doctor, the doctor said 'She is not sick. She is sick in the head.' She used to see a doctor and took pills for three months. What did the doctor prescribe? Gastric pills and coronary pills. G.E. (59, high school, married, mother of three, housewife.

As can be seen in the quotations above, the people who are defined by the respondents as psychologically ill are all women. Based on these examples, it can be concluded that saying that they are sick is also a communicational strategy employed by women. The women defined as "hypochondriacs" in these interviews may be saying that they are sick instead of they are unhappy, for they cannot mention the hardships they face in their daily lives and because being sick is relatively more socially acceptable.

This case presents that women prefer to be talking about their problems through expressing their ill health. In our context, the answers given by some respondents lead

us to conclude that illness is a way of social labeling for women that the respondents used when talking about the people they referred to in their exemplifications. On the other hand, for the women mentioned by the respondents, it is a communication strategy for women that they develop to communicate with others in the family. All these are evidence that health has meanings beyond its biological sense.It is clearly understood that the common characteristic of health- related discourse of respondent's is that it doesn't represent the individualism of health.

As illustrated in the examples, there is a strong relationship between family roles and healh accounts of women where the gendered responsibilities have a big role in determining women's perception of health. For this reason, talking to the interviewees about their health status leads inevitably to their family roles as mothers or wives, which was something often witnessed throughout the interviews. When asked about their own health status, they often ignore their illness since they were subjected to be healthy for their family.

Significantly, most of the women label other women in their families as hypochondriacs. This case presents two situtations. The first one is that the illness is used by women as a means of labelling others and secondly, women use this illness as a strategy to communicate with other family members in Turkey. To me, this is one of the most peculiar aspects of studying health through the perspectives of women in Turkey because it is possible to see how the health of women is socially and culturally constructed rather than being an individual issue. This situation is no doubt related to the patriarchal ideology, which was fostered by the neoliberal political rationality (Brown, 2015).

Regarding the strategy of individualism of health, the results of the second phase of the field work suggest that health- related discourse is constructed by respondents with the embediment of their family roles. In many of those answers, the priority was given to being wife or mother than being an individual. This is both observed in the women's definition of health, expressing their own health status and using the illness as a means of labelling others and communication strategy in the family. The similar qualities are

also seen during the analysis of television health shows that family roles of women's as being mother and wife are freguently emphasized in the programs. Actually it is clearly seen that this common quality do not reflect the "individualism" with its generally known definition. To me this case can be analyzed from Wendy Brown's arguments on the relationship between patriarchy and neoliberalism. For her, the responsibilization of self as a gendered process "in the context of privatizing public goods uniquely penaliz[ing] women to the extent that they remain disproportionately responsible for those who cannot be responsible for themselves" (Brown, 2015, pp. 105-106). Therefore, familialism becomes an imperative, rather than the enemy, of neoliberal political rationality.

7.4. Concluding Remarks

Throughout this chapter, it is aimed to understand the subject perspective of neoliberal governmentality of health. With this aim, respondents' anwers are analyzed with reference to the categories of medicalization, commodification of health and individualization of health.

Firstly, from the answers of all the women interviewed, it can be understood that women's everyday life is medicalized through the discourse of healthy lifestyle. Espacially through their dietary habits, women's everyday life is under the control of the medical paradigm. It is notable that respondents tend to use self-healing methods instead of using pharmaceuticals and this can be understood as the pervasion of medical control in every domain of women's lives. Moreover, it is particularly common for the younger women to perceive the biological phases such as pregnancy, motherhood, and meanpouse as medical issues that require medical support.

Secondly, regardless of the generation and the educational level to which they belong, most of the women tend to perceive health as a commodity. This common quality is clearly understood when they say they prefer to go to private hospitals for a better service. It should be underlined that the respondents in general carried the characteristics of the middle class. Neoliberal efforts of privatization and

marketization of health care service are evident in the respondents' prefererence of private hospitals. Another important common quality of the respondents' answer is that the motive behind their some consumption habits is being healthy. Espaciallly their food consumption pattern has a strong link to their desire to be healthy.

Thirdly, as the answers of the women clearly show, a great number of women perceive health as an individual responsibility rather than their right as citizens. Accordingly, women feel themselselves responsible for obtaining medical knowledge and they make an effort to achieve the reliable medical knowledge from a variety of sources. It is worth mentioning that as a strategy of neoliberal governmentality, the individualization of health risk is clearly seen in the answers of respondents. Based on the interviews, I argue that women not only assess their own health risk but also develop strategies to manage it. Furthermore, the respondents reveal that their social role and gendered division of labour in the family play a decisive role in their health perception. Here, it should be underlined that the respondents answered the question as mothers, wives or daughters in the family rather than individuals. Another conclusion that can be derived from the respondents' answers is that illness is both a means of social labelling and a strategy of communication for women.

Following the line of the common qualities of the respondents' answers that emphasise the notion of familialism in their health account, I argue that neoliberal governmentality of health strengthened the gendered roles of women in Turkey (Brown, 2015). In line with the aforementioned discussion on neoliberal governmentality, the interviews reveal that although neoliberal governmentality of health promotes the responsibilized, individualized human capital, women's "responsibilization" in the context of "privatizing public goods uniquely penalizes women to the extent that they remain disproportionately responsible for those who cannot be responsible for themselves" (Brown, 2015, p. 105). According to the findings of the second phase of field research it can be said that the strategies of neoliberal governmentality of health as medicalization, commodification of health and individualization of health play an important role in constitution of healthy woman

subject from the perspective of subject itself. For this reason, it can be argued for the respondents that they are neoliberal healthy women who are homo oeconomicus whose subject position is constituted by the new forms of gender subordination as they remain caregivers and healers of the family and are also the supporters of the organization of the neoliberal market. Both the first and second phase of the field research points to increasing familialization of health care and intensification of gender subordination in the health domain (Brown, 2015). In this respect, it can be concluded that results of two phases of field research show that the indivudal unit is not a single person but a family in the network of neoliberal governmentality of health in Turkey.

CHAPTER 8

CONCLUSION

> If you aren't well, if you aren't strong, if you aren't healthy, you can't be of use to anyone. You are the pillars of your homes. You are the pillars of society. My sisters, my elder sisters, be healthy! Be strong! (15.02.17 FK.)

> We must stand erect in front of our children and our husbands and be healthy. I am able-bodied. If I live my life without being indebted to anyone or needing anyone, for me the best indicator of my health is doing my own chores. Not needing anyone and not whining about my aches and pains. I.K. (48)

This thesis studies the particular experience of neoliberalism in Turkey by focusing on the health domain, through the lens of governmentality. Understanding the neoliberal art of governance with a governmentality perspective helps us to reveal the systematic ties between structure and agency, subject and power, market and the state, power and knowledge. Academic debates frequently state the neoliberalism as a shift in the political –economic sphere from welfarism towards a new economic and poltical agenda. In these discussions the concept of neoliberalism denotes varying definitions from political project to economic transformation but this thesis approaches neoliberalism as a political rationality, a normative reason which discursively constructs the new forms of subjectivities. Approaching neoliberalism as a political rationality helps us to unearth its "epistemological character in that they embody particular conceptions of the objects to be governed-nation, population, economy, society, community and the subjects to be governed-citizens, subjects and individuals" (Rose, 1996, p. 42).

This study tries to understand the neoliberal experience of Turkey by focusing on the health dimension, here it can be asked: why the health is chose as a domain of neoliberal governmentality? The contemporary rise of neoliberalism should be considered as one of the most effective transformation in health field. It is generally

argued that, with the decline of Welfare state, neoliberalism redefined the role of the state, the public sector and also the state-society relations in the health sector. As it is well known, starting with the structural adjustment programs of World Bank, there have been serious attempts to transform the health care systems all over the world. In this way, neoliberalism influences socio-economic, political, managerial, clinical and cultural aspects of health care systems. Hence, the health domain provides us a fruitful field to understand how the mechanisms of neoliberal governmentality operate in Turkey. By focusing on the neoliberal governmentality of health, this thesis attempts to answer the question of how 'the healthy woman' is constituted as a subject by the neoliberal discourse in Turkey.

In this study, I am following a specific line of thought that leads to understanding neoliberalism as a form of governmentality. This path thought is based on the works of Michel Foucault and scholars of governmentality studies. Firstly, the Foucauldian account provides us a relational understanding of power in contemporary world and his formulations of subject and power-knowledge are all well suited to examine the relations between power, medical knowledge and subject in the contemporary society. Secondly, the governmetality studies also help us to discursively analyze different mechanisms and strategies of neoliberal art of govarnence.

This study is inspired by the works of the governmentality studies' scholars (*e.g.* Brown, 2015; Lemke, 2001; Miller and Rose, 2008, Dean, 1999). The radical transformation from welfare to neoliberal mode of government has called for new theoretical instruments and analytical tools to account for the social and political ruptures (Lemke, 2012, p. 78). In order to fill this analytical gap, the governmentality studies literature focused on understanding this complex structure of power relations in neoliberal form of government. As Miller and Rose says, "political power is exercised today through a multitude of agencies and techniques, so analysis of modern government needs to pay particular attention to the role accorded to indirect mechanisms for relating socio-political objectives with economic social and personal conduct" (Miller and Rose, 2008, p. 26).

The scholars of governmentality studies "address the rationalities of historically specific forms of government such as neoliberalism shaping everyday interpersonal and institutional life thereby brings micro and macro level of analysis together" (Gordon, 1991, cited in Nadesan, 2008, p. 1) These scholars also highlight that the changes in economic field result in changes in discourse of policy making and strategies of governing. They also stress that governmentality is a fruitful perspective to understand the new strategies and tactics of power that the new forms of subjects are discursively constructed. They also formulate neoliberalism as a political rationality which extends the values of market to every dimension of life from state, welfare policy to the daily life and also to the formation of the subject.

As a theoretical and conceptual framework, this thesis tries to answer the question of what are the strategies of neoliberal governmentality for the formulation of new subjectivities.

Drawing on the governmentality studies literature, firstly it can be argued that the personal autonomy has become key term in the exercise of power and more control over individual commenced to be exercised since they are not merely the subjects of power but play a part of its operations (Miller and Rose, 2008, p. 53). Secondly, there has been a new relationship between expertise and politics, and the pluralization of social techniques emerges in advanced liberal mode of rule (Rose 1996, pp. 54-57). Thirdly, neoliberal governmentality operates with a concept of technology that includes not only material but also symbolic device. Here, the discourses, narratives, regimes of representation are not reduced to pure semiotic propositions; instead, they are regarded as performative practice (Lemke, 2007, p. 50). Fourthly, there is a new specification of subject of government as the consumer of the health services; of education; of training; of transport. Next, technologies of neoliberal governmentality encourage people to understand themselves and act as if they are autonomous and self-determined, active individuals who seek to enterprise themselves to maximize their quality of life through free choices (Rose, 1996, p. 57). Moreover, the responsibilities of individuals by neoliberal technologies as active subjects here assume a particular

mode of freedom that specifies the 'conduct of conduct' (Rose, 2004). Furthermore, neoliberal governmentality also favours the subjects who is responsible for management of her/his own risk (O'Malley, 1996). Lastly, Wendy Brown argues that the neoliberal subject as an economic man is very different from Adam Smith's homo oeconomicus who takes its shape as human capital seeking to strengthen its competitive position, and whose life is reshaped by neoliberalism as a homo oeconomicus not only in economic context but also in every sphere of its existence (Brown, 2015). In this framework, following questions are aimed to be answered in this study.

- How is 'healthy woman' constituted as a subject by the neoliberal discourse in Turkey?
- Who is the 'ideal healthy woman' for neoliberal discourse?
- What kind of a neoliberal transformation is actualized in health policy in Turkey?
- How do the strategies of neoliberal governmentality of health affect the discourse of television health programs in Turkey?
- How do the strategies of neoliberal governmentality of health affect the health perception and behaviours of women in Ankara?
- How do women living in Ankara interact with the neoliberal health discourse?

As mentioned before, the thesis focuses on the health as a domain of governance by focusing on the process of constitution of 'healthy woman' subject through the neoliberal discourse. Since the governmentality perspective stresses how the tactics and strategies of neoliberal governmentality operate for discursive formation of the new subjectivities, this thesis aims to understand the neoliberal governmentality of health by focusing on its strategies. Following the literature review, it is possible to conclude that there are three main strategies of neoliberal governmentality of health which are medicalization, commodification of health and individualization of health. These strategies are operationalized as the guiding categories of the research study.

Before the field research, in order to understand the political background of the neoliberal transformation of health in Turkey, Health Transformation Program (HTP) of 2003 is examined in terms of its content and impacts. HTP has led to many neoliberal transformations. For example, the Ministry of Health's role in healthcare provision has transformed; the state is no longer a service provider and is transformed into a regulator or a control mechanism. Additionally, the requirements for opening private hospitals are rearranged. With the City Hospitals Model which is newly introduced as a form of public-private partnership, hospitals are now becoming campuses offering various consumption areas. The privatization of health care and the commodification of health can also be traced in the increased number of private hospitals and increased out-of-pocked expenditures for health care. Even though the General (Universal) Health Insurance introduced by HTP is relatively more comprehensive and thus more successful compared to the previous system, the working people who have contribution debts and their families are left outside the scope of this insurance scheme as the system is based on contributions. The Family Physician System also introduced by HTP is based on the principle of patient's choice as the individuals are free to choose their own family physicians. The preventive health care which is one of the main elements of the primary health care system has been removed from the field of state responsibility and the individuals are held responsible for their own health alongside the freedom of choosing one's physician. In this political background, the main indicators of the neoliberal transformation, which can be listed as privatization, marketization, responsibilization and individualism, have been put into practice through Health Transformation Program of 2003 in Turkey.

Since this dissertation aims to investigate how the healthy woman subject is constituted by the neoliberal discourse, two different mechanisms in the health network of neoliberal governmentality which are the media and the subject perspectives are analysed during the field study. The field study employs two analytical methods: a discourse analysis on media and following that in-depth interviews conducted with the women living in Ankara. In the first stage of the field study, three television health programs, namely Feridun Kunak Show (Channel 7), My

Doctor (Channel D) and My Dear Doctor (NTV), are selected for analysis as mechanisms of truth regime and the discourse which is produced in neoliberal governmentality network is studied. Moreover, these three selected heath programs, which were broadcasted between 2016 and 2017 on Kanal D, NTV and Kanal 7, were available in digital archives and to add variety, the programs broadcasted during the summer and the winter seasons were included. For each program, 20 episodes were analyzed, which makes 60 shows in total. In order to analyze the data of the media analysis, the textual and visual content of 3600 minutes was analysed, firstly in terms of production practices and then using categorized discourse analysis technique. Then in order to understand the embodiment of the neoliberal governmentality of health in television health programs, the data collected from the television health programs is analysed through the lens of the guiding categories of medicalization, commodification of health and individualization of health.

In the second stage of the field research of the study, in order to understand the subject perspective of neoliberal governmentality of health semi-structured in-depth interviews were conducted with 27 women living in Ankara between December 2017 and March 2018. Interviewees were selected by the snowball sampling technique. Following the completion of interviews, the data is analysed in a similar way with the first stage of the field. In line with the literature review, I focused on three strategies of neoliberal governmentality of health, namely medicalization, individualization of health and commodification of health. These strategies are the guiding principles in my data analysis.

The dissertation only focuses on two aspects of governmentality in health which are media and subject construction, yet the network of governmentality in this respect has various mechanisms in place. Therefore health care providers, executives, civil society etc. should also be taken into consideration in order to grasp a wider perspective.

To understand the media aspect of the neoliberal governmentality of health, health related television programmes are examined. However it is seen that the internet and

the social media are also major resources producing the health discourse. It is worth considering these to broaden the perspective in future studies of similar kind.

Although this thesis is not directed by feminist methodology, the results give clues that a neoliberal governmentality of health in Turkey cannot be understood sufficiently without considering gender dynamics. As the results illustrates, the constitution of healthy women by neoliberal discourse is a social process that is embedded in and reproduces patriarchal gender hierarchy simultaneously. Hence this thesis shows that on the issues of neoliberalism and women's health, it is possible to conduct further research through the lens of feminist methodology. This study convincingly addresses the necessity of follow-up studies that scrutinize the intricate relations between women's health and neoliberalism.

The study contributes to sociological knowledge by means of inquiring woman's health as not only composed of biologic health indicators, but also its relation with political rationalities, truth regimes and discursive formations in the governmentality network. Moreover, it is understood that health is not an issue that only belongs to the field of medicine rather it deserves critical sociological scrutinies. Hence this study gives clues for the future research on woman's health and neoliberalism which adopts medical sociology as a theoretical framework.

Here in this study, I portray the mechanisms that neoliberal governmentality institutionalizes in the context of health domain in Turkey. I believe that it resourcefully provides critical knowledge in the fields of sociology of health and governmentality studies, as summarised below.

When the main findings of the study is examined, firstly, this study asks the question of how the neoliberal governmentality of health affect the discourse of television health programs in Turkey. In order to answer the question, a categorized discourse analysis is conducted on three television health programs in Turkey.

The findings of the analysis of television health programs suggest that the phases of menopause and motherhood in women's life cycle are medicalized in the discourses used in the three analysed programs. Many of the areas of women's lives are medicalized and everything in women's lives become subjects of medicine. In other words, the women's everyday lives are medicalized through the special mixtures they prepare for self-healing and their dietary choices. In the discourses used in these programs, the women are told to be active citizen-consumers in order to heal themselves and to spend most of their day trying to prepare this healthy food for the other members of their families.

Regarding the commodification of the health in the analysed programs, the women are encouraged to consume healthy products through preparing the cures, teas and mixtures. The women are told to make varying herbal teas bought from herbalists or to spread some oil mixtures on their bodies to relieve their pains or to recover from their illnesses. All these discourses lead women to consume natural products rather than pharmaceuticals in order to be healthy. The emphasis on "naturalness" is a commonly observed discourse formation in the analysed programs. Furthermore, through the connection made between beauty and health, and the discourses produced in these programs, women are interpellated to consume certain products in order to be beautiful and healthy.

Moreover, in the analysed television programs, the discourses supporting the idea that health is one's own responsibility are seen in three aspects. The first one is that individuals are continuously hailed to be their own doctors and to check their bodies

To present health as an individual domain of responsibility and to distance it from its social context by holding the individual's behaviours or lifestyle responsible, they should observe their bodies and diagnose their ailments.

In most of the analysed programs, it is observed that women's health is defined in relation to their roles as mothers. For the discourse structures in the health programs on television, women's health is a socially constructed issue rather than an individual

one. In these programs, it can be argued that the discourse on women's health is formulated through motherhood or wifehood rather than individuality. The findings of the first phase of the field research also suggest that neoliberal implication for health is embodied in the ways that health related discourse is produced by the analyzed television health programs. According to the findings of the first phase of field research, it can be said that the strategies of neoliberal governmentality of health such as medicalization, commodification of health and individualization of health play an important role in constitution of healthy woman subject from the media perspective. In the meanwhile, I should add that selection criteria for sampling the health programs on television is based on the ideological differences that are represented in three broadcast companies. However, the findings do not suggest dramatic differentiation in discursive formation of healthy subjectivities.

In addition to these, I also examine the public service announcements that generates ties between policy makers and subjects through various media contents. Analyzing the 45 public announcements broadcasted on television in the last three years, which are digitally available on the website of the Ministry of Health, I found that only two of them are relevant to women's health. More importantly, these contents are about mother-related issues of women's health.

Secondly, this thesis questions how the neoliberal governmentality of health is operationalized in the subject level. The findings of the in-depth interviews with women living in Ankara reveal that their everyday routines are channelled by medicalization as the impact area of the latter expand with the articulation of the concepts like healthism and/or healthy lifestyle. Moreover, it is observed that the women's dietary choices need to be tackled in the context of the subjects' relationship with health and medicalization of everyday life. It is possible to state that, for the respondents, the health behaviours are only related to food such as eating vegetables in season, eating additive-free products, and consuming organic food. Regarding the medicalization strategy of neoliberal governmentality of health, it is seen that the majority of the respondents who are below the age of 40 assert that they have gone

through their pregnancy by implementing their doctors' recommendations. They state that they have used folic acid, iron supplement and various vitamins prescribed by the doctor. Apart from these, one of them says that she did prenatal yoga. In this age group, most of them have had a caesarean delivery. All these present us that their pregnancy and birth periods of life are medicalized by neoliberal discourses. Moreover, self-care is also considered as a kind of medicalization in this study; it is seen that the majority of respondents use self-care methods and take actions to become healthy. They also seek advice from other experts, they make their own remedies and they use certain ingredients for preparing these remedies.

Regarding the commodification of health, the findings of the second phase of the field research present that most of the respondent prefer private hospitals to receive a much better care. They also believe that they can be healthy if they pay the price for a high-quality health service, which suggests that health has become a commodity.

Furthermore, the commodification of health is also embodied in respondent's consumption habits of health products which are not only limited to pharmaceuticals but also include organic food, supplements, healthy cleaning products, organic clothes. The respondents perceive themselves as health consumers who consume things in order to be healthy. The common quality of the answers is that 'naturalness' is the important factor for respondents to consume for the health.

Most of the respondents are of the opinion that health is an issue which should be considered as the individual's responsibility. They feel themselves responsible for both their health and their family member's health. They feel themselves responsible for assessing and managing their health risks.

Regarding the individualization of health strategy, it can be said that respondent's social role and gendered division of labour in the family play a decisive role in their health perception. In this context, it should be underlined that the respondents answered the question as mothers, wives or daughters in the family rather than individuals. Another conclusion that can be derived from the respondents' answers is

that illness is both a means of social labelling and a strategy of communication for women. To conclude, the findings of the second phase of field research suggests that the strategies of neoliberal governmentality of health as medicalization, commodification of health and individualization of health play an important role in constitution of healthy woman subject from the perspective of subject itself. In terms of the individualization of health, it can be said that results of two phases of field research reveal that individual unit is not a single person but a family in the network of neoliberal governmentality of health in Turkey.

This thesis aims to understand the particular experience of neoliberal art of government in Turkey by focusing on the process of constitution of healthy woman subject. Based on the findings of the field research, it can be concluded that neoliberalism in Turkey is experienced as a political rationality that both "articulates the nature and the meaning of political, social and the subject"(Brown, 2006, p.694) and it also operates as a governmentality, a mode of governing that produce subjects (Brown, 2005, p.37) From the perspective of governmentality, it is possible to argue that findings of the field research present that neoliberal mode of subjectivation is embedded in heterogeneous and sometimes conflicting discourses. In this context, Lemke argues neoliberalism "admittedly ties the rationality of the government to the rational action of individuals" (2001, p. 200).

In Chapter 5, the political background of neoliberal transformation of health is examined by focusing on Health Transformation Program of 2003 and it is clearly understood that from the program that in neoliberal transformation of health in Turkey "the state is constructed in market terms as well as develop policies and promulgate a political culture that figure citizens exhaustively as rational economic actors" (Brown, 2006, p. 694) That's to say, Health Transformation Program should be consider as an example of "host of policies that figure and produce citizens as individual entrepreneurs and consumers whose moral autonomy is measured by their capacity of self-care" (Brown, 2006, p. 694) From the governmentality perspective, the HTP cultivates a political rationality, in line with the neoliberal transformation goals which

imagine citizens who are accountable for their own health, who can manage their health risks and who are highly health conscious (Dean, 2010).

Moreover, the findings of the analysis of television health programs suggests that media should be considered as a technology of government that does not "have their origin or principle of intelligibility in state but made it possible to govern in" neoliberal way (Rose, 1996, p. 58). The analysis of television health programs reveals that these programs produce discourse on health and provide medical knowledge, they also present the truth regimes on being healthy so it is possible to consider them as a technology of governmentality which provides the condition of possibility for "action at distance" in neoliberal forms of governing (Rose, 1996, p. 43). Moreover it can be concluded that findings of the analysis of television programs show that new experts have emerged in the health field. These experts configures the new formula of relation between government, experts and subjects in neoliberal governmentality of health (Rose, 1996, p. 52).

In line with the neoliberal governmentality of health, the findings of the analysis of television health programs reveal that discourse of media promotes the healthy lifestyle which makes subjects to become more responsible for their health who feels themselves free to choose as a health consumer. As Burchell argues under the influence of neoliberalism "individuals are assumed to be the subject of their lives" (1996, p. 29).

> (In neoliberal societies) the rhetoric of empowerment, choice and self-determination dominate 'healthy living' discourse (since) 'taking responsibility' for one's own health and exercising choice is portrayed as the path to freedom' and 'fulfilment" constructs the subject whose life is under the control of medicalization and who perceive the health as him/her self-responsibility and commodity (Petersen et al., 2010, p. 394).

With respect to the governmentality studies literature, the findings of this research lead to the below-mentioned conclusions:

In the subject perspective of the field research, it can be concluded that neoliberal healthy women is a homo oecomicus who is responsible citizen, who is the

entrepreneur of herself and rationally assesses her own risks, who is an active and free agent to make the optimum choice among an array of courses of life; who is homo oeconomicus in all fields of life, who invests in herself as an automatized individual acting upon competitive logic, whose lifestyle is reshaped by the truths and knowledge gained via expertise, and finally, whose wishes, world of thought and the even sense of him or herself are governed by the modern forms of governmental rationality (Gordon 1991, Rose 1996, Brown, 2015)

Moreover, it can be concluded that the everyday life of women is medicalized through the discourse of healthism or healthy lifestyle (Crawford, 1980). Majority of women tend to heal themselves and prefer to use "natural" goods instead of using pharmaceuticals. The respondents also perceive health as a commodity, they perceive themselves as health care consumers exercising their own freedom of choice. Regarding the commodification of health, the answers of respondents suggest that "individuals can be governed through their freedom of choice" (Rose and Miller, 1992, p. 201).

The findings of the field research suggests that strategies of neoliberal governmentality of health such as medicalization, commodification of health and individualization of health play a significant role in the constitution of healthy woman both from perspective of media and subject. The embodiment of neoliberal rationality is seen both in the ways that television health programs produce the discourse and the subjects conduct themselves.

The most striking issue established by this dissertation on the individualization of health care is the following: The discourses of women on health emphasize family and gender roles. Women do not perceive health as an individual matter. In their relation to health, motherhood or wifehood comes before individuality. On this matter, it is possible to say that the neoliberal rationality discursively create new subjects. Such a subject is a rational and active homo oeconomicus self-investing in its own human capital with a life that is economized in every domain. In both stages of the field study, it is concluded that health is an instrument for being able to fulfil domestic

responsibilities both for the women interviewed and the understanding promoted by the media. Women feel responsible not only for their own health both also the health of other members of the family. At the same time, the women use 'illnesses' both for social labelling and as a communication strategy. All these data do not lead us to an individualization in the western orthodox sense.

This can be explained with the help of Brown's remarks.

Brown asks the following question: what holds families together in neoliberal regimes on the one hand while the neoliberal reason casts each human as self-investing entrepreneurial capital, responsible for itself and striving to appreciate its value vis à vis other capital entities and on the other hand, there lies the family life based on the idea of sacrifice and affection.

For neoliberalism, women looking after the human capital -children, the adults and the elderly long past their productive years- are an important mechanism. Such care work which can as well be part of public services are on the shoulders of the women. In this sense, familialism is severely featured in neoliberalism. Women tend to believe that these responsibilities are given to them because of their biological traits. And all of these demonstrate that gender subordinations are exacerbated in neoliberalism (Brown, 2015)

For the epilogue, Thatcher's remarks from the interview mentioned at the very beginning of the dissertation explains it all: "Who is society? There is no such thing! There are individual men and women and there are families" (Thatcher, 1984).

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APPENDICES

A. APPROVAL OF METU HUMAN SUBJECT ETHICS COMMITTEE

UYGULAMALI ETİK ARAŞTIRMA MERKEZİ
APPLIED ETHICS RESEARCH CENTER

ORTA DOĞU TEKNİK ÜNİVERSİTESİ
MIDDLE EAST TECHNICAL UNIVERSITY

DUMLUPINAR BULVARI 06800
ÇANKAYA ANKARA/TURKEY
T: +90 312 210 22 91
F: +90 312 210 79 59
ueam@metu.edu.tr
www.ueam.metu.edu.tr

Sayı: 28620816 /215

05 NİSAN 2017

Konu: Değerlendirme Sonucu

Gönderen: ODTÜ İnsan Araştırmaları Etik Kurulu (İAEK)

İlgi: İnsan Araştırmaları Etik Kurulu Başvurusu

Sayın Prof. Dr. Sibel KALAYCIOĞLU;

Danışmanlığını yaptığınız doktora öğrencisi Deniz Bilge ÜLKER' in **"The Sociological Analysis of Health Perception of Women in Different Educational Levels in Ankara"** başlıklı araştırması İnsan Araştırmaları Etik Kurulu tarafından uygun görülerek gerekli onay **2017-SOS-069** protokol numarası ile **05.04.2017 – 30.08.2017** tarihleri arasında geçerli olmak üzere verilmiştir.

Bilgilerinize saygılarımla sunarım.

Prof. Dr. Ş. Halil TURAN
Başkan V

Prof. Dr. Ayhan SOL
Üye

Prof. Dr. Ayhan Gürbüz DEMİR
Üye

Doç. Dr. Yaşar KONDAKÇI
Üye

Doç. Dr. Zana ÇITAK
Üye

Yrd. Doç. Dr. Pınar KAYGAN
Üye

Yrd. Doç. Dr. Emre SELÇUK
Üye

B. QUESTIONS OF IN-DEPTH INTERVIEWS IN TURKISH

A) SES

1) Kaç Yaşındasınız?
2) Eğitim Durumuz nedir?
3) Medeni durumuz nedir?
4) Çocuğunuz var mı eğer vas rise kaç çocuğunuz var?
5) Çalışıyor musunuz? Nerede Çalışıyorsunuz?
6) Hane halkı gelirinizi yaklaşık olarak söyleyebilir misiniz?
7) Hangi semtte/ mahallede oturuyorsunuz? Ne zamandan beri?
8) Eviniz kendininiz mi? Eşinizin mi?
9) Eviniz kaç odalı nasıl ısınıyorsunuz?
10) Evde kaç kişi yaşıyorsunuz?

B) SOSYAL GÜVENCE DURUMU

1) Sosyal güvenceniz var mı?(Kendinizin mi eşiniz ya da babanızdan mı?)
2) Herhangi bir sosyal güvenceniz yoksa neden?
3) Sağlık güvencesiz olmanın size getirdiği sıkıntılar nelerdir?

C) DOĞURGANLIK

1) Evli ya da boşanmış ise – Kaç yaşında evlendiniz?
2) Çocuğunuz var mı kaç tane? İlk Kaç yaşında anne oldunuz?
3) Hiç düşük yaptınız mı kürtaj oldunuz mu?

D) MEDİKALLEŞME

1) Doğumunuz sezaryen mi normal doğum muydu? Buna kim karar verdi?
2) Gebeliğiniz boyunca sağlıklı olmak için neler yaptınız bunları nereden öğrendiniz?
3) Gebeliğiniz boyunca sık sık doktora gidip tüm taramaları yaptırdınız mı?
4) Adet döneminizi hatırladığınızda bu dönemdeki bilgi kaynağınız kimdi? Adet döneminde doktora gittiniz mi ?
5) Menapoz sürecini deneyimlediniz mi (evetse doktora gittiniz mi tıbbi bir yardım aldınız mı hayırsa gelecekte bu süreçte doktora gitmeyi tıbbi yardım almayı düşünür müsünüz?)

E) SAĞLIK DURUMU/ SAĞLIK TANIMI

1) Sizce Sağlık / Sağlıksızlık ne demektir?
2) Hangi durumlardaki kişileri sağlıklı veya sağlıksız olarak nitelendirirsiniz?
3) Çevrenizde akrabalarınızda arkadaşlarınızda sağlıklı diyebileceğiniz kişiler var mı? Nedenleri nelerdir?
4) Şu anda kendinizi sağlıklı hissediyor musunuz? Herhangi bir sağlık sorununuz var mı?

F) HASTALIK NEDENİ

1) Çevrenizde akrabalarınızda arkadaşlarınızda sağlıksız diyebileceğiniz kişiler var mı? Nedenleri nelerdir? Neden bu kişiler sağlıksız sizce?
2) Sizce insan neden hastalanır?

G) SAĞLIK BİLGİSİ KAYNAĞI

1) Kendinize ait sağlık bilgilerini nereden alırsınız?
2) Bu bilgilerin hangilerini güvenilir ya da güvenilmez bulursunuz?
3) Televizyonlarda sağlık programlarını izler misiniz?
4) Hatırladığınız böyle bir sağlık programının adını söyler misiniz?
5) Yukarıda belirtiğiniz kaynaklardan öğrendiniz bu bilgiler sizin dağlık davranışlarınızı etkiliyor mu?

H) SAĞLIK DAVRANIŞI – TIPLA İLİŞKİ

1) Kendinizi sağlıksız hissettiğinizde öncelikle ne yaparsınız? Hangi durumlarda doktora gidersiniz?
2) Doktorun verdiği tedaviyi tamamıyla uygular mısınız? Örneğin ilaçları bitirir misiniz? Tüm iğneleri vurdurur musunuz? Evinizde bitirmediğiniz yarım kalan ilcalar var mıdır?
3) Son beş yılda doktora gitme eğilimleriniz değişti mi?
4) Hiç kendinizi hasta hissedip doktor dışında gittiğiniz bir iyileştirici kırıkçı –çıkıkçı enerji uzmanı ya da hoca oldu mu? Bu kişiyi nerden duydunuz nasıl ulaştınız?
5) Spor yapıyor musunuz? Spor salonuna üyeliğiniz var mı? Eğer yapıyorsanız sağlığınıza iyi geldiğini düşünüyor musunuz? Bunu nereden öğrendiniz?
6) Beslenme alışkanlıklarınızı düşünelim eskiden yediğiniz ama artık yemeyi bıraktığınız gıdalar var mı ya da sağlıklı diye yeni tüketmeye başladığınız gıdalar var mı bunları nereden öğrendiniz?
7) Televizyondan bir doktordan duyduğunuz ve uygulayıp sağlığınıza iyi geldiğini düşündüğünüz bir şey var mı? Bu duyduklarınızı çevrenizle paylaşır mısınız onlara tavsiyeler verir misiniz?

I) SAĞLIK RİSK ALGISI VE SORUMLULUK

1) Sağlığınızla ilgili gelecekte en çok kaygı duyduğunuz risk sizce nedir?
2) Neden bu hastalık sizin için bir risktir açıklar mısınız?
3) Bu riski engellemek için neler yapıyorsunuz bunları nereden öğrendiniz?
4) Hiç sağlığınızı kontrol için check- up kan tahlili ya da tarama yaptırdınız mı? (mamografi smear testivs)
5) Sizce sağlık bireyin mi devletin mi sorumluluğunda olan bir konudur? Neden bireyin ya da devletindir? Açıklar mısınız?

C. QUESTIONS OF IN-DEPTH INTERVIEWS

A) SES

1) How old are you?

2) What is your educational background?

3) What is your marital status?

4) Do you have a child? If yes, how many?

5) Are you working? Where?

6) Can you please approximately share your household income?

7) In which neighborhood are you living? How long?

8) Do you have the ownership of the house? Or your husband/wife?

9) How many rooms is your house? How you warm up the house?

10) How many people stay in your house?

B) SOCIAL SECURITY CONDITIONS

1) Do you have a social security? (Your own? Or as dependent of your father / husband?)

2) If you do not have any social security, what is the reason?

3) What are the challenges of not having any health coverage?

C) FERTILITY

1) If married or divorced – When did you marry?

2) Do you have children? How many? How old were you when you become a mother for the first time?

3) Have you ever had a miscarriage or abortion?

D) MEDICALIZTION

1) Was your delivery a cesarean or normal? Who decided on the delivery modality?

2) During your pregnancy, what kind of measures to took to feel healthy and where did you learn these measures?

3) During your pregnancy, did you frequently visit the doctor and conduct screenings?

4) Adet döneminizi hatırladığınızda bu dönemdeki bilgi kaynağınız kimdi? Adet döneminde doktora gittiniz mi ?

5) Have you experienced menopausal (if yes, did you go to a doctor? Did you receive a medical assistance? If no, would you like to go to a doctor and receive medical assistance in the future?)

E) HEALTH CONDITION/ HEALTH DEFINITION

1) What does healthy/ unhealthy mean according to you?

2) In which circumstances you define a person as healthy/unhealthy?

3) Can you define anyone from your environment, among relatives or friends as healthy? What are the reasons?

4) At the moment, do you feel yourself as healthy? Do you have any health problems?

F) CAUSE OF DISEASE

1) Can you define anyone from your environment, among relatives or friends as unhealthy? What are the reasons? In your opinion, what is the reason behind their unhealthy condition?

2) In your opinion, what is the reason behind having a disease?

G) RESOURCE OF KNOWLEDGE ABOUT HEALTH

1) Where do you get information about your health condition?

2) Which of this information you find reliable/unreliable?

3) Do you watch health programs on TV?

4) Can you please give the name of the TV health program that you remember?

5) Does the information you learnt from above mentioned resources affect your health behavior?

H) HEALTH BEHAIVOUR – RELATION WITH MEDICINE

1) What will be the first thing you do in case you feel unhealthy?

2) Do you follow one to one the treatment plan of the doctor? For example, do you finish the medicines? Do you finish all injections? Do you have unfinished medicines at your house?

3) Is there any change in your tendency to visit a doctor?

4) Hiç kendinizi hasta hissedip doktor dışında gittiğiniz bir iyileştirici kırıkçı – çıkıkçı enerji uzmanı ya da hoca oldu mu? Bu kişiyi nerden duydunuz nasıl ulaştınız?

5) Are you doing sports? Do you have gym/sports center membership? If you are doing sports, do you think that it is good for your health? Where did you get this information?

6) Let's think about your nutrition habits; is there any food that you have used to consume but quitted consumption? Or is there any food that you recently start to consume as it is healthy? Where did you get this information?

7) Is there any practice which you had learnt from a TV doctor and implementing, and you think that it is good for your health? Do you share such information with your environment? Do you give recommendations based on such information?

I) HEALTH RISK PERCEPTION AND RESPONSIBILITY

1) With respect to your health, what is the future risk that you concern most?

2) Can you please explain the reason why this disease is a risk for you?

3) What are you doing to prevent this risk? Where did you get this information?

4) Have you ever go to check-up or conduct health screening? (mammography smear test etc.)

5) In your opinion, is health a personal responsibility or state's responsibility? Why? Can you please explain?

D. CURRICULUM VITAE

PERSONAL INFORMATION

Name-Surname: Deniz Bilge Ülker
Place of Birth: İzmir
Date of Birth: 26.03.1983
e-Mail: dnzblg@gmail.com

EDUCATION

Year	**Degree**	**Institution**
2019	PhD	METU Sociology
2008	MS	METU Media and Cultural Studies
2004	BA	EMU Radio, Television and Cinema

WORK EXPERIENCE

2008 –2015 Araştırma Görevlisi, Research Assistant in Yaşar University, Dept. of Radio Television and Cinema.

2016 -2017 Central Project Assistant, EU Funded -Supporting Registered Employment of Women through Home-Based Child Care (Direct Grant Project)

LANGUAGES

Turkish (native), English (fluent), German (basic)

E. TURKISH SUMMARY / TÜRKÇE ÖZET

TÜRKİYE'DE SAĞLIĞIN NEOLİBERAL YÖNETİMSELLİĞİ: 'SAĞLIKLI KADIN' ÖZNESİNİN OLUŞUMU ÜZERİNE BİR VAKA ÇALIŞMASI

Giriş

Bu tezin ana amacı tüm dünyada yönetim düzeninin krizlerine müdahale olarak doğan, yeni bir yönetim arayışı olarak neoliberal dönüşümün Türkiye'de nasıl denemiylendiğini anlamaktır. Bu doğrultuda bu çalışma neoliberal dönüşümlerin en güçlü hissedilidği alan olan sağlık alanındaki dönüşümlere odaklanmış, bu dönüşümleri de sağlıklı kadın öznesinin oluşum sürecinine odaklanarak anlamaya çalışmaktadır. Özelikle 1980'li yıllarda, Türkiye'de neo-liberal politikaların uygulanması ekonomik ve sosyal alanda çok önemli değişimlere sahne olmuştur. Neoliberal politikaların neden olduğu bu değişim öznelerin çalışma ve tüketim biçimlerini değiştirmekle kalmayıp onların kendilerini ve dünyayı algılama şekillerini de yeniden yarattı. Neo-liberalizmi tanımlaya yönelik farklı yaklaşımlar oldu, neoliberalizmi politik bir proje, ekonomik bir değişim olarak görenlerin yanında neoliberalizmi yeni bir yol olarak tanımlayanlar da oldu. (Dardot, P. and Laval, C., 2013) Bu tez neoliberalizmi bir politik akıl biçimi olarak tanımlamaktadır. Bu doğrultuda bu tez Türkiye'de neoliberalizmin deneyimini anlamak için yönetimsellik perspektifinden yaralanmaktadır. Yönetimsellik kavramını Micheal Foucault ortaya koymuş ardından 1990'lı yıllardan sonra yönetimsellik perspektifinden etkilenen birçok akademik çalışma yapılmıştır. Nikolas Rose (1996), Peter Miller and Nikolas Rose (2008), Thomas Lemke (2001) ve Mitcheal Dean (1999) ve Wendy Brown (2006) yönetimsellik perspetifini kullanarak özelikle neoliberal dönemi anlamaya yönelik çalışmalar yapmaktadırlar. Tezin araştırma soruları şu şekilde sıralanabilir:

Türkiye'de sağlıklı kadın öznesi neoliberal söylem tarafından nasıl oluşuyordur?

Neoliberal söylem için 'ideal sağlıklı kadın' öznesi kimdir?

Neoliberal sağlıkta dönüşüm Türkiye'deki sağlık politikalarını nasıl etkilemiştir?

Neoliberal yönetimselliğin stratejileri Ankara'da yaşayan kadınların sağlık algı ve davranışlarını nasıl etkilemektedir?

Ankara'da yaşayan kadınlar neoliberal sağlık söylemiyle nasıl bir etkileşime girmişlerdir?

Teorik Çerçeve

Yönetimsellik perspektifinden bakmak bu teze ne gibi katkılarda bulundu? Yönetimsellik perspektifi bugünkü iktidar ilişkilerinin heterojen, içinden birden fazla mekanizmayı barındıran yapısını anlamamıza yardımcı olur. Çünkü yönetimsellik tek yönlü bir iktidar anlayışını reddeder ve eylemlerin üzerine eyleyen (conduct of conduct) bir yönetim tarzını kabul eder. Bu noktada yönetimselliği söylemsel olarak birçok mekanizmanın içinde yer aldığı ve bu mekanizmaların bir biriyle illişkide olduğu bir ağ olarak tanımlayabiliriz. Yönetimsellik perspektifi bu çalışmada nasıl oluyor da yönetimsel aygıtlar, mekanizmalar, stratejiler ile bireyin kendi kendiyle kurduğu ilişki arasında bir uyum ya da uyumsuzluk olduğunu anlamamıza yardımcı olmaktadır. Bir başka değişle yönetimsellik makroekonomik programların öznelerin gündelik hayat deneyimlerine nasıl sirayet ettiğini görmemizi sağlayan bir mercektir. Örnek vermek gerekirse, yönetimsellik tanımıyla IMF'nin yapısal uyum paketleri ile öznenin evde kendi yoğurdunu kendi mayalaması eylemi arasındaki ilişkiyi anlamamız mümkündür.

Özellikle sağlık gibi birden fazla aktörün ve birçok mekanizmanın devrede olduğu ve neoliberal dönüşümün tüm gücüyle hissedildiği bir alanı açıklayabilmek için bu çalışmanın teorik ekseni yönetimsellik çalışmalarına kaydırılmıştır.

Yönetimsellik kavramı, Foucault'a ait bir kavram olduğu için çalışmada bu perspetifi anlamak için Foucault'un özne, söylem, güç ve bilgiyi nasıl kavramsallaştırdığı açıklanmaya çalışılmıştır. Bu kavramlar netleştirildikten sonra yönetimsellik kavramı ve neoliberal yönetimsellik ile ilgili teroik bir çerçeve çizilmiştir (Foucault, 1984).

Aslında, Micheal Foucault'un tüm çalışmalarının temel amacı özneyi anlamaktır. Arkeolojik bir araştırma yöntemi izlediği erken dönem çalışmalarında Foucault, akıl ve delili, kliniğin oluşumu ve beşeri bilimlerin ortaya çıkışını; daha sonra soykütüksel yaklaşımla gerçekleştirdiği çalışmalarında bilgi-iktidar ilişkilerini ve bu ilişkilerin disiplinci yapısını, bu dönemden sonra da yönetimsel yaklaşımlar, teknolojiler, cinsellik ve kendiliği konu alan çalışmalar yapmıştır. Foucault yönetimsellik çalışmalarında biyo-iktidar modelini açıklamaya çalışmıştır. Biyo-iktidar modeli yaşam üzerine uygulanan iki farklı iktidarı kapsar bunlar; anatomo-politik ve biyopolitiktir. Bu iki farklı iktidar türü ile Foucault, bireylerin başkaları tarafından yönetilmesi ve bireylerin kendililerini yönetmesi arasında bir bağ kurar. Biyoiktidar kavramı bedenlerin tek tek kontrol edilmesi yerine nüfusun doğum-ölüm oranı, sağlık düzeyi, yaşam süresi gibi istatiksel veriler doğrultusunda bir bütün olarak denetlenmesine işaret eder. Siyasi analizlerde hakim olan iktidar tanımlamasından farklı olarak, Foucault'un iktidarı baskı kuran, kısıtlayan bir şey değil aynı zamanda inşa eden oluşturan bir kavramdır. Ona göre iktidar yalnızca kurumsal yapılarda var olan, kurumsal ilişkilerle kurulan bir yapı değildir, ikidar öznenin gündelik hayatına müdahale eden bir kurumdur.

Tüm bunlar doğrultusunda bu tez neoliberalizme yönetimsellik perspektifinden bakmatadır ve bu tez için neoliberalizm bir ekonomik yapılandırma, bir politik proje olmaktan çok bir tür siyasal akıldır. Bir siyasal akıl olarak neoliberalizm, belirli hakikat iddalarının üretildiği söylemsel bir evrendir. Ve bu evren kendi norm yapıcı özelliğiyle söylemsel olarak yeni öznellikler doğurur. Bu tez kapsamında söylem Foucault'un izinden giderek yapısal bir söz dizimi veya anlamsal bir bütünlük olarak kabul edilmektedir. Foucault'un perspektifinden söylem kavramını açıklamak ancak onun söylem, güç ve bilgi arasına kurduğu ilişkiyi kabul ederek mümkün olur. Bu noktada diyebiliriz ki söylemsel yapılar (discursive formations) normative bir yapıya sahiptir. Neyin doğru neyin yanlış neyin makbul neyin kabul görmeyen olduğunu söylemler belirler.

Teorik çerçevenin en son ayağı sağlığın neoliberal yönetimselliğidir. Bu çalışma kapsamında yapılan literatür taramasının ardından, sağlığın neoliberal yönetimselliğini üç farklı boyutunun olduğu öne sürülmüştür. Bu boyutlar aynı zamanda neoliberal yönetimselliğin işlemesi için gerekli olan stratejileri olarak da tanımlanabilir. Bu çalışma için neoliberal yönetimsellik üç ana strateji üzerinden işlemektedir bunlar; medikalleşme, sağlığın metalaşması ve sağlığın bireyselleştirilmesidir. Bu üç strateji aynı zamanda tezin verilerinin analizi için rehberlik eden kategoriler olarak da tanımlanmaktadır.

Sağlık Politikalarındaki Neoliberal Dönüşüm: Sağlıkta Dönüşüm Programı (2003)

Tezin alan çalışmasına geçmeden önce sağlıkta neoliberal dönüşümün politik söylemde nasıl gerçekleştiğini anlamak için 2003 yılında yürürlüğe giren Sağlıkta Dönüşüm Programının içeriği ve etkilerinden bahsedilmiştir. Türkiye'de 1980'li yıllarda başlayan sağlık sistemindeki neoliberal dönüşümün en son aşaması 2003 yılında hayata geçen Sağlıkta Dönüşüm Programı'dır. (SDP) Bu program sağlık sisteminde finansal, yapısal ve yönetimsel boyutlarda önemli dönüşümlere neden olduğu gibi toplumsal dönüşümlere de neden olmuştur. Sağlıkta Dönüşüm Programı bir tür yönetimsel uygulamadır. (Dean, 1999) Ya da Miller ve Rose (2008) 'un kavramsallaştırmasıyla, SDP, neoliberal yönetimsellik ağındaki (network) doğrudan müdahale eden bir mekanizmadır. Sağlıkta Dönüşüm Programının içeriği ve etkilerine bakıldığı şu sonuçlara varılmıştır:

SDP, öncelikle sağlık hizmetlerindeki anlayışı değiştirmiştir. Sağlık vatandaşlık hakkı olmaktan, satın alınan bir meta haline dönüşmektedir. Buna ek olarak, sağlık konusu devletin sorumluluğundan çıkarak bireylerin sorumluluğuna bırakmıştır.

SDP en önemli etkisi Sağlık Bakanlığı'nın rolünün sağlık alanında düzenleyici, kuralları koyucu olarak değişmesidir. Bu noktada sorulan soru; devlet bu rol ile sağlık alanından tamamen çekilmiş ve tamamıyla piyasa mekanizmalarınca yönetilen bir sağlık sistemi mi oluşmuştur sorusudur. Yenimahaleli –Yaşar, devletin sağlık

hizmetleri sisteminden tamamen çekilmediğini, kural koyucu ve düzenleyici rolünün aslında devletin sistem içerisindeki gücünü pekiştirdiğini ileri sürer (Yenimaleli-Yaşar, 2008).

SDP ile hastanelere finansal ve yönetimsel otonomi sağlanmış, özel hastanelerin açılması için gerekli koşullar yeniden düzenlenmiştir. Ayrıca kamu-özel ortaklığında yapılan yeni bir hastane modeli olarak Şehir Hastaneleri modeli ile hastaneler içinde birçok tüketim alanının olduğu kampüsler haline gelecektir. Bu noktada sağlık hizmetlerinin özelleştirilmesi, sağlığın metalaşması durumu artan özel hastane sayısı ve cepten ödenen sağlık harcama miktarlarından da anlaşılmaktadır.

SDP ile gelen Genel Sağlık Sigortası kapsayıcılığı bakımından bir önceki sisteme göre başarılı olsa da, sistem prime dayalı olduğu için prim borcu olan çalışanlar ve aileleri sağlık sigortası kapsamının dışında kalmaktadır. Ayrıca gelir bildirimi uygulaması ile belirlenen gelirin hane halkı temelli olması Türkiye'de çekirdek aile dışında yapılanan diğer aile modellerinde sorunlara neden olmaktadır. Prime dayalı sağlık sigortası Türkiye'de iş yaşamında birçok zorluk yaşayan, kayıt dışı çalışan birçok kadın için sağlık hizmetlerinden yararlanamamak anlamında gelmektedir.

Yine SDP ile gelen, Aile Hekimliği Modeli, aile hekimlerinin performansa dayalı ücretlendirilmesi, sigortası olmayan kadınların temel sağlık hizmetlerinden mahrum kalmalarına neden olmaktadır. Ayrıca SDP ile sigortası olmayan kadınlara temel sağlık hizmetlerinin sadece gebelik ve doğum durumlarında sağlanması, kadınların sağlık politikalarının hizmet verme alanına sadece annelik kimlikleriyle dâhil olduğunun göstergesidir. Aile hekimliği modeli, 'hastanın seçimi' ilkesine dayanmaktadır, yani bireyler kendi aile hekimlerini seçmekte özgür bırakılmaktadırlar. Temel sağlık hizmetlerinin en temel basamağı olan koruyucu sağlık hizmeti aile hekimi modeli ile devletin sorumluluk alanından uzaklaştırılmış, bireyler kendi sağlıkları ile ilgili seçimde özgür bırakılarak aynı zamanda kendi sağlıkları ile ilgili sorumlu tutulmuşlardır. SDP'nin etkilerine itstatiksel veriler araçlığıyla bakıldığında bu programın özelleştirme, piyasalaştırma ve sağlığın

bireyselleştirilmesi gibi neoliberal dönüşümün izlerini taşıdığını söylemek mümkündür.

Alan Araştırması ve Sonuçlar

Tezin alan çalışmasına geldiğimizde, bu tez sağlığın yönetimselliğini iki farklı perspektiften bakarak analiz etmektedir bunlar medya perspektifi ve özne perspektifidir. Bu iki perspektif aslında sağlığın neoliberal yönetimsellik ağında yer alan mekanizmalardır.

Alan araştırmasının ilk aşaması medya analizidir. Medya söylem üretici olarak normatif yapısıyla yönetimsellik ağında etkili bir mekanizmadır. Sağlıkla ilgili medya içeriklerine baktığımızda, bu içeriklerin öznelere sağlık ile ilgili hakikat rejimlerini sunduğu ve sağlık bilgisi sağladığı söylenebilir. Bu nedenle alan araştırmasının bu bölümünde medyadaki söylemlerde sağlığın neoliberal yönetimselliğinin izleri aranmıştır. Alan araştırmasının ilk bölümünde, TV'de yayınlanan üç sağlık programında kadınlara yönelik sağlıkla ilgili hangi söylemler üretildiği analiz edilmiştir. Medya'da kadınların sağlığına yönelik üretilen söylemleri anlamak için görsel medya seçilmiş, yazılı basın örnekleme dâhil edilmemiştir. Bunun nedeni televizyon en yaygın kitlesel erişime sahip medyadır ve televizyon tüm medya kuramlarının ve pratiklerinde merkezde yer alır. Ayrıca sağlıkla ilgili içeriklerde çoğunlukla hafta içi öğlen kuşağında yer alan programların direk hedef kitlesinin o anda evde bulunan kadınlar olduğu bilinmektedir. Bu nedenle televizyonda sağlık programları medyada kadınlara yönelik sunulan sağlık içeriğindeki söylemleri analiz etmek için gerekli veriyi sunmaktadır.

Analiz için Kanal D'de yayınlanan Doktorum, Kanal 7' de yayınlanan Dr. Feridun Kunak Show ve NTV'de yayınlanan Canım Doktorum programları amaçsal örneklem tekniğiyle seçilmiştir. Bu programları seçerken öncelikle RTUK'ün televizyon izleme eğilimleri raporları incelenmiş kadın izleyicilerin izlediği içerikler olarak önce programlar belirlenmiş ardında bu programların içinden amaçsal örneklem yoluyla bu üç program seçilmiştir. Türkiye'deki televizyon kanallarında farklı ideolojileri temsil

ettiği düşünülen Kanal D, NTV ve Kanal 7 kanallarında yayınlanan bu programların 2016- 2017 yıllarında yayınlanan kayıtlarına internetten ulaşılmış ulaşılan programların çeşitliği açısından yaz ve kış sezonundan bölümler analize dâhil edilmiştir. Her program için on kış on yaz dönemine ait program izlenilerek toplam yaklaşık 3600 dakikalık görsel ve işitsel veri analiz edilmiştir.

Öncelikle programların yapısal özeliklerine bakılmıştır. Çünkü bilinmektedir ki, medya içeriklerinin ürettikleri söylemler türsel özelikleriyle yakından ilişkilidir. Yapım dinamikleri diye tanımlanabilecek, programın bölümleri, sunucular, stüdyo, kullanılan dekorlar gibi özelikler programların söylemlerinin üretilmesine önemli katkıda bulunurlar. 1990'lı yıllardan sonra haber bültenlerinde artan magazin içeriklerini eleştirmek için kullanılmıştır. Türkiye'de bunun en güzel örnekleri ana haber bültenlerinde ciddi siyasi haberlerden sonra yayınlanan komik hayvan videolarının yer alması olarak yaşanmıştır. Sağlık programlarında yer alan yemek tarifleri, yarışmalar, müzik gibi içerikler sağlık içeriğinin magazinleşmesine neden olmaktadır.

Feridun Kunak Show Ankara'da küçük bir stüdyoda, az sayıda stüdyo içi izleyici ile yayın yapmaktadır. Bu izleyiciler çoğunlukla kadındır, analiz edilen programlarda çok nadir erkek izleyicinin stüdyoda programı izlediği görülmüştür. Gelen izleyici kitlesi genellikle belediyelerin kadınlarla ilgili faaliyetlerine katılan gruplardır. Analiz süresince Kadın Eğitim ve Kültür merkezi, Etimesgut Halk Eğitim ve Kültür Merkezi Katıldığı görülmüştür. Hatta gelen bu izleyici gruplarının müzik hocaları bazı programlarda türkü söylemiş, diğer izleyiciler kalkıp oynamıştır. Bu içerikler de eğlence programlarının özeliklerini taşımaktadır. Yarışma, Gezi, Yemek ve müzik eğlence programlarının türsel özeliklerini içine alan "sağlık programı" Feridun Kunak Show bu türsel karmaşa içinde izleyicilere sürekli tıbbi bilgi sunmaktadır. Program kendisini giriş bölümünde şu şekilde tanımlar "Sağlığınız hakkındaki doğru bilgiyi keyifli sohbetle ekranlarınıza taşıyan Dr. Feridun Kunak Show"

Feridun Kunak ve Serap Kunak bu izleyicilere evlerine gelmiş gibi seslenir, programda sık sık izleyicilere mikrofon tutularak sorular sorulur. O programda

faydaları anlatılacak olan bitki elden ele gezdirilerek adının stüdyodaki izleyiciler tarafından tarif edilmesi istenir. Programın o günkü konusu olan konuyla ilgili tedavi uygulaması yine stüdyodaki seyircilerin üzerinde yapılır. Seyirciler sedyeye yatırılarak programda tarifi verilen lapa ya da kremler onların bedenleri üzerinde denenmekte ve kısa sürede etkisi olduğuna dair izleyicileri ikna etmek için uygulama yapılan seyirciye ağrısının geçtiği kremin iyi geldiği lapanın acısını azalttığı gibi sözler söyletilmektedir. Programda doktor olan sunucu adeta klinikte muayene yapar gibi stüdyoya getirilen sedyede yatan izleyiciyi muayene etmekte, teşhis koymakta hatta tedavi uygulamaktadır. Her şey canlı yayında olduğu için program anında başı örtülü bir izleyicinin bel ağrıları için önerilen tuvalet pompasıyla yapılan bir masaj izleyicinin bel bölgesi açılarak yapıldığı için izleyicilerden çok fazla tepki görmüştür. İnternet gazetelerinde Feridun Kunak'tan tepki çeken tedavi gibi başlıklarla yer almıştır.

Feridun Kunak programda tıbbi bilgi ile ilgili tek kaynaktır, kendi uzmanlık alanı olan ortopedi dışında tüm uzmanlık alanlarında izleyicilere neler yapmaları gerektiğini anlatır. Feridun Kunak show'da bazen semptomlar ele alınır bel ağrısı, sırt ağrısı, kabızlık gibi bazen ayak sağlığı ele alınırken bazen de kalp krizi, kansızlık, kemik erimesi gibi hastalıklar ele alınmaktadır.

Feridun Kunak Show önce ele aldığı bilgiyle ilgili tıbbi terimleri kullanmaktan kaçınarak izleyicilere bilgi verir sonra bu hastalığa yakalanmamak için ne yapmak lazım ya da bu hastalığı evde nasıl tedavi edebiliriz diye ayrı başlıklar açarak ele alır. Programa ele alınan hastalıkla ilgili yüksek görsel teknolojiyle hazırlanmış görseller yerine düz beyaz tahtaya kendisi basit çizimler yaparak anlatır. Analiz edilen birçok bölümde de gerçek kemik, kemik erimesini anlatmak için ponza taşı, beyin kanaması anlatmak için içinden kırmızı su geçen hortumla yapılmış basit bir düzenek ya da bazı organların maketlerini kullanmaktadır.

Feridiun Kunak tıbbi bilgiyi verirken ikinci sunucu olan Serap Kunak izleyici kitlesi olan hanımlarla çok daha yakın bir iletişim kurar, verilen bilginin uygulaması evin mutfağında gerçekleşecek olan eylemin anlatımı Serap Kunak'a aittir. Programda

ayrıca sıklıkla sağlık ve güzellik ilişkisi kurularak kadınlara evde uygulanabilecek güzellik reçetelerini Serap Kunak anlatır bazen hazırladığı maskeleri stüdyodaki bir seyirciye uygular ve ne kadar etkili olduğunu tekrar eder. Serap Kunak'ın bu konud Güzelik Sırları isimli bir kitabı vardır program sırasında yarışma bölümünde bu kitap izleyicilere hediye edilirken tanıtımı gerçekleştirilir. Serap Kunak nasıl sağlıklı çamaşır yıkanır, kestane nasıl pişirilir, zayıflamak için kahvaltılık gıda tarifleri vermektedir. Ayrıca Serap Kunak aile içinde de bu tarifleri uyguladıklarını "kendimiz in uygulamadığımız hiçbir şeyi size anlatmayacağız bundan emin olun" diyerek tarifleri konusunda izleyiciyi ikna eder.(15.02.17)

Feridun Kunak her programa adeta bir spor hocası gibi eşortman takım ve spor ayakkabı giymektedir. Zaten her programın başında stüdyodaki izleyicilere sabah sporu yaptırmaktadır. Bunun dışında hiçbir programda beyaz önlük ya da yeşil ameliyathane kıyafeti giydiğine rastlanmamıştır. Diğer sunucu olan Serap Kunak'ta her hangi bir tıbbi kıyafet giymemektedir.

Feridun Kunak hem stüdyodaki izleyicilere hem telefonla programa bağlanan izleyicilere "Sevgili Kardeşlerim, hanım kardeşlerim, ablalarım, can kardeşlerim" gibi gündelik dildeki samimiyetle seslenmektedir. Programda izleyicilerle iletilmek istenen mesaj tek bir cümle kalıbı içine sokularak alt yazı ile verilmektedir. Bu nedenle söylem analizi yapılırken programda kullanılan alt yazılar dikkate alınmıştır.

Kanal D'de yayınlanan Doktorum adlı sağlık programı öğlen gündüz kuşağında hafta içi her gün yayınlanmaktadır. Programın süresi yaklaşık bir buçuk saattir. Programı damar cerrahı Dr. Murat Aksoy ile sunucu Hilal Ergenekon sunmaktadır. Programın en ayırt edici özeliği konu aldığı hastalıkları hastaların hikâyesi olarak ele almasıdır. Belgesel dilinde çekilen bu bölümlerde hastalar ve hasta yakınları hastalık deneyimlerini izleyicilere anlatmaktadırlar.

İzleyiciler program aracılığıyla hastanın hastalığı nasıl deneyimlediği, doktoruyla kurduğu iletişimi, doktorun teşhise tedavi aşamalarına tanıklık etmektedir. Program türü olarak belgesel dili kullanımı ve gerçek yaşam hikâyelerini anlatması nedeniyle

real time özeliği taşımaktadır Tıp sosyolojisi alanında meslek dışı yaklaşım olarak tanımlanan sıradan insanın hastalık deneyimlerine odaklanan yaklaşım Doktorum programında açıkça görülebilir. Programa konuk olan diyetisyenlerin uyguladığı yemek tarifleri tıpkı Feridun Kunak Show'da görüldüğü gibi tıbbi bilginin yanında eğlence içeriklerinin sunulması sağlığın medya içerikleri aracılığıyla magazinleştirilmesi olarak değerlendirilebilir.

Programda ele alınan konular anlatılırken animasyonlar kullanılmıştır. Üst ses hastalığın tamının yaparken bu animasyonlarda görsel olarak o hastalık ile ilgili tıbbi bilgiyi izleyicilere aktarmaktadır. Programın çekim mekânları dış alanlardır, sokakta, pazarda, alışveriş merkezlerinde sunucular programı sunmaktadır. Bu mekânlar programın hasta deneyimlerinin aktarıldığı bölümlerde hastaların evleri ve doktorların muayenehane olarak çeşitlilik gösterir. Programda dikkat çekici bir diğer özelik ise ameliyat sürecine programda yer verilmesidir. Ameliyathane adeta bir stüdyo haline gelmiş ve yapılan operasyon kameralar tarafından kayıt edilmiştir.

Programda ele alınan konuları o konuların uzmanı olan doktorlar izleyiciye anlatmaktadır. Konuk doktorlar ve sunucu sürekli olarak tıbbi kıyafet giymektedir. Programa uzman doktorlar dışında bilgi kaynağı olarak yoga hocaları, güzellik uzmanları, spor hocaları ve diyetisyenler de katılmaktadır. Program kendi içeriğini izleyicilerine "Sağlığınızı korumak adına yapmanız gerekenlerden tutun da mutlu yaşam sırlarına dair önemli bilgiler, sağlığınız için ipuçlar "olarak teaserında tanımlamaktadır. Programda sadece hastalıklar ve sağlıkla ilgili yapılması gereken değil güzellik konusu sıklıkla ele alınmaktadır. Programların bir bölümünde cilt maskesi tarifi ya da cilt gençliği gibi konularda cilt uzmanı güzellik uzmanı gibi doktor olmayan kişiler tarafından çeşitli tarifler izleyicilere anlatılmaktadır. Programın güzellik ve estetik ile ilgili bu bölümleri sağlığın estetikleşmesi söylemine uyum göstermektedir.

Fizik tedavi uzmanı Prof. Dr. Cihan Aksoy tarafından sunulan Canım Doktor NTV kanalında Cumartesi sabahları haftada bir kez yayınlanmıştır. Program yayın hayatına son vermiştir. Program analiz edilen diğer iki programa göre daha kısa sürelidir,

yaklaşık 30dakika sürmektedir. Canım Doktor programı yayın günü ve saati nedeniyle diğer iki programa göre hedef kitlesinde sadece kadınlar olan bir program değildir. Bu nedenle izleyicilere hitap ederken diğer programlarda görülen diğer kadınlara yönelik hitap çok nadir gözlemlenmiştir. Program ele aldığı sağlık konuları bakımından da diğer iki programdan ayrılır. Örneğin ruhsal hastalıklara daha fazla yer vermektedir, hedef kitlesini ilgilendirecek hafta içi çalışan kadın ve erkeklere yönelik çalışan insanların sağlık sorunlarına sıklıkla içeriğinde yer vermektedir. Programda uzmanlaşma konusuna çok önem verilmektedir öyle ki sadece o hastalığın alanındaki uzmanlık dalındaki doktorlar değil üniversitelerin o hastalığın uzmanlık dalında bölüm başkanları ya da o hastalıkla mücadele için kurulan derneklerin başkanları olan uzman doktorlar konunun konuk edilmektedir. Bu durumda denilebilir ki tıbbi bilginin kaynağı olarak konun en yetkin kişisi seçilerek programda yer almaktadır.

Canım Doktorum programını sunan Prof. Dr. Cihan Aksoy doktor kıyafeti giymeden gündelik kıyafetlerle programı tek başına sunmaktadır. Her programın başında yoga ve pilates eğitmeni Mert Güler izleyicilere çok kısa sürede yapabilecekleri egzersizleri öğretmektedir. Bu egzersizler öğretilirken çalışan hedef kitleye yönelik olarak ofislerde yapabilecek hareketler sözü sıklıkla dile getirilmektedir.

Programın stüdyoda çekilmektedir bazı bölümlerinin üniversitelerin konferans salonlarında üniversite öğrencilerinin seyirci olarak katılımıyla çekildiği görülmüştür. Programın içeriğinde ele alınan konunun uzman doktoru ile sunucunun karşılıklı soru cevapları şeklinde gelişen diyalogları yer almaktadır. Bu diyaloglarda sunucu sıklıkla tıbbi terimlerden kaçınıp soruyu izleyicilerin ağzından sormaya özen gösterse konuk uzman doktorların çok fazla tıbbi terim kullandığına dikkat edilmiştir. Programın en sonunda sunucu "öğrendik ki" diye başlayarak program boyunca izleyicilere verilmek istenen tıbbi bilginin özetini yapmaktadır.

Canım Doktorum programında stüdyoda yer alan ekranlardan ele alınan konu ile ilgili canlı animasyonlar sıklıkla gösterilmektedir. Bazı programlarda hastalık belirtileri ya da tedavi yöntemleri ile ilgili tabloların bu ekranlardan gösterildiği görülmüştür. Programa konuk olan uzman doktorların sözlerinden bir cümle alınarak alt yazı olarak

sıklıkla verilmektedir. Bu nedenle diğer programlarda olduğu gibi alt yazılar öne çıkan altı çizilen söylemler olarak söylem analizine dahil edilmiştir.

Medya analizinin söylemsel verileri toplandıktan sonra veriler üç ana kategoriye göre analiz edildi. Medikalleşme kategorisine göre baktığımızda öncelikle bu programlarda ele alınan konuların çoğunlukla hastalıklar olduğu programlarda bu hastalıkların tanıtılıp korunma yöntemlerinin anlatıldığı görülmüştür. Bu noktada denilebilir ki bu programlarda sağlık, hasta olmamak olarak tanımlanmaktadır. Teorik çerçevede bahsediliği gibi bu programlarda neoliberal stratejilerin gereği olarak yeni uzmanlık dalları ve yeni uzmanlara sıklıkla rastlanmıştır.

Gündelik hayatın tıbbıleşmesi açısından baktığımızda, programlarda sağlıklı halı yıkama, sağlıklı ev temizliği gibi birçok gündelik pratiğin sağlık alanına girdiğini farkedebiliriz. Ayrıca kadınların doğal biyolojik yaşam evreleri olan menapoz ve hamilelik konularının sıklıkla işlendiği görülmüştür. Bir diğer önemli sonuç ise programlarda sağlıkla bireylerin beslenme seçimleri arasında bağ kurulmasdır. Bu durumu şu şekilde açıklamak mümkündür: Yemek yeme eylemi bireylerin yapmak zorunda oldukları gündelik hayatlarının çoğunu kapsayan bir eylemdir, sağlık ile ilgili kontrol, yemek yeme ile kadınların hayatlarına sızdığında, onların hayatlarının büyük bölümüne hâkim hale gelir. Bu programlarda sıklıkla sağlıklı yemek tarifleri izleyicilere verilmektedir.

Sağlığın metalaşması kategorisinden verileri analiz ettiğimizde şu önemli noktalara ulaşırız: bu programlarda kadınlara kendi kendilerini iyileştirmek için sunulan tarifler özneleri yine aktif hale getirerek onları tüketici olmaya yönlendirmektedir. Özelikle doğallık vurgusu ile doğal olan ürünleri tüketirseniz sağlıklı olursunuz düşüncesinin söylemlerde sıklıkla vurgulandığı farkedilmiştir. Yine bu programlarda güzelik ve sağlık kavramları sıklıkla birlikte sunulmakta güzel olmak sağlıklı olmak demektir bilgisiyle izleyicilere bu amaçla tüketim yapmaları söylenmektedir. Programlarda sıklıkla yüz güzelliği, saç güzelliği için maskeler tarif edilmekte ayrıca yeni tekniklerle güzel olmanın yolları tanıtılmaktadır. Tüm bu söylemler izleyicileri birer sağlık tüketicisi haline getirirken sağlığı da metalaştırmaktadır. Mesaj medya tarafından

toplumsal olarak yayılmadan önce anlamlı bir biçimde kodlanır. Burada medya içeriğinin türü önemlidir, gazete haberinde fotoğraf ve metin bir kodlama aracı iken televizyon programlarında stüdyonun tasarımı, sunucu, konuk seçimi, kullanılan çeşitli görseller gibi birçok unsur bir kodlama aracı olarak devreye sokulur. İşte bu kodlanmış anlam içeriği kitleleri doğrular ve normlar konusunda ikna eder ve onları harekete geçirir.

Dünya'da başlayıp Türkiye'de de hızla yayılan sağlık içeriğinin televizyon programlarında artışı yeni bir tür olarak sağlık programlarını ortaya çıkarmıştır. Bir içerik olarak sağlığın medyadaki programlara, dizilere, haberlere sızması sağlıklı yaşam söyleminin yayılması için önemli bir araçtır Bozok Sağlıklı yaşam biçiminin yaygınlaşma biçimini bir bombandırmana benzetir. Bu söylemin içeriğinde sağlıklı olmak için yapılması gerekenler listeleri, hastalıklara dair çözümler, hastalıklardan korunma yöntemleri, kendi kendinin doktoru olma becerileri, şifalı bitki kürleri, sağlıklı yiyecekler, uzun yaşama sırları gibi yaşlandırmayan öldürmeyen yaşam tarzı seçeneklerinin sunulduğu birçok içeriğin yer aldığının altını çizer.

Sağlığın bireyselleşmesi boyutunda verileri analiz ettiğimizde şu sonuçlara ulaşırız: analiz edilen sağlık programlarında izleyecilere sıklıla kendi kendilerinin doktoru olmaları gerektiği söylenmektedir. Ayrıca izleyiciler kendi bedenleri sürekli gözlemlemeleri, semptomların farkında olmaları konusunda risk ve korku söylemiyle uyarılmaktadırlar. Baş ağrısı büyük hastalıkların habercisi olabilir, idarınızın rengini kontrol edin, vücudunuzdaki benleri gözlemleyin gibi söylemlerle izleyiciler sürekli uyarılmaktadır. Yine bu programlardaki risk ve korku söylemi kadınların anne olarak sürekli çocuklarının bedenlerini gözlemleyip riskleri farkında olmaları gerektiği söylenerek tekrarlanmaktadır.

Alan çalışmasının ikinci aşamasında, özne perspektfinden sağlığın neoliberal yönetimselliğini anlamak için, Ankara'da yaşayan kadınlara sağlık algıları, sağlık davranışları ve sağlık bilgi kaynakları gibi konularda derinlemesine mülakat yapıldı. Bu aşamada da kadınların sağlığı kavramsallaştırmaları ve deneyimlerinde sağlığın neoliberal yönetimselliğinin izleri aranmıştır. Ankara şehir merkezine yaşayan 27

kadına kartopu örneklem yöntemiyle ulaşılmıştır. Yapılan derinlemesine mülakatın verileri ilk aşamada olduğu gibi sağlığın neoliberal yönetimselliğinin üç boyutu üzerinden analiz edilmiştir.

Derinlemesine mülakatlarda sorulan soruların ana kategorileri şu şekilde sıralanabilir: Sosyo-demografik özellikler, sosyal güvenlik durumu, sağlık ve hastalık tanımı, sağlık durumu, sağlık davranışı, hastalık nedeni, tıpla kurulan ilişki, sağlık bilgi kaynağı, sağlık risk algısı ve sorumluluk, medikalleşme.İlk olarak medikalleşme stratejisi ile analiz ettiğimizde şu bulgulara ulaştık:

Görüşme yapılan kadınların doğum ve menapoz evrelerini tıbbi bir süreç olarak görmelerinde yaşları önemli bir etkendir. Çünkü kırk yaşın altındaki kadınlar bu biyolojik evreleri deneyimlerken tıbbı yardım almaları gerektğini düşünürken kırk yaşın üzerindeki kadınlar bu süreçlerde tıbbı yardım alma gereksinimi fazla duymamaktadırlar.

Görüşme yapılan kadınların çoğunda ilaca kullanımına karşı mesafe gözlemlenmiştir. Kadınlar ilaç kullanmak yerine evde kendi yaptıkları karışımlarla iyileşmeyi tercih etmektedirler. Bu kadınlar arasında yaygın bir inanış ilaçların bir yeri iyileştirirken vücutlarının başka yerlerini hasta ettiğidir. Bu noktada kadınlar kendi kendileri iyileşmek için yine aktif tüketici olmaktadır. Kadınların bir kısmı doktor dışında bazı uzmanlara danışıp tıbbı bilgi aldıklarını belirtmiştir, bu uzmanlar neoliberal yönetimselliğin bir stratejisi olarak kadınların hayatlarına adeta sızmıştır.

Görüşme yapılan kadınların birçoğu beslenme seçimleri ile sağlık arasında güçlü bir bağ olduğuna inanmaktadır. Bu kadınlara göre sağlıklı olmak, sağlığı korumak için yapılan en temel sağlık davranışı “sağlıklı” gıda tüketimidir. Bu durumda bize kadınların gündelik hayatlarının gıda tüketimi üzerinden tıbbın alanına girerek medikalleştiğini gösterir.

Metalaşma kategorisinden görüşmecilerin cevaplarını analiz edersek şu sonuçlara ulaşırız:

Görüşmecilerin çoğu daha iyi bir hizmet almak için özel hastaneyi tercih ettiklerini belirtmiştir. Bunu birçok seçenek içinden kendi için en iyisini seçtiği inancıyla seçim özgürlüğü olarak tanımlamaktadır. Bu noktada neoliberal yönetimsellikle ortaya çıkan yeni özgürlük tanımları akla gelmektedir.

Yine görüşmeciler birçok hastalıkla önce kendi kendilerini iyileştirmeyi tercih ettiklerini belirtmişlerdir. Bu durum onları neoliberal yönetimsellik ağında birer sağlık tüketicisi haline getirmektedir. Daha önce belirtildiği gibi görüşmeciler ilaç kullanmayarak doğal yöntemlerle iyileşmeyi tercih etmektedir. Bu tercih de onları yine sağlık için tüketmeye yönlendirmektedir. Tüm bunlar bize sağlığın metalaştığını açıkça kanıtlar.

Sağlığın bireyselleşmesi kategorisinden görüşemelerden elde edilen analizlere baktığımızda ise şu sonuçlara ulaşılmıştır:

Öncelikle görüşmeciler tıbbı bilgi edinmekte kendileri sorumlu görmektedireler. Görüşmecilerin çoğu sağlık bilgisi edinmek için internetten araştırma yapmakta, televizyon programlarını izlemekte ya da sosyal medyadan belirli doktorların hesaplarını takip etmektedir. Görüşmecilerin çoğu sağlığı bireyin sorumluğuğu olarak gördüklerini belirtmiştir. Görüşmeciler kendileri bekleyen sağlık risklerini bildiklerini ve bu riskleri yönetmek için bazı girişimlerde bulunduklarını belirtmişlerdir. Bu cevaplar bize, sağık risklerinin bireyselleştirildiğini ve bu riskleri yönetme konusunda bireylerin sorumluluğu üstlendiklerini ortaya koyar.

Yine sağlığın bireyselleşmesi kategorisinde görüşmecilerin sağlıkla kurdukları bağ bağlamında değerlendirme yaptığımızda şu sonuçlara ulaşırız:

Görüşmecilerin çoğu sorulara cevap verirken birey olarak değil sosyal rolleri üzerinden ailenin bir üyesi olarak cevap vermiştir. Örneğin görüşmeciler ailelerindeki bireylere yardımcı olmak için sağlıklı olmaları gerektiğini vurgulamışlardır. Yine bir başka sonuç ise görüşmecilerinin bir kısmı kronik hastalıkları olduğu halde iyi ve sağlıklı olduklarını söylemiştir. Bu veri bize kadınların hastalığı bir kırılganlık olarak

gördüğünü ve hastayım demekten çekindiklerini anlatır. Yine kadınların bir çoğuna göre ailelerindeki bazı kadınlar hasta olmadıkları halde dikkat çekmek için hastayım demektedir. Görüşmecilere göre bu kadınlar hastalık hastasıdır. Bu verilerden yola çıkarak, kadınların hastalığı aile içinde bir iletişim stratejisi olarak kullandığını söyleyebiliriz. Sağlık görüşmeciler için bireysel bir olgudan çok sosyal olarak kurgulanan bir kavramdır.

Sonuç olarak diyebiliriz ki hem sağlık programlarındaki söylemler hem kadınların kendi cevapları bize sağlıklı kadın öznesinin neoliberal yönetimsel stratejiler olan medikalleşme, sağlığın metalaşması ve sağlığın bireyselleşmesi ile kurulmaktadır. Bu çalışma ile Türkiye'de sağlığın neoliberal yönetimselliğinin resmini çizilmiştir. Sağlıklı kadın öznesinin kurulumu sürecinde neoliberal yönetimselliğin aile kurumuyla kurduğu ortaklık bu çalışmanın en önemli buğularından biridir. Bu durumu Wendy Brown'un argümanıyla açıkayabiliriz. Brown'a göre çocuk, yaşlı, engelli, hasta bakımını üstlenen kadınlar neoliberalizmin işlemesine görünmeyen bir katkıda bulunur. Kadınlar bu bakım işlerini zorlama ile değil biyolojik farklılıklarından doğan bir durum olduğunu düşünerek bu durumu kabullenmektedirler. Neoliberalizmle ortaya çıkan, kamusal hizmetlerin özelleştirilmesi ya da tamamen ortadan kalması durumu kadınları aile içindeki diğer bireylerin bakımından da sorumlu olmalarına yol açmıştır. Bu nedenle ailecilik neoliberalizmin "teasdüfü bir özelliği değil esaslı bir gereğidir" (Brown, 2015, p.124)

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YAZARIN / AUTHOR

Soyadı / Surname : Bilge Ülker
Adı / Name : Deniz
Bölümü / Department : Sosyoloji

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