PUBLIC-PRIVATE PARTNERSHIP IN TURKISH HEALTHCARE PROVISION: THE CITY HOSPITAL MODEL

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PUBLIC-PRIVATE PARTNERSHIP IN TURKISH HEALTHCARE PROVISION: THE CITY HOSPITAL MODEL

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DECLARATION OF ORIGINALITY

I, Çağla Gün, certify that

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ABSTRACT

Public-Private Partnership in Turkish Healthcare Provision:

The City Hospital Model

The city hospital program has been the latest example of the public-private partnership (PPP) paradigm in the Turkish healthcare system, which has transformed the role the public sector plays in public service provision. This thesis examines the city hospital model as a case study of PPP that has emerged out of a process of policy transfer and an interplay of public and private actors within policy transfer networks. In this regard, this thesis explores the policy networks, motivations of actors to involve in these networks, political dynamics behind the introduction of PPP in healthcare provision in Turkey, and the perceptions, contributions and resistances of different actors about this introduction. This thesis relies on participant observation and a comprehensive review of legal and policy documents. The analysis has unveiled four key findings. First, the model emerged out of the government's relationing to epistemic communities and is an example of policy transfer in which the state was voluntarily involved and appreciated contributions of private actors. Second, the model was implemented in a top-down, undemocratic manner, with critical details of projects not disclosed to the public. Third, the lack of expertise of the public sector created information and power asymmetries, which resulted in pushing the public sector into a passive role and the empowerment of private actors. Fourth, rapid implementation of the PPP model in healthcare without ample planning is in line with the appreciation of health care as a short-termist economic growth strategy that is capable of yielding popular support and legitimacy.

ÖZET

Türkiye'de Sağlık Hizmetleri Sunumunda Kamu-Özel Ortaklığı: Şehir Hastanesi Modeli

Şehir hastanesi programı, kamu sektörünün kamu hizmetleri sunumundaki rolünde dönüşüme yol açan kamu-özel ortaklığı (KÖO) modelinin Türkiye sağlık sistemindeki en güncel uygulamasıdır. Bu tez, politika transfer süreci ve kamu ile özel aktörlerin politika transfer ağlarındaki etkileşimi sonucu ortaya çıkan şehir hastanesi modelini, KÖO'nun bir örnek vakası olarak incelemektedir. Bu bağlamda bu tez, politika ağlarını, aktörlerin bu ağlara dahil olmaktaki motivasyonlarını, Türkiye'deki sağlık hizmetleri sunumunda KÖO modelinin ortaya çıkışının arkasındaki siyasi dinamikleri ve çeşitli aktörlerin sağlık hizmetleri sunumunda KÖO modelinin uygulanmasına yönelik algı, katkı ve dirençlerini incelemektedir. Tezin temelinde katılımcı gözlem ile birlikte mevzuat ve politika belgelerinin kapsamlı incelemesi yer almaktadır. Bu analiz dört sonuç ortaya çıkarmıştır. İlk olarak, devletin gönüllü olarak katıldığı ve özel aktörlerin katkılarını desteklediği bir politika transferi örneği olan şehir hastanesi modeli, hükümetin epistemik topluluklarla ilişkilenmesi sonucunda ortaya çıkmıştır. İkinci olarak, bu model tepeden inme ve demokratik olmayan bir şekilde uygulanmış ve projelerin mühim detayları kamuya açıklanmamıştır. Üçüncü olarak, kamu sektörünün uzmanlık eksikliği bilgi ve güç asimetrileri yaratmış, bunun sonucu olarak kamu sektörü edilgen bir role itilmiş ve özel aktörler güçlü bir konum edinmiştir. Son olarak, KÖO modelinin hızlı bir şekilde, yeterli plan yapılmadan uygulanması, sağlık hizmetlerinin halk desteği ve meşruiyet yaratma potansiyeli ile birlikte kısa vadeci bir ekonomik kalkınma stratejisi olarak ön plana çıkarılmasıyla uyumlu bir şekilde gerçekleşmiştir.

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TO MY BELOVED GRANDMOTHER

SABİHA GÜN

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ABBREVIATIONS

BLT	Build-lease-transfer
DFID	Department for International Development
DHI	DH International
EBRD	European Bank for Reconstruction and Development
EPEC	European PPP Expertise Center
EU	European Union
Eurodad	European Network on Debt and Development
FDI	Foreign direct investment
FYDP	Five-year development plan (*Beş yıllık kalkınma planı*)
GATS	General Agreement on Trade in Services
GHI	General health insurance (*Genel sağlık sigortası*)
HTP	Health Transformation Program (*Sağlıkta Dönüşüm Programı*)
IAOs	International aid granting organizations
IBRD	International Bank for Reconstruction and Development
IFC	International Finance Corporation
IMF	International Monetary Fund
ISI	Import substitution industrialization
JDP	Justice and Development Party (*Adalet ve Kalkınma Partisi*)
KWS	Keynesian welfare state
MIGA	Multilateral Investment Guarantee Agency
MoH	Ministry of Health of Turkey (*Türkiye Cumhuriyeti Sağlık Bakanlığı*)
NAFTA	North American Free Trade Agreement
NHS	National Health Service of the UK

NPM	New Public Management
OECD	Organization for Economic Cooperation and Development
OHSAD	Association of Private Hospitals and Health Institutions (*Özel Hastaneler ve Sağlık Kuruluşları Derneği*)
PFI	Public Finance Initiative
PPP	Public-private partnership
SAYED	Association for Healthcare Management and Training (*Sağlık Yönetimi ve Eğitimi Derneği*)
SPV	Special purpose vehicle (*özel amaçlı şirket*)
SII	Social Insurance Institution (*Sosyal Sigortalar Kurumu*)
SSI	Social Security Institution (*Sosyal Güvenlik Kurumu*)
TMA	Turkish Medical Association (*Türk Tabipleri Birliği*)
TOBB	Union of Chambers and Commodity Exchanges of Turkey (*Türkiye Odalar ve Borsalar Birliği*)
TOR	Transfer of operating rights
TRH	Training and research hospital (*Eğitim ve araştırma hastanesi*)
TRIPS	The Agreement on Trade-Related Aspects of Intellectual Property Rights
TÜSİAD	Turkish Industry and Business Association (*Türkiye Sanayici ve İş İnsanları Derneği*)
UK	United Kingdom
UN	United Nations
US	United States (of America)
USD	United States dollar
VAT	Value-added tax

WB	World Bank
WHO	World Health Organization
WTO	World Trade Organization

CHAPTER 1

INTRODUCTION

This thesis examines a case of policy transfer process: the PPP model implemented in healthcare in Turkey, called 'city hospitals' (*şehir hastaneleri*). In doing this, the city hospital program is placed within the historical framework of transformation in healthcare policy together with the intensification of neoliberal economic practices, in which policy transfer also plays a major role.

Commercialization, marketization and policy transfer are concepts that have been prevalent in the Turkish healthcare context especially since the 1980s. With the 1982 Constitution and 1987 Basic Law on Healthcare Services, the main ideas of the Health Transformation Program of 2000s were officially brought to the Turkish political arena. These emerged in line with the country's adoption of neoliberal economic policies and its turbulent economic situation. Loan agreements with the World Bank and the IMF and working closely with international organizations and consultancy firms in the late 1980s and 1990s served as main media of policy transfer that supported the trends of commercialization and marketization in healthcare.

In the light of these developments, the Turkish healthcare system arrived the new millennium with several problems. First, inefficient compensation scheme of doctors and the resultant prevalence of dual practice –the practice of doctors employed at public hospitals to work part time at either private hospitals or their own clinics-, resulted in high levels of out-of-pocket payments. Second, fragmented healthcare financing system based on occupational status created inequalities in access and service quality. Other problems include unequal regional distribution of

healthcare facilities and human workforce, inadequacies in emergency service organization, insufficient levels of primary and preventive services and programs, increasing levels of drug prices without necessary state supervision, problems in terms of placement policies and motivation of healthcare personnel, and lack of institutionalized patients' rights. Coupled with the financial crisis in 2001 having elevated the issues of access of the poorer segments of the population, these problems placed healthcare policy at the center of public discussions and party platforms especially of the JDP, which contributed to its electoral victory.

The JDP era of government started in 2002, which hosted intensification of neoliberal economic policies and development discourse fueled by a populist rhetoric. Recovering from the 2001 financial crisis, Turkey benefited from the global fiscal relaxation, and had a process of further integration to the global economy. The Health Transformation Program was born in this context. In 2003, the Health Transformation Program emerged as the realization of a high priority electoral promise of the new governing party. From financing to provision, it effectively restructured every aspect of healthcare policy. With the rise of the practice of outsourcing support services in public healthcare facilities, the extension of coverage of the GHI to include private healthcare facilities and the rising volume of private provision of healthcare, the HTP supported further private presence in the sector and thus paved the way for the introduction of city hospitals. The city hospital model, on the other hand, was linked to the high growth rates, ongoing boom in the construction sector, creation of new business elites, and strong ties of bureaucrats and politicians with the business and international organizations. While economic and financial determinants played an important role in the formation of the city hospital model from the government's point of view, the neoliberalization process

and the populist discourse, which had already been prevalent in the Turkish policymaking scene but gained momentum in the first years of the JDP era, were also strong determinants in this formation process.

The introduction of the model was thus a central part of the policy transfer process that reshaped healthcare in Turkey. With the input from epistemic communities, this model was designed based on the failed model of PFI hospitals of the UK that the UK itself promotes along with a number of international and private actors ranging from the World Bank and EBRD to McKinsey & Company and Deloitte. In this model, mega city hospitals are constructed by contractor companies with financing that they provide, which then they operate for 25-30 years. In return, the MoH pays rent and service fees to the contractor companies. The contractors as well as their financiers are also granted remarkable legal and financial concessions under the name of incentives. Currently, there are 21 city hospital projects across Turkey, with nine city hospitals having started operating.

My intention to write this thesis comes from such complex relations between the different actors that took part in the policy process leading to the implementation of city hospital model in Turkey. During the HTP, the healthcare sector underwent a major wave of transformation with commercialization and increased private activity. However, this did not take place in the form of direct privatization of healthcare, i.e. transfer of ownership of public healthcare facilities. Instead, a complex form of relation was formed between the public and the private actors, which served as the basis for the healthcare transformation in the last decade. When for-profit providers have started to play a larger role in the provision of health services, one has to understand both global and national level political developments and their complex interactions that pave the way for such “processes of reform that alter the balance

between direct state provision, subsidy, regulation in the health sector of different countries, and the ways in which these interact with international processes" (Holden, 2005b, p. 217).

Coming from this background, this thesis employs this theoretical framework of policy transfer network in order the find out the emerging patterns involved in the relations within the public-private partnerships in the health sector and the emergence of particular kind of agency among the key actors, which in turn shape the consequences of policymaking process. In this regard, I will scrutinize the context within which the PPP has been elevated to the agenda of Turkish health policymakers and through what political processes it is transferred and implemented into the Turkish health political context. Not merely elaborating on the contractual PPPs in Turkish large-scale hospital modernization process, I will trace the roots of the emerging links between the private and public sector in the healthcare provision in order to lay the basis for the implementation of 'the PPP city hospital project' that have arrived in the Turkish scene very recently with much fanfare. The research explores the following questions: 1) Through what kind of policy networks and with what motivations have the actors been involved in this network of transfer of the PPP paradigm to Turkish health care provision? 2) What are the political dynamics behind the introduction of public-private partnerships in health care provision in Turkey, and how do different actors perceive, contribute or resist the introduction of public-private partnerships in health care provision?

The thesis draws mainly on Evans and Davies' (1999) comprehensive research framework of 'policy transfer network' along with Stone's (2004) threefold actor analysis within these networks, which are states, international institutions and

non-state actors. Combination of these two frameworks allows for a structural approach to the case of PPP model in general and the city hospitals in particular.

I carried out a case study research that draws on collection of gray literature and documents, as well as participant observation. More precisely, first of all, I made use of a wide variety of primary and secondary resources, as well as my observations from the sectoral events that I participated. First, I analyzed official documents, online documents, media reflections and public statements. In this regard, I made use of reports, statements and figures of Turkish MoH, Investment Office and Presidency of Strategy and Budget, parliamentary discussions, tender notices. I also referred to the reports and statements of consulting firms such as PwC and Deloitte, international organizations such as the EBRD and the IFC, websites of contractors, and declarations and reports of TMA and OHSAD. These were supported by the media reflections of sectoral events, speeches of politicians and bureaucrats and pieces of investigative journalism. While I am lucky to have utilized such a large volume of resources, the absence of a consolidated official database and the non-disclosure of important project and tender details that are deemed as 'trade secrets' required significant effort for data collection and accuracy controls. On the other hand, the issue of non-disclosure of details and categorization of them as 'trade secrets' provided a significant input to my arguments.

In an effort to supplement the above-stated sources, I participated in three sectoral events thanks to the connections offered by the company my father works for, which provided me with first-hand observations about the policy transfer process. More specifically, these events displayed the policy transfer discussions prevalent in Turkish health policy, which is my main area of research in this thesis. These events, sponsored by the company my father works for, were designed for

businesses, helping (potential) investors meet bureaucrats and politicians. These events were closed to the public, including the press and stakeholders such as the TMA. Thus, since the details of discussion in such events are not made extensively available to the public, I had the chance to gain a vital insight that helped me complete my research.

The first event I participated in was the sectoral meeting titled "National Health Programs" that was organized by Acıbadem University's Health Policies Center on March 31, 2017 in Istanbul. High-level representatives from MoH, Istanbul Medipol University, the Public Health Institution of Turkey, Novartis and Deloitte Belgium participated in this event.

On April 2, 2017, I participated in another event. This event was a symposium titled 'City Hospitals, Medical Tourism and Public-Private Partnership'. It was co-organized by the SAYED and the Public-Private Partnership Association as part of an annual medical fair titled Expomed in Istanbul. The panelists included high-level representatives from MoH, financiers, international organizations -i.e. EBRD, IFC, Islamic Development Bank-, management consulting firms such as McKinsey & Company and Deloitte, contractors, technology sub-contractors, as well as foreign government representatives.

Lastly, I participated in the 6th PPP Forum of Turkey on November 29 and 30, 2017. This forum was organized in Ankara by a UK-based event agency named EEL Events that organized forums that brought together representatives from governments, private sector and the academia for networking and exchange of ideas (EEL Events, n.d.) . The body of participants comprised the following: high-level representatives from the Ministry of Development, the EBRD's Turkey Office, financing partners of PPP projects such as Garanti Bank, Isbank, QNB Finansbank,

Siemens Bank GmbH, Sumitomo Mitsui Banking Corporation and Export Development Canada, contractor companies such as CCN Holding, YDA, Ronesans Holding and Gama Holding, law firms such as Erdem & Erdem, and other stakeholders such as Beckman Coulter and ValueHealth.

After collecting data from the sources stated above, I conducted documentary analysis and review of legal documents in order to reach meaningful results and answer my research questions. These analyses show that the case of healthcare policy in general, and the case of Turkish city hospitals in particular, provide vital insights about the processes of policy transfer in public policymaking. Turkish city hospital program is very recent with its first inception in 2013 and the opening of the first city hospital in 2017. Therefore, not enough data is available for considering the long-term impact of this program to the state of public health and public expenditures for health care in Turkey. However, the process of fast adoption and embodiment of the idea of implementing the PPP model in public healthcare provision carries a significant potential in terms of analyzing the process itself. This thesis will contribute to the literature on the PPP and its implementation in healthcare particularly in Turkey by implementing the policy network approach to the case. With this start, I believe this thesis will help this recently emerging area receive further scholarly attention.

The rest of the thesis is structured as follows. Chapter 2 presents the review of the literature on commercialization in healthcare and increase in private activity in this sector, with an emphasis on the NPM paradigm. NPM paradigm and its implications are relevant to my research questions as its integration into the context of public policymaking in Turkey set the frame for the introduction of the PPP model in healthcare. In this regard, commercialization and increased private activity, as well

as the contributions of the epistemic communities, served as the initial events of public-private relations that helped the government easily integrate into partnering with private actors in healthcare projects and engaging in policy transfer.

Building on the discussion in Chapter 2, Chapter 3 firstly sets the general framework of the PPP and its implementation in healthcare, and then presents the policy transfer approach. This chapter serves as the conceptual basis of this thesis. It first conceptualizes the PPP, presents its general framework and provides insight about Turkey's experience with the PPP model. Second, it offers an overview of the literature around the power distribution within PPP contracts, with reference to the asymmetric distribution of power between the state and other actors. Then, it presents the specific framework of the PPP model in healthcare, in relation to a discussion around its link to commercialization and privatization. Lastly, it discusses the politics of healthcare with regard to the implementation of the PPP model in healthcare, differential positioning and power distribution between involved actors, and framework of policy transfer.

Chapter 4 covers the story of commercialization and increased private activity in the Turkish healthcare system with an emphasis on the Health Transformation Program. In this chapter, the conditions, discussions and factors that paved the way for the HTP are discussed in relation to the processes of commercialization, increased private activity in healthcare and the adoption of the NPM paradigm. This is followed by the discussion on the policymaking process with an emphasis on the actors involved and the policy transfer process. As explained below, commercialization, increased private activity and the integration of NPM paradigm into the context of public policymaking allowed for easier implementation of the PPP model. Here, the HTP's linkage to commercialization and NPM paradigm and its

realization of processes of policy transfer helped the emergence of the city hospital program in collaboration with private actors and epistemic communities.

In Chapter 5, the Turkish program of PPP in healthcare -the city hospital program- is discussed firstly with its structure and the details of the ongoing projects. Then, the policymaking process before the program was introduced and during its implementation is discussed again with an emphasis on the actors involved and the policy transfer process. This chapter presents my findings that respond to the research questions of this thesis in a detailed manner.

Lastly, Chapter 6 is the conclusion of this thesis, offering a structured review of the story of transformation in Turkish healthcare and city hospital program in particular in line with the research questions of this thesis. Starting from the general overview of healthcare policy and provision in Turkey together with the actors and changing structure, this chapter situates the frameworks of PPP and policy transfer to the evolving structure of Turkish healthcare system. After this review, this chapter ends the thesis with possible areas of research that would build on this thesis.

CHAPTER 2

COMMERCIALIZATION AND NPM IN HEALTHCARE

The PPP model, and the Turkish city hospital model in particular, has emerged out of the historical transformation of public service provision. Commercialization and privatization on one hand, and internationalization on the other hand, were key elements of this change. Established in the aftermath of the World War II, the Keynesian welfare state paradigm lost its appeal and the mentioned key elements prevailed, out of which the NPM paradigm emanated. This chapter examines these key elements and the NPM paradigm in the area of healthcare in an effort to establish the historical development of the PPP model in healthcare.

2.1 Commercialization of healthcare in relation to changing welfare regimes

Since the 1980s, profound restructuring processes in the welfare systems of both industrialized and industrializing countries have been undergoing. Starting from the early 1970s, the global economy has witnessed large-scale economic crisis that led into rapidly increasing inflation rates, public sector budget deficits and increased unemployment rates across the world. The breakdown of the Bretton Woods system, which coincided with the hit of two oil crises and the concomitant tentativeness of the currencies, enormously affected the functioning of global economic system (Scharpf & Schmidt, 2000).

From this time onwards, the KWS paradigm and its foundations that were structured during the post-World War II period were said to be ‘in crisis’ by many politicians as well as academics. In that environment, the premise that greater state responsibility is needed for the economic and social prosperity came under scrutiny

and thus the market, not the state, came forward as an enabler of industrial development and employment creator (Gough, 1987). Corruption and inefficient bureaucracy of state intervention in the economy have been identified as the main reasons of underdevelopment of countries, rather than the lack of infrastructure, value-added investments and money.

The KWS was a regime of social, economic and political institutions supporting a Fordist-type of capital accumulation with mass consumption and production through various mechanisms including demand-management, public ownership of many enterprises and high expenditure on social services (Gough, 1987). An economic downturn in the late 1970s capitalism, coupled with the newly established regressive taxation policies, rendered a great difficulty in sustaining these premises of KWS institutions of high rates of growth, productivity, full employment and high wages. In this increasingly globalizing world, national development has begun to be associated with the international trade and FDIs, rather than the domestic internal consumption with the increased welfare. Therefore, as opposed to the state, the market has been given prominence to enhance the economic development, which in turn was believed to fuel the well-being of the societies with the growing need for employment. In this context, many scholars have discussed the impact of changing mode of production and globalization on the welfare state institutions of nation states (Moran, 1988; Esping-Andersen, 1996; Offe, 1984).

Although the general trends impinging upon the healthcare services of countries will be discussed in the following parts, it is necessary to mention that all public services including healthcare, education, water, and housing are affected highly by this changing mode of production, the (side) effects of globalization and

prominence of privatization and increased private involvement in public service provision.

Touching upon the fundamental points of changes in the global economic system of the post-1980s, this was the context within which welfare state institutions were brought forward as policy areas that promptly necessitated a large-scale reform agenda. Starting from the 1980s with the coming of conservative right-wing governments across the world, we have witnessed the end of 'national-developmentalist' model (Jessop, 1999). Following that, market enablement through privatization, trade-liberalization, and the deregulation of labor markets has become a norm. Increasingly deregulated capital flows and globalization of production gave rise to novel regime of flexible post-Fordist mode of production (Jessop, 1999). Here, it is worth directly quoting Moran's (2000) words as he aptly explained the 'crisis of welfare states' in such an environment:

> The economic world to which the welfare statecraft of the golden age was addressed has been irretrievably altered by changes in forms of economic production and exchange: the end of Bretton Woods system; the creation of globally organized markets trading a wide range of financial instruments; *and the rising significance of the transnational corporation as an agent of global integration in the creation, production and marketing of goods and services* [emphasis added]. (p.137)

Subsequent to these developments and profound neoliberal restructuring processes across the world; social, political and institutional support mechanisms of KWSs have come under scrutiny and still seem to remain as such.

In line with the aforementioned developments, debates that recognized many welfare state institutions such as healthcare and pension systems as major consumers of public budget became widespread throughout the world (Moran, 2000). What is important in that environment is that the proposed reform agenda, that was seen to cure the crises of the welfare state and would eventually cut down the rapidly rising

public spending, have reflected the profit-driven interests of the market ideology (Gonzales-Block, 1997). The rhetoric of market integration and liberalization and recourse to more FDI of the global capital have become the main elements of the solution to these fiscal crises of public services in the nation states (Gonzales-Block, 1997).

The welfare state institutions of Keynesian paradigm, crucial for establishing the "favorable conditions for the Fordist-capital accumulation [sic]" and "ensuring popular legitimation for the capitalist system" (O'Connor & Robinson, 2008) was started to be seen as inefficient and unproductive. The social, political and economic institutions sustaining the Keynesian economic order were rhetorically rendered as inefficient, requiring a novel reform agenda in which market efficiency arose as a main component.

In addition to predominance of this paradigm of market efficiency, rising longevity, ageing population leading to an increased volume of dependent population, rapidly increasing population and transformed labor market through the growing informality and atypical flexible jobs were indicated as the prevalent factors necessitating the large-scale reconfiguration of the social policy institutions (Moran, 2000, p. 139).

In this novel economic and social context, governments pursued a policy of not increasing public spending for gradually rising costs of healthcare services and medical technology and thus initiated the process of cost-containment and investigated the ways of more efficient resource allocation. Moran (2000) succinctly described the particular relevance of this trend for healthcare as follows: "No policy area has been more dominated by the search for cost containment since the end of the long boom" (p. 156).

Yet, before providing a more detailed explanation of the effects of these above-mentioned general trends of welfare state restructuring process on the healthcare reforms, I will mention the distinctive characteristics of healthcare systems to better explain how healthcare services have turned to be marketable commodities and how the market has been created within the healthcare provision of countries. In this regard, we need to look at the institutionalization of healthcare in order to understand this change, as institutional shifts are at the center of this restructuring.

The literature on the institutionalization of healthcare and the development of public health measures has been well established. The reasons that pave the way for the systematic state intervention in the health and wellbeing of the societies are threefold in the literature.

First, an influential public health scholar Rosen (2015), realizing the interdependency between the poverty, social distress and health problems, posited that the coming of industrialism in the early nineteenth century had been preceding the stimuli of the low health outcomes, widespread epidemics and increasing mortality rates on a vast scale all over Europe. Rapid industrialization accompanied with the inadequate housing, poor working conditions, weak infrastructure and nutrition conditions on the urban place rendered the governmental action and the institutionalization of the healthcare, which was hitherto the concern of the individuals and traditional informal systems of agrarian life.

Scholars with another line of thinking assert that the concern for the health of the people among the ruling elite is associated with the concern for the well-being of working classes. According to this approach, healthcare along with the other welfare state mechanisms emerge to ensure wellbeing of laborers as they perform the

capitalist production and vast consumption. This so-called ‘social reproduction thesis’ argued that the drive for accumulation is sustained through the reproduction of labor in the institutions of schools, households, hospitals and prisons and states need to/have to provide these public services in order to enable capital accumulation (Navarro, 1976).

The third school of thought proposes that the political reaction and demand of the organized labor and left-wing parties sparked off the need for the systematic state intervention in the health of societies. Towards the end of the nineteenth century, the rising power of the socialist parties in many industrialized as well as industrializing countries and the growing unionization rates among the working class brought forward the organized demand of the working class for the broader inclusion of the state in the provision and finance of heath care services (Leys, 2009).

Although these explanations in the literature diverge from each other in fundamental ways, all these three lines of argumentations reflect the characteristics and development of healthcare institutions as a vital element of social policy intervention in the wellbeing of citizens. Through achieving the public health goals in the society and preserving the wellbeing of its citizens or through sustaining a healthy labor force, all states at some point had to institutionalize healthcare services. Nevertheless, the process has changed shapes in different economic, social and political contexts and have been shaped by emerging different vested interests, in turn giving rise to distinctive models in the delivery, finance and regulation of healthcare services. In this regard, it should be depicted that the changing social and economic outlook paved the way to different institutional configurations of healthcare systems.

In this thesis, I will employ the OECD's healthcare system typology (1987) as it offered a comprehensive one that took into consideration all three pillars of health systems, namely the financing, provision and governance/regulation. This typology entitled by the OECD suggested three-fold health systems in different countries, namely the National Health Service model, social insurance model and private insurance model.

First is the National Health Service model where healthcare is delivered predominantly by the public authorities and the health personnel are generally public service employers. In such systems, all population is included within the universally covered public health schemes and health spending is financed through the general tax-funding. Healthcare systems of the UK and Sweden may be given prominent examples of such model. Another type includes the social insurance model of Germany and the Netherlands in which both employers and employees pay the premiums of social insurance packages. It is publicly dominated and generally free at the point of utilization, yet private provision may more easily operate compared to National Health systems, as the public funder (social security organization or central government) may purchase services from both private and public providers. The last typology presented by the OECD is the private insurance model in which citizens purchase services from the private providers in market, through either the direct service fees or the private insurance packages (OECD, 1987).

This typology offered by the OECD has proven to be influential in explaining the different roles of the state as well as the market in the healthcare services of countries. This typology is also illustrative for the purposes of this thesis in understanding the complex relations between the finance, provision and regulation in

paving the way for increased commercial private sector activities, and the structure of new relations between the public and private actors.

To demonstrate this complex constellation of public and private sectors in healthcare systems, the statistical comparisons of the healthcare spending of OECD countries is indicative. When the statistics is examined, we see that the public healthcare spending is predominant among the OECD countries with the 72.4 percent of public healthcare expenditure, while private spending is limited to 27.5 percent, constituted by 6.5 percent of private health insurance and 21 percent of out-of-pocket spending (OECD, 2018).

Therefore, the public healthcare financing is still dominant in the advanced capitalist countries, yet it needs to be stated that this statistical culmination does not reflect the diverse characteristics of contemporary healthcare systems of countries. This relative weight of the public and private in financing does not correspond to a similar balance between the public and private provision. While in the social health insurance systems such as the ones in France and Germany, the private provision has played a significant role, it is more marginal in the national health systems of UK and northern European countries. In the countries where the national health system has been established, the private sector inclusion into the healthcare provision has generally sparked off a political reaction in the civil society, as the public mostly perceive that it is the duty of the state to provide healthcare to its citizens (Holden, 2005a). In mostly these systems, commercialization such as the reform of the purchaser and provider split has been more commonly observed than the direct privatization to include the role of private sector in the service provision (Holden, 2005a). Canada may be given as another example of this observation as it has high

percentage of public financing, i.e. 70.3% public spending, while there are various kinds of provision including non-profit and for-profit hospitals (OECD, 2018).

On the other hand, given the diverse forms of interaction between the finance, provision and regulation of healthcare systems in different contexts, there needs to be further analysis of other distinctive components of the healthcare so as to explain the rationale behind contemporary healthcare reforms and how healthcare has turned into a novel destination for the global capital accumulation strategies.

Moran (2000) explained why healthcare programs constituted the major part of the welfare state structure but why it had distinctive features that should be analyzed separately from "the wider experience of welfare states" (p. 135). He criticized the existing typologies put forth by Esping-Andersen (1990) in the comparative social policy literature as they neglect the health policy dimension in explaining the evolution of welfare regimes. Emphasizing that the healthcare was the "biggest single consumers of resources in modern welfare states", he underlined that what was happening in the domain of health policy has strong repercussions in the structure of welfare state in general (Moran, 2000, p. 138). Therefore, he suggested that the changing healthcare policies also reflect the general trends of transformations in the welfare state institutions of countries. His explanation of governing the health systems was threefold: namely "governing consumption, governing provision and governing technology" (p. 138). Governing consumption and provision was associated with the aforementioned financing and provision of healthcare services. However, under the heading of governing technology, Moran identified the factors that made healthcare depart from the sole domain of social policy interventions: healthcare was not only a social policy, but it was also part of industrial policy. Identifying this characteristic of healthcare was crucial for

clarifying the prominent contradictions between the healthcare as an area of industrial development strategy of economic policies and the healthcare system as a major domain of social policy seeking to provide public health needs and universal health coverage.

To explain this contradiction between two characteristics of healthcare, Moran (2000) asserted that the production of medical technology was central to the provision of the health care and states especially in the golden age of healthcare spending had assumed a major role in the creation and maintenance of the sophisticated innovation of medical industries. Constituting one of the most growing areas of global market, production of medical equipment bore a vital importance in the economic development of states and had a determining effect on their comparative advantage in the international political economy (p. 140). However, Moran aptly recognized that technological medical innovation was both a source of weakness and a source of strength for the states. Boosting the cost of healthcare provision, medical technology was a major problem for the healthcare resource allocation and the inflated healthcare spending. On the other hand, as one of the substantial domains of industry sector, medical innovation might stimulate industrial development of countries which was desired by all countries seeking to enhance their comparative advantage in the global economic order.

This situation may elicit prominent contradictions for the states that aim to provide free healthcare for all, along with achieving the necessary public health goals, but also they had to limit the rising healthcare spending stemming from the high cost of medical technological innovation (Moran, 2000, p. 145). Considering also that the medical technology and pharmaceutical industry are largely produced and marketed by the private sector, large medical industry corporations increasingly

have a determining voice over the marketing and investment of healthcare services of governments. Thus, investors looking for the broader areas of investment have to establish an effective collaboration with the public health bureaucrats, social security bureaucrats or private insurance companies who mostly determine the route healthcare policies take. This contributed to the weakening capacity of governments in making healthcare policies as necessitated by public needs only.

Even if publicly owned facilities for healthcare provision is still the common practice, most governments have limited capacity in producing and marketing medical technology and pharmaceutical industry, thus need to purchase this essential equipment from the private sector. The US firms mostly control this sector as the production and consumption of devices tend to be driven by the US (Moran, 2000, p. 147). As Moran and Wood (1996) noted, health was a service

> whose delivery [was] only possible with the use of a complex and highly advanced technology. Much of the healthcare industry [was] concerned with the creation and marketing of that technology, and with the provision of a physical infrastructure allowing its delivery. Technological innovation ha[d] placed large parts of the industry in healthcare products at the forefront of modern industrial economies (p. 134).

In that regard, one should emphasize that Moran's (2000) conceptualization of "government of technology" is highly determined by the organization of government of consumption and production. To clarify, the relative weights of the private sector and the public sector in the provision and finance of healthcare services determine the power of "gatekeepers regulating the diffusion of technological innovations throughout the healthcare system" (p. 148). Strong presence of state in both areas provides a more effective capacity to states in constraining and regulating "the engine of the technological innovation" driven by the incentives of private sector in the market. Therefore, in this setting, the private

sector serves as the engine of medical advances, while the public sector guarantees equity in access to services.

Moran argued that the globally organized medical technology, which was mostly controlled by the large multinational corporations, continually tried to find or establish contexts of a suitable healthcare system for the capital accumulation, thus "widening the range and expense of medical care" (p. 158). In this regard, it is noteworthy that advancing medical technology triggers restructuring of healthcare provision according further to the needs of the technological developments than to the healthcare needs of the population. This is realized by the construction of new hospitals and dedication of rising amounts of investment to the purchase of high-technology medical devices. Therefore, effective regulatory capacity of states is indicative for the instrumental public healthcare measures for the general health quality of societies. The effects of contradiction between the economic and social policies of states in the area of healthcare services can only be tackled by an effective state regulation that takes into account the long-term prospects of countries.

Given this aspect of healthcare, this discussion on this industrial dimension of healthcare sector will be elucidative for us while clarifying the growing interest of market actors in the healthcare restructuring and policymaking processes. Given so far the distinctive features of healthcare services that encapsulate both social policy and economic development policies, from now on I will discuss the general characteristics of healthcare reform processes diffusing among both developed and developing countries, especially after the period of 'welfare state crises' explained in the first part.

The literature on the healthcare systems provides us with a set of factors and pressures paving the way for the diffusion of healthcare reform agendas all over the

world. While the first group of factors is associated with the rising demand for the healthcare services, growing healthcare utilization and consequent rise in healthcare spending, the second group is more about the structural problems arising from the global and regional economic changes discussed in the first section. Yet, I will later discuss that all these developments together are added up to the total increase in the healthcare market activity and in the emergence of new health-related sectors.

First, innovations in medical technology and huge developments in pharmaceutical interventions have become more effective in curing or controlling the symptoms of many different illnesses, which lead to more confidence in the mainstream allopathic medicine among the society (Moran, 2000, p. 136). Second, aging population who generally use health services more often compared to the younger population, coupled with the global population increase, has resulted in a higher total of number of persons demanding healthcare (Saltman, Figueras, & Sakellarides, 1998). Third, access to publicly funded healthcare has gradually become universal, thus leading to increasing number of people in the scope of the coverage and growing use of healthcare resources by the public. Fourth, the prevalence of chronic illnesses that are less treatable and necessitate more routine medical intervention has increased among people, mostly due to the ageing demographic structure (Freeman & Moran, 2000, p. 39). Lastly, more informed patients through the availability of digital communication tools and health-related information have demonstrated a greater demand for the health services (Twaddle, 1996).

Another group of factors is mostly associated with the structural economic changes that impinged upon the capacity of states to finance and provide healthcare services. First, rapidly globalizing world economic system has put pressures on the

ability of states to control and regulate public expenditures (Walt, 1994). Second, the transformation of labor market and the growth of informal working practices along with the regressive tax policies of neoliberal governments have rendered a substantial decrease in the capacity of states to collect taxes, leading to diminishing public revenues (Lloyd Sherlock, 2005). Third, rising bureaucratic complexity of the healthcare provision through the more specialized health personnel and fragmented healthcare system has complicated the delivery of healthcare services, together with the impact of already growing cost of services (Twaddle, 1996).

These factors related to changing demand structure and structural factors together made the healthcare systems uncontrollably costly, which sparked off the need for full-scale reform agendas to make them as more efficient, first for the advanced industrial world, at the same time diffusing to the developing world.

So far, I have discussed the 'welfare state crises' and distinctive characteristics of healthcare both as an institution of welfare state structure and as a subset of economic development policy of nations. In the subsequent part, the emphasis will be on the NPM paradigm, as it bears fundamental importance for two reasons. Focusing on the NPM is crucial in explaining how public services has responded the changing structure of the welfare state. Second, examining the NPM displays how political context and debates have drawn the boundaries of reform proposals for the healthcare services. What is important in these scholarly discussions over the characteristics of reform agendas is the notable dominance and popularity of the market ideology as a solution to growing healthcare expenditures, as Ağartan (2008) succinctly noted: "Market ideology has not only fundamentally shaped the way we analyze the current situation of the healthcare systems, but it has also set the boundaries for policy options" (p. 55).

2.2 Paving the way for marketization: NPM reforms in healthcare

In the mid-1980s, the world witnessed a radical transformation in both labor market structures and welfare state institutions. Deteriorating economic situation and large fiscal deficits have led to general austerity, cost-containment and in turn giving way to changing public service provision (Mossialos & Le Grand, 1999; Rick, 2014). Even though restructuring was not specific to the healthcare services, above-mentioned distinctive conditions of healthcare provision have elicited the novel developments in the healthcare delivery that needs to be analyzed specifically. Thus, first, I will elaborate on the general patterns of changing public service provision, and then the emphasis will be on the healthcare sector. After giving a brief review of literature, I will elaborate mostly on the specific healthcare reforms and their functions in paving the way for the processes of broader marketization and commercialization in the healthcare services.

The post-1980s witnessed the creation of a new model of public service delivery, manifested itself as 'New Public Management' reforms. Initiated as a part of neoliberal restructuring policies, these reforms have reflected some convergence tendencies among European countries with the involvement of the managerial techniques of private sector into the public service provision (Simonet, 2008, p. 619). The idea that bureaucratically organized top-down policies are essentially inefficient and unresponsive to the needs of the people is promoted by the pro-market governments of the decade. New types of managerial relations, efficiency-based quality tests and performance-related incentive generation were the main tools of the transformations within the public services.

The classical neoliberal paradigm of the post-1980s has dictated increased activity of the private sector as the basic premise of the reform proposals. This

dictation is different from direct privatization, which denotes transfer of ownership from the public sector to the private sector. A more appropriate concept would be commercialization, which includes restructuring of the service organization in which a state-owned public enterprise is turned to be an autonomous body competing in the marketplace (Starr, 1988). Corresponding to this understanding, Aldred (2008) clarified the logic behind the NPM by suggesting that: "Whether or not actual markets are created, and whether or not provision is shifted to a private-sector provider, goods, services, staff and service users are reconceptualized within a commodified discourse" (p. 35). Yet, it should be kept in mind that most scholars accept the commercialization process as an initial stage of privatization, which will be crucial point while analyzing the change in the provision of healthcare services, as emerging quasi-market relations and commercialization have substantially increased the influence of private sector in provision as well as financing of health services (Savas, 2000; Mackintosh & Koivusalo, 2005; Yılmaz, 2017c).

The most apparent form of these debates took place in the United Kingdom as soon as the pro-market government of Thatcher came to power. The increasing recourse to private sector, through the mechanisms like outsourcing, sub-contracting and public-private partnerships, has substantially changed "the traditional role of the state as a service provider and employer" (Grimshaw, Vincent, & Willmott, 2002, p. 475). The traditional state bureaucracy in the public service provision has begun to be questioned in terms of its efficiency, effectiveness and responsiveness (Le Grand, 1999). It was a general compromise that the public services have reached their limits and 'efficient' resource allocation could only be reached through an increasing reliance on market or quasi-market relationships. The idea that monopolistic public service provision has prevented the free choice of people, entailing an inefficient

consumption of resources and low quality outcomes, has rendered a commonsense of a need for the inclusion of market mechanisms into the publicly funded service provision (Rhodes, 1994).

In that regard, bringing the market incentives into traditional centrally organized public service provision is proclaimed as a response to the incapacity of states to provide the delivery of public services, and respond to public demands efficiently, while undertaking the financial burden of such services on the public balance sheet (Hood, 1995). Here, it is important to note that the increasing recourse to private sector does not lead to a full-fledged privatization of national health services due to institutionalized public dominance in healthcare provision and public demand of public provision of healthcare services. In this regard, Holden (2005b) highlighted the difference between suppliers and providers, where private activity in the former was common, while it was not as common in the latter. He linked this difference to the history of welfare state institutionalization, as historically many healthcare services were directly provided by the state and it was only recently that many countries had opened up the private provision on a larger scale. However, he noted that support services, medical equipment and pharmaceutical production tended to be fulfilled by the private sector much more previously than the involvement of the private sector in direct healthcare provision (p. 214).

These organizational reforms in the public management of the services have been identified as ‘New Public Management’ in the literature, key phrases of which are pointed out as “value for money” and “better use of resources”. The market ethos of “customer satisfaction” has begun to characterize the new public service provision (Rhodes, 1994, p. 144). Hood (1995), the inventor of the concept of ‘New Public

Management', analyzed this shift as a different kind of accountability within the public arena, as he noted:

> lessening or removing differences between the public and the private sector and shifting the emphasis from process accountability towards a greater element of accountability in terms of results. Accounting was to be a key element in this new conception of accountability, since it reflected high trust in the market and private business methods and low trust in public servants and professionals (now seen as budget-maximizing bureaucrats), whose activities therefore needed to be more closely costed, evaluated by accounting techniques. The ideas of NPM were couched in the language of economic rationalism. (p. 94)

In that specific point, the term "economic rationalism" requires a deeper analysis as it was the basic logic of the transformation within the public service provision. The basis of economic rationalism is indicated as "competitiveness" within the market place and it is justified by market rhetoric that efficient service provision can be attained only if there are competing autonomous providers within different public institutions, as well as between public and private institutions (Le Grand, 1999). More precisely, the main belief has become that competition will foster efficiency.

Additionally, the emphasis on the "institutional continuity" within the traditional public service finance is left aside in the search for "more rational use of resources", implying that states have begun to "prefer all-public, all-private or public–private partnership depending on which option cuts costs more significantly" (Kadirbeyoğlu & Sümer, 2012, p. 4). The idea was that the centrally organized and financed services would lead to unnecessary resource consumption, and autonomous public entities managing their own funds and staff would be much more efficient with regards to their budget control.

As elaborated above in detail, all these legitimation claims of the reform proposals in the public service management were based around the economistic

language and the rhetoric of best practice, full efficiency, value for money, innovation, and cost containment. As will be discussed later in the following parts, in the period of late capitalism, the claim to the information, knowledge and best practice has become the novel power of most of the international organizations, consultants, multinational corporations, think-thanks selling their 'experience' to the countries and influencing the transformation of the public services in a way that their profit-making interests will be materialized as well.

Here I will provide a detailed analysis of the NPM paradigm in the healthcare sector with a specific focus on the reforms that enhanced the marketization and commercialization process of healthcare services. The first step of the commercialization within the healthcare services is the development of quasi-market relations that involve the premises of NPM reforms (McKee, Edwards, & Atun, 2006). The market mentality of these reforms thoroughly transformed the "modes of regulation, structures of incentives and set goals for the health personnel" which then proliferated the inclusion of market actors in the health policymaking processes (Ağartan, 2008, p. 317). The NPM has introduced or strengthened the market incentives in the healthcare systems. The paradigm suggested two fundamental shifts in the traditional role government undertakes in provision of healthcare, on the one hand as a reduced position as the provider and a strengthened role as the regulator, and on the other hand as restructuring of public healthcare facilities with market practices including the introduction of autonomous public healthcare facilities. Pollock (2004) argued that this type of reorganization in the healthcare services and the penetration of market forces first appeared in British NHS in the mid-1980s and then spread throughout the Europe in the mid-1990s. In the beginning of 2000s,

nearly all European countries experienced similar commercialization processes in their healthcare services.

The main reforms that will be discussed here are the purchaser-provider split, the autonomization of hospitals, contracting out the hospital services and the introduction of pay for performance model for health personnel remuneration. I particularly bring forward these reform proposals due to the reason that they have transformed the core elements of healthcare provision and commercialized the healthcare provision, which then set the foundations of the PPP hospitals and further commercialization/privatization of healthcare provision in the Turkish case.

There are four proposals that the NPM paradigm promotes. These are purchaser-provider split, granting autonomy to public hospitals, the practice of contracting out hospital services, and the introduction of a pay-for-performance remuneration model. Given these proposals, the NPM transformed the role of government by placing the private sector as a significant provider of healthcare services, thus limiting the role of governments compared to all-public provision of healthcare. Therefore, the governments and international organizations frame NPM reforms in healthcare as a mechanism for generating value for money through lowering the costs and transferring the risk and accountability to the private sector that are framed to render the healthcare services more efficient. The reform agendas of healthcare service throughout the world dovetail many NPM prescriptions and presented as 'the best option' to save the healthcare services from the crisis traps they are agonizing, yet NPM has actually paved the way for the commercialization of healthcare services and increasing influence of private interests in the health service provision. Outsourcing has generated the suitable environment for the emergence of more commercialized interests in the public healthcare provision and increased

competition between the private and public providers has reorganized the public in the image of the market.

A first and perhaps foremost example of the NPM reform proposals for the healthcare services was the purchaser-provider split within the healthcare services, initiated with a purpose of dismantling the old bureaucratic, centrally organized healthcare provision. Paton (1999) identified that this strategy had turned to be the most widely used policy ideal in providing healthcare services through a more commercialized basis in the advanced countries as well as the developing ones.

With the introduction of the purchaser-provider split, “purchasers”, namely the funder of healthcare services, have turned to be autonomous entities and they are separated from “providers”. On the other hand, providers began to manage their own budgets, financing themselves through placing contacts with the purchasers. This split between purchasers and providers has generated suitable conditions for the competition between providers irrespective of their ownership types (Le Grand & Bartlett, 1993). Corresponding to the basic logic of NPM, it was proposed that this enhanced competition between providers would render a high-service quality as they would have to compete and attract the patients in a market-like place. Bailey and Davidson (1999) explained this dimension of the NPM reforms as follows: “Competition has become increasingly popular because it is seen as a fair way of securing best value for money spent. Competitive tendering for the health service delivery contracts has become an integral part of the purchaser-provider split which, in turn, is part of 'reinventing government' and of 'post welfarism” (p. 161).

One should again underline that this subsequent quasi-market, generated through the competition between the providers, was different from the purely marketized model due to two reasons. First, the model does not necessarily lead to a

diminished role of the state in financing services. Second, service users do not pay for the services offered at the point of the consumption, meaning that patients could still access the healthcare service without any further payments. That is why; Le Grand (2009) identified this market model as “managed market” rather than a free market.

In this managed market model, public and private providers have to compete for the patients in order to attract adequate number of “customers” to secure their financial sustainability. In every step of service provision, the imperative of cost containment and the necessary consideration of the price of the service offered by the purchaser has substantially altered the behavior of providers. Especially in the context of public-contract system of healthcare, in which the public insurer places contacts with for-profit private providers on a pre-payment basis, for-profit providers have begun to be assumed as an alternative for the public healthcare providers by the patients who are able to afford complementary payments (Schieber, 1987).

Nowadays, this strategy has proved to establish a suitable environment for the growth of for-profit providers. Lapsley (1994) described such contract-based internal market, as she suggested: “the rationale of the market is to force them to consider all of these alternatives to obtain the most cost-effective use of the resources at their disposal. The consequence of this is that efficient hospitals should gain, inefficient hospitals may lose contracts and decline or even cease to exist” (p. 20). As understood from this quotation, efficiency imperative has replaced the public health goals of providers and public hospitals have turned to be under huge pressure to sustain themselves financially. Therefore, the organization of hospitals has gradually been determined according to the market logic, rather than public health interests, based on the assumption that efficiency that market logic provides will result in

better public health outcomes. This emphasis on marketization at the expense of public health interests, and the aspect of competition in particular, should be considered together with the outcomes. In this regard, the unsuccessful outcomes this logic produces will be discussed in Chapter 3 and 5, with an emphasis on the global examples in the former and the Turkish case of city hospitals in the latter.

Another important point that I would like to stress here is that this increased competition between the providers for the patients as well as for the contracts with the purchasers, has ultimately changed the behavior of healthcare demand among the patients. In this intensely commercialized environment, patients turn to behave like a real-customer, consuming the healthcare services according to the luxury standards, comfort-related objectives and waiting lines, rather than considering the quality of healthcare service itself, which definitely give a comparative advantage to for-profit providers over the public ones (Lewis, Smith, & Harrison, 2009).

The second proposal of NPM reforms in healthcare is granting autonomy to public hospitals. With an intention to improve the efficiency of hospitals, many countries have embarked upon the process of hospital restructuring through giving more autonomy to the public hospitals. Hospitals managed directly by the health ministry, have been granted a self-management responsibility with the changes in their mechanism of financing methods in order to "help public hospitals officially acquire the necessary decision space in order to improve quality care, clinical outcomes, and patient responsiveness" (Durán & Saltman, 2015, p. 447). This apparently insignificant change in their financial management at first glance has in fact profoundly altered the "incentive environment in which they operate" (Hanson, Archard, & McPake, 2001, p. 747). Coupled with the purchaser-provider split, autonomous public hospitals are required to raise revenues through competing with

private or other public hospitals and through placing contracts with the purchasers of healthcare services or "in the form of user fees to supplement the reduced governments grants" (p. 747). To clarify, hospital revenue is mainly collected "on the cost of care achieved in the hospital deemed to be most efficient through the mechanisms of diagnostic related group points" (Holden, 2005a, p. 679). In order to secure financial sustainability, operational decision-making autonomy that public hospitals traditionally enjoy has been impaired. Consequently, the strategies of staff management, initiating and closing services, and budget issues have begun to be implemented with respect to their impact on the financial conditions of hospital (Durán & Saltman, 2015, p. 447). This emerging imperative of financial sustainability and increasing pressures on public hospitals has brought about dramatic impacts on the decisions about the purchase of equipment and drugs, as well as conducting clinical interventions. To be more precise, increasing financial stresses on the providers have altered the logic of healthcare provision, fostering the privatization of medical services according to the reimbursement strategies of the purchaser. Here, it should be noted that without the effective regulation from the central government, the excessive autonomy and decision-making independence from the central health authority might lead to divergence of hospitals from the central health policymaking strategies and the public health goals.

The autonomization of public hospitals was common in the NHS reforms of the UK in the early 1990s, then later arrived in the developing countries such as Indonesia, Zambia and Uganda through the policy advices of international organizations including the WHO and the World Bank. It was mainly believed that through increased competition for the patients and the introduction of fees, the demand and supply will be more efficiently balanced in the marketplace, meaning

that the reorganization of healthcare service provision based on the mainstream economic ideology of neoliberalism is furthered one more step (Hanson, Archard, & McPake, 2001, p. 747).

The NPM paradigm thirdly proposed the practice of contracting-out of several hospital services. Faced with the intensified financial difficulties and self-responsibility in the management of financing, hospitals have ended up with challenge of maintaining the healthcare quality. To tackle with this difficulty, they tend to prefer outsourcing strategy in the hospital management, which is justified by the NPM paradigm in generating value for money for the government healthcare spending. Outsourcing was defined by Moschuris and Kondylis (2006) as follows: "the process of contracting an outside company to provide a service previously performed by staff. In many cases, outsourcing involves a transfer of management responsibility for delivery of service and internal staffing patterns to an outside organization" (p. 4). Through this policy, business enterprises have increasingly begun to be the supplier to governments, beginning from the late 1980s. In this respect, outsourcing is not a novel strategy, yet its changing growth and the extent of its involvement in the public service provision needs further explanation.

Beginning from the late 1980s, outsourcing of public services was imposed to many countries by the World Bank and the IMF with the promise of cutting costs and improvements in provision (Whiteside, 2009). Public hospital services such radiology, ground maintenance, engineering, cleaning services and food services are considered suitable for contracting-out to the outside private company and they began to be provided by the private sector. Yet, such ancillary service provision is of vital importance with regards to the core clinical services provided in the hospital. For example, the quality of outsourced cleaning services in the hospital is crucial for

the health quality of patients. Given that the sanitary conditions in the hospital worsen due to the increasingly aggravating working conditions of outsourced cleaning staff, the healthcare provision would definitely suffer from such deterioration. Actually, the privatization of support services may not necessarily lead to worsening conditions if the state assumes a public responsibility in regulating and controlling the conditions of privatized medical services in the hospitals, which is another regulatory challenge for the state and the result of such reform may vary according to the regulatory attempts of the state. In this regard, Nunes, Cristina and Rego (2011) emphasized the importance of a direct and transparent regulatory control mechanisms to be placed by the state over healthcare activities with publicized performance indicators and decision-making processes, which were crucial and effective in providing assurances against market failures, making effective quality control possible, and ensuring fair competition (p. 352).

In this model, outsourced companies assume the responsibility of the service provision through offering the lowest cost in the competitive tendering process. However, the way they decrease the cost is problematic for the nature of service provision. They often enable such low costs through offering less payment to the staff or worsening their working conditions, especially for the low-skilled workers. For example, the quality of outsourced cleaning services in the hospital is fundamental for the core clinical service provision and thus health quality of patients and infection control (Whiteside, 2009, p. 94). If prioritized, public health interests would require governments set the necessary regulatory framework to counter this effect of cost saving (Nunes, Cristina, & Rego, 2011, p. 359). However, subordination of public health interests results in overlooking such issues, as will be discussed in subsequent chapters.

Overall, through this strategy of contracting-out, private sector has become responsible in providing non-clinical services such as cleaning, catering laundry and building maintenance or the clinical services such as radiology and laboratory services, while public sector is left only with the provision of core clinical services and staff and the management of hospital. Thus, contracting-out in turn rendered an environment in which private sector has gained a greater voice over the services provided and it is granted with more opportunity to operate within public sector hospitals.

Especially for the radiology and laboratory services, outsourcing of public hospital services have generated new areas for capital accumulation of the medical equipment industry, as they have consolidated their power in determining what equipment is necessary and what is not 'crucial' for the better healthcare provision. For ancillary services, through the increased recourse to the contracting-out in the public hospitals, multinational companies from various countries have considerably benefitted from the growing number of public-contracts they received in the public hospitals. On this point, Whiteside asserted that multinationals such as Aramak in the US, Compass in the UK and Sodexho in France have ensured their rising profits through creating oligopolies in the ancillary service provision (p. 94).

News appeared on the well-regarded webpage 'New Internationalist' of the UK points out the prominence of this centralization of capital in the ancillary private service provision due to the growing use of contracting-out in the country. The report by Nelson (2018) suggested that Carillion, a major ancillary private providers to the NHS in the UK had gone bankrupt in the beginning of 2018, "leaving the questions over who will now provide vital cleaning and maintenance services" in the hospitals.

This example demonstrates once again the importance of support service for the core elements of healthcare provision and proving that such privatization may not bring efficiency to the public healthcare service provision. Public Administration and Constitutional Affairs Committee of the UK House of Commons (2018), in a related report, noted the reasons for this failure as the following:

> UK governments have often transferred risks to contractors that they cannot possibly manage. This is driven, in part, by the decision to use contractual models such as payment by results which involve risk transfer on a huge scale. The transfer of large amounts of risk is often counter-productive: leading to more conservative approaches to service delivery. This situation has been made worse by the fact that governments have often not understood fully the services or projects they have wanted the private sector to manage and without any understanding or data about the assets being handed over. (p. 45)

This means the attitude and motives of governments with regard to risk transfer might render PPP hospitals not as profitable and easy-to-administer as expected from the point of view of the contractors.

One should emphasize here that this strategy of privatization in the support services of healthcare has proved to be precursor of the PFI or PPP projects where the private inclusion in the support services are further consolidated through the long-term public contracts, which will be discussed in the subsequent sections.

The last proposal of the NPM paradigm in healthcare was the introduction of a pay-for-performance remuneration model for health professionals, instead of the traditional seniority-based model. With the introduction of neoliberal reforms into the healthcare systems since the 1980s, many policymakers perceive this situation as a form of disincentive for the quality of healthcare services and as a mode of employment without any financial incentives for health professionals to improve the quality of healthcare provision. This idea emerged out of the emphasis on more rational use of resources, competition and customer satisfaction of the NPM

paradigm; which resulted in states pointing out the need for new performance criteria among public officials. The dominant rhetoric of reform proposals suggested that the competition among the health personnel to attract patients would also produce more effective outcomes. Thus, a novel system of 'pay for performance' is increasingly appealed within the healthcare service provision along with other kinds of public service delivery, in which, similar to the organization of private provision, the salaries of public physicians have begun to vary according to "their performance" in the workplace. In line with this, various methods of performance measurement have been implemented nearly all over Europe.

As Hood (1995) suggested, this new public management understanding framed the public officials as "budget maximizing bureaucrats" (p. 98). That is why; this system of pay for performance was brought forward as a model that would increase the efficiency of public officials. Indeed, atomizing and individualizing both service providers and users has now proved to be the most widely used technology of the neoliberal paradigm and "another way of breaking the welfare deadlock in terms of favorable to capital" (Aldred, 2008, p. 34). The pay for performance model is substantially influential in determining the behavior of the health personnel towards the central reform proposals and thus used by the central authorities to reconfigure their traditional political power on the healthcare policymaking processes. This tool is increasingly employed by the health authorities especially in the times of reform proposals in order to enforce work standards with a top-down process and set the boundaries of behaviors of physicians in line with the necessities of the reform agenda (Petersen, Woodard, Urech, Daw, & Sookanan, 2006).

After having discussed commercialization in healthcare and the NPM paradigm, I will now discuss how private activity has intensified under premises of

the NPM paradigm. Especially for the subject of this thesis, discussions of these NPM strategies will be relevant in understanding the organization of PPP/PFI projects and intensification of marketization in the health services.

2.3 Intensification of private activity in the healthcare services

The use of prospective payment systems, supplementary payments through user fees, the contracting-out of services and transfer of responsibilities to the private sector were reforms that may not lead to the direct privatization, but may prove to be the precursor of the further direct privatization. Holden clarified the impact of the NPM strategies as follows: "Where such policies do not lead to direct privatization, they may lead to the 'melting' of public-private boundaries" (Holden, 2005a, p. 679). In this context of blurred boundaries, when the consumer faced with the problems in the public system due to lack of central funding and budget constraints, they might increasingly tend to go to private providers, which in turn widened the extent of private provision in the country.

The extent of private provision takes various shapes in different contexts. In the developing world, the direct private provision used to be limited to the delivery of primary and curative care due to the high demand of consumers for such provision. The reasons for the historically limited private provision activity in the developing world contexts are several in the literature: First, the clinical provision of self-practitioner physicians is more prevalent rather than the chain hospitals of large corporations, as the demand for private hospital provision is low and the public financing generally backs the public hospital provision. Second, out-of-pocket payments constitute the most of private health expenditure due to the low incentive for the private medical insurance creation (Leon & Walt, 2001). Third, private sector

mostly provides small-scale ambulatory care and the reason behind it was explained by Holden (2005a) as: “Since the hospital services are very expensive at the point of payment unless costs are pooled through insurance schemes” (p. 681). Fourth, lack of technological and physical capital and limited availability of medical personnel in the developing countries limits the increased market activity of private hospitals.

Holden (2005a) indicated two main strategies of international institutions in facilitating increased private sector activity in healthcare systems of developing countries. First, the World Bank addressed the problem of limited demand for private hospitals by promoting private insurance schemes or the contract of government purchasers with the private providers, which is a form of public-private partnership. This also shows how purchaser-provider split was an initial step of increased privatization, given that it was proposed as a solution to the demand problem of the private provision of healthcare. Second, the GATS addressed supply-side constraints by enhancing trade in healthcare services and enhancing FDI. Holden explained that when the public provision fell short of meeting the demand of rising population and the growing middle-income people, private hospital sector easily proliferated in developing countries, as Indian and Chinese cases evidenced. The growth in the private hospital sector is in fact supported by subsidies such as tax exemption or loans provided by international finance institutions such as the IFC (p. 683).

Here, it is highly relevant to mention again Moran’s (2000) insights on the relationship between the private healthcare provision and the development of expensive medical technologies. Combined with the changing demographic profiles and increasing number of people demanding better quality healthcare provision, companies involved in the medical sector have become more eager to sell their equipment and broaden their investment destinations into the developing countries as

well. Through the spread of NPM reforms in the public healthcare provision such as purchaser-provider split; granting autonomy to public hospitals, and the furthered inclusion of private sector into the clinical and non-clinical services through outsourcing; medical private sector and health-related companies have gained much more incentive to deepen their health market activity into the developing world.

In this context, the extension of global companies into the health sector as a promising area of capital accumulation is furthered with "the diffusion of medical technologies that are expected to be profitable" (Blank, 1996, p. 332). Keaney (2002) assessed this trend as a contradiction between the advanced industrial countries and the developing ones, as he noted: "For some governments this represents an opportunity: to be first in the race to develop a financial and skills base capable of competing in a global market for healthcare. Hence the well-publicized moves of the British government to encourage private provision of healthcare and thereby give their healthcare sector a competitive advantage over late starters" (p. 351).

In addition, especially for developing countries that are struggling with high fiscal conditions and huge budget deficits, this process has given way to the intensification of "the central contradiction of ever greater reliance on expensive technologies for individuals at the expense of universal, equitable healthcare provision" (p. 338). As the advances in healthcare is increasingly associated with the improvement in the medical technologies, public demand for the technology intensive healthcare proliferates and the pressures on the healthcare spending increases with more resources targeted towards to industry and costly curative healthcare policies.

However, the reform agendas proposed to make healthcare systems more efficient through the inclusion of market mechanisms, explained as part of the

"retrenchment" process and limiting the role and responsibilities of the state, may not be adequate to understand the complex interrelation between the private and the public sector. Different roles and regulatory capacities of the governments in the finance and provision of healthcare in different political-economic institutional settings have brought more diverse interactions sets between the two camps and generated more variegated elements in the health policy agendas.

2.4 Globalization of healthcare privatization

I have elaborated on the processes of how healthcare services have increasingly been subject to the process of commercialization. The patterns of these changes have been discussed widely above, particularly with respect to the inclusion of quasi-market relations into the provision of healthcare services and changing consumption habits of patients. Yet, the process of privatization and its interaction with the liberalization at the global level still needs to be discussed to clarify how healthcare markets are expanding at the national level and what the processes and regulations that integrate them at the global level are. With the aim of answering such questions, many scholars trace the roots of the development of markets in healthcare services and argued that country-level privatization processes generally tend to interact with the global health markets and thus paving the way for the increased health market activity at the international trade (Hall, 2001). Two dynamics are at play. First, international organizations, mostly the IMF and the World Bank promote the private sector provision within the developing countries with the backing of the US and EU governments for the benefits of their health-related corporations in the pharmaceutical, insurance and medical equipment sectors.

Second, the World Trade Organization creates regulations for lifting the barriers to the foreign providers (Price, Pollock, & Shaoul, 1999).

The main reason behind the increased liberalization in trade in services was the saturated markets of more developed countries and their strong interests to sell their goods and services in the novel destinations of developing countries. Holden's (2005a) argued that increased liberalization in trade in healthcare services fit well with the unmet needs in the developing world with immature welfare and healthcare systems (p. 685).

Beginning from the late 1990s, the effects of globalization have been more severely witnessed in almost every sector including agriculture, production, extraction and service industries. The globalization in this sense was identified by Hall (2001) as a problem due to its severe implications for the economic sustainability of countries: Investment with foreign capital had proven to be a booster of growth in every sector rather than domestic-only provision of investment capital. This was especially the case for developing countries which have low levels of capital accumulation and have undergone late industrialization. The impact of globalization on public services including education, water, energy and healthcare was primarily associated with privatization, as it accelerated its impact through the inclusion of foreign capital into the already privatized public services of many countries. There were various channels through which globalization influenced the privatization of public services such as 'the rules of regional trading zones' of NAFTA or the EU and their specific public procurement rules for the member states or bilateral economic agreements between them. For example, the member state of EU, Italy could tender for a public sector contract in the other member state of Spain, which in turn might spoil the national development goals of Spain as the EU Public

Procurement Directive required member states to comply with non-discrimination principle between domestic and foreign suppliers (Holden, 2005b, p. 215).

Hall (2001) argued that the notable agents of globalization of public services were the international organizations and financial institutions including the IMF, the World Bank Group (IFC, IBRD, and MIGA), the OECD and the WHO. Yet, in this process of globalization of privatization in public services, he presented the World Trade Organization, an international organization established in 1995 to expand free market and liberalize trade, and its agreements on trade in services as the most prominent actor. Price et al. (1999) identified the agenda of WTO in this process as they posited:

> High up on the agenda of the World Trade Organization is the privatization of education, health, welfare, social housing and transport. The WTO's aim is to extend the free market in the provision of traditional public services. Governments in Europe and the US link the expansion of trade in public services to economic success, and with the backing of powerful medico-pharmaceutical, insurance, and a service corporation, the race is on the capture the share of gross domestic product that governments currently spend on public services. (p. 1889)

This high emphasis on the service industry actually lied at the growing competition in the manufacturing sector and rising importance of service industry as a new promising area for the profitable investment. For example, the European Commission also signified the importance of service sector for the trade activities of union as follows: "The [service] sector accounts for two thirds of the [European] Union's economy and jobs, almost a quarter of the EU's total exports and a half of all foreign investment flowing from the Union to other parts of the world" (European Commission, 1999, p. 3).

As governments across the world expand their healthcare markets into the other countries through globalization and the scope of the inclusion of private medical corporations in the service provision extends through the large-scale

healthcare reforms, the multinational corporations specialized in healthcare provision tend to increase dramatically (Holden, 2005b, p. 202). Holden's work is influential as he provided us with the typology of multinational private corporations involved in health-related services in order to present the scope of their growing market activities and corporatization of healthcare across the world. He categorized companies involved in the healthcare provision into five sub-titles for a more systematic study of the extent of their activities:

- "Providers of services to the end consumer" including the services such as hospital care, home care, dentist, pharmacies for which individuals might pay privately or by social insurance or they were directly paid by the state through tax-funding,
- Under the category of "Producers of good" Holden discussed the goods that were directly supplied to private or public providers such as medical equipment, drugs and information technology.
- "Supplier of services" included the ancillary services like cleaning and catering or management and consultancy services to the hospitals that might be supplied to both private and public hospitals.
- "Private insurers" were traditional health insurance services as a substitution or complementary to the public social insurance.
- "Companies involved in the provision or maintenance of premises" included the construction and maintenance companies, finance and accounting firms, health consultancy firms such as the ones involved in the PPP hospitals in the UK and Turkey (p. 203).

What is important in Holden's categorization is that he provided us with a very useful research tool to understand how the privatization took different forms

from sector to sector and in what areas the internationalization of privatization was more likely than the others. According to the results of Holden's study, out of *Fortune* magazine's 'Global 500' list of the world's largest 500 companies, 82 of them were found to have health-related business activity and 32 directly health-care ventures (p. 206). Even this data alone is enough to show the extent of the size of the for-profit health related business groups.

Yet, there are major differences that need to be discussed with respect to these corporations' area of their specialization. First, there is a clear division between the market activity of good producers/supplier of services and direct service providers. The former is more advantageous in operating globally with the effect of huge economies of scale in production due to the high costs of research/development and the regulations of intellectual property rights through TRIPS. This applies to the case for pharmaceutical companies. The latter has a limited activity in the international sphere as direct provision is a more complicated process and it is dramatically affected from the health system of countries and regulations of the states. In this regard, it should be noted that states tend to refrain from endangering the public health goals of their health policy agendas and thus intervene extensively to preserve the health needs of their citizens.

However, it should be highlighted that the extent of this internationalization of private provision is highly determined by the pivotal roles of the states, as Holden noted: "state providers of healthcare have also provided a massive subsidy to private producers of pharmaceutical and other health goods, thus funding their expansion. The relationship between different kinds of health and social care-related firms and other actors, particularly states, is thus especially important" (p. 213). In the UK, we see a very illustrative example of this relationship between the state and firms

through the introduction of purchaser and provider split reform. With this reform, autonomous purchasers entitled 'Primary Care Trusts' have given opportunities to buy services from the European and American private providers of the healthcare services.

Overall, this process of restructuring, large multinational private companies within the healthcare sector and their growing role in the healthcare policymaking recently have received scholarly attention. The distinct desires of the companies, the international and local financial institutions, and states have been reconfiguring the outcome of the policymaking processes. The companies get involved in the process with a desire for pro-market reforms in the destinations of their investments, and international and local financial institutions back these reforms through providing credits and loans. On the other hand, states have more complex demands including on the one hand, enhancing their economic development through more FDI and a value-added industrial development in the healthcare sector, on the other hand addressing the health needs of their citizens and provide necessary care for all.

In another study of his, Holden (2003) scrutinized the parameters of this complex relation between the welfare state and growing health business activity and looked at the shifts in the balance of welfare state intervention into the healthcare services. Through employing the transformation of British healthcare system as a case study, he identified the changing role of state from provision towards to the subsidization and regulation of private providers.

In that specific point, Le Grand et al. (1992) provided us with a sophisticated categorization of the mode of state intervention into the healthcare provision, namely direct provision, taxes and subsidies and regulation. Changes in the states' mode of intervention have substantial impact on the role of private providers. For example,

even for purely marketized relationship between the private providers and private insurance companies, the role of government has very decisive influence. Although one can suggest at the first glance that increase in the number of private providers will lead to a concomitant rise in the private insurance market activity, this may not materialize. The private providers may choose to benefit from direct state subsidy or prefer inclusion into the social insurance schemes (p. 292). For example, in Ireland, private insurers can use public hospitals thus expanding their area of involvement; in Finland, we see the increase in private insurance due to the growing private provider sector. However, in a publicly dominated national health system such as the UK, state support is in the form of tax incentives and subsidies to private provision. Similar to Turkey's healthcare policy, the UK has undertook a partnership between the private providers through use of public funds to purchase private providers, "thereby retaining the core NHS principle that healthcare should be free at the point of use" (p. 295).

Furthermore, other diverse strategies of government regulation may induce different sets of incentives or disincentives for the health business activity. For example, large private providers may benefit from increased government regulations including accreditation of hospital according to international standards, health quality tests, outcome measures or strict performance criteria, as small local providers tend to have difficulty in meeting these high regulations (Leon & Walt, 2001). Similarly, private hospitals may be subject to grading in categories by the governments according to their quality standards, and as a result, subsidies may go in compliance with this categorization. Again, for the trade in healthcare services government may introduce policies such as foreign equity limitations to determine the extent of the

internationalization of health service provision. This showcases the limits of international trade regime pertaining to healthcare services.

2.5 Conclusion

So far, I have elaborated on the literature pertaining the issues of increased commercialization, privatization and internationalization of healthcare service provision and more specifically the changing mode of interactions between these developments. At the intersection of all these developments and the dictates of the NPM comes the PPP paradigm, which furthered and consolidated the repercussions of extensively discussed above-mentioned developments. The next chapter will present the general framework of PPP and its applications to healthcare. It will then discuss the policymaking processes in such settings, and the processes of policy transfer.

CHAPTER 3

PPP MODEL IN HEALTHCARE AND POLICY TRANSFER FRAMEWORK

After examining the foundations of the PPP model in healthcare that are processes of commercialization and marketization, increased private activity, globalization and the NPM reforms, a general discussion of the PPP model and policymaking processes is vital for establishing the basis for the main discussion on the research questions of this thesis. To this end, this chapter will start by conceptualizing the PPP model, examining the nature and practice of PPP contracts with real-life examples, and touching upon Turkey's experience with the PPP model. These will be followed by a discussion on the power distribution within the PPP contracts, which will form the foundations for the subsequent discussion on the policymaking. Then will be introduced the implementation of the PPP model in healthcare, along with a discussion on the similarities and differences between privatization and the PPP model in the field of healthcare provision. This chapter will then be concluded with a brief introduction of the politics of healthcare with reference to the national and international actors and factors, as well as the policy transfer framework that applies well to the cases of implementation of the PPP model in healthcare in developing countries, including Turkey. These will provide the background for my answers to the research questions of this thesis.

3.1 The conceptualization of PPP

The traditional conceptualization of private and public sector, operating autonomously in the pursuit of their goals while the former seeking the profit maximization and the latter serving the public interest, has been challenged

nowadays. Many scholars have asserted that novel developments in the increasingly globalized world have given way to the mix of public and private, in turn blurring the boundaries between each other. The global success of privatization and the increasing involvement of private-sector managerial techniques into the public sector has sparked off the scholarly interests in the public-private partnerships. The growing use of public assets sale, outsourcing and commercialization of public services that dovetails many NPM premises have led to the new partnering arrangements and interdependencies between the two actors in this context of mixed economy, "neither totally dominated by state enterprises nor operating under a totally unregulated systems of competitive private firms" (Pongsiri, 2002, p. 488).

In this regard, Savas (2000) gave us the details of the differences between the concepts to provide clarity about the usage of terms. To provide a foundation for my analysis in the subsequent sections, I will briefly focus on the literature on the definitions of the public-private partnerships. As noted in the previous chapter, while privatization was "the transfer of enterprise ownership- in whole or in part- from state to private hands" including the form of contracting out for public services, marketization occurred "when a government agency [was] forced to operate in a market environment, for example, raising funds in capital markets and selling it services to willing buyers". However, PPP diverged from them, as Savas aptly realized:

> It is defined broadly as an arrangement in which a government and a private entity, for-profit or nonprofit, jointly perform or undertake a traditionally public activity. It is defined narrowly as a complex relationship −often involving at least one government unit and a consortium of private firms− created to build large, capital-intensive, long-lived public infrastructure, such as a highway, airport, public building, or water system, or to undertake a major civic redevelopment project. Private capital and management of the design, construction and long-term operation of the infrastructure is characteristic of such projects, along with eventual public ownership. [sic] (p. 1)

Savas also emphasized that the term PPP was used to sweep away the strong ideological opposition to the privatization among civil society, yet it still bore fundamental points of privatization. While the PPP built on the premises of the NPM, it went beyond to radically 'reinventing' the government activities. The policy was proposed as a strategy of building public service infrastructure without immediate public expenditure, as a policy of collaboration with the private sector, delegation of responsibilities and generating value for money for the public budget (Jütting, 1999, p. 5). Once again, the emphasis is on the efficiency of private sector managerial techniques and the benefits of bringing the competition into the previously monopolistic public services such as electricity, telecommunications and postal services.

This argument that the inclusion of private sector managerial techniques into the public service provision would increase the efficiency and quality of the services is especially relevant for developing countries which lack the institutional structure for not only embedding the markets and but also providing the formal links between the state and society as well as the state and for-profit private sector. Therefore, the recourse to international organization as a potential partner of governments such as the World Bank is not merely for the financial aid or loan, it is also for the sake of its expertise on the legal, judicial and economic dimensions of establishing institutional ties with diverse range of private actors. Since the weak capacity of government in these areas would eventually lead to ineffective collaboration processes and policy outcomes, capacity building is a key phrase of the rhetoric of international and regional organizations to build such partnerships.

3.2 PPP contracts

Against this background, my focus in this section will be on the contract-based partnership strategies between the state and private sector for delivering the public services and building the necessary infrastructure for them. No clear-cut definition of this contractual PPP exists in the literature. For the purposes of this thesis, it can be conceptualized as long term contractual arrangements between the public and private sector in which private actors finance and provide services that were previously provided by the state including railways, prisons, hospitals, schools, motorways, bridges, waste collection and so on. The European Commission (n.d.) defined this type of PPP in a similar way positing that:

> Private-Public Partnerships (PPP) are a well-known instrument. They not only cover road infrastructure but provide for a wide range of public services, like telecommunication, water plants, financial support, innovative financing, general public services, education and research. Public-Private Partnership arrangements are made attractive by limitations in public funds and also by efforts to increase the quality and efficiency of public services.

As can be grasped from the definition above, these arrangements are generally characterized by long-term fixed relationships between the two parties, which involve complex funding structures in which private sector bears the initial capital costs, service responsibility and maintenance costs during the relatively long (25-30 years) period. PPPs are promoted as a collaboration model aimed at enhanced public infrastructure development through the availability of financial and operational resources of both sectors. It has been claimed that such arrangements will generate efficiency through producing low cost projects and attract the private capital, increasing the quality in the public service provision.

Physical infrastructure development projects such as transportation, telecommunication, energy and water sectors, and the social infrastructure projects such as school and hospital construction, have always been instrumental in sustaining

the economic growth of countries, through creating inputs in the economy and through delivering these inputs into the market. In the context of increasing population and subsequent growth of market activity necessitated large-scale investment initiatives in physical as well as social infrastructure projects. Both advanced industrial and the developing countries have been struggling to develop and renovate the infrastructure capabilities to respond such a rising demand for better equipped physical infrastructure projects. More precisely, these efforts are not exclusive to the advanced countries which also need to update their infrastructure with respect to changing technological developments.

According to findings of McKinsey Global Institute report, there was an emerging need for 69.4 trillion US dollar worth infrastructure investment across the globe until the year 2035, while 63 percent of this amount should go to the emerging economies (Woetzel, Garemo, Mischke, Kamra, & Palter, 2017, pp. 3-4). Within this highly globalized world, countries seeking to preserve their comparative advantage in the world economy and sustaining their economic growth have to find necessary funds to finance these investment initiatives in the infrastructure sector of roads, hospitals, schools, energy, and telecommunication and so on. Therefore, given the high fiscal pressures on the public sector budgets, the option of private finance and the concomitant of private involvement in the public service delivery draw remarkable attention from the government policy networks.

Against these developments, according to the findings of Eurodad report, the money invested in the PPP projects had risen dramatically throughout the world since 2004, specifically from 25 billion US dollar to 164 billion US dollar (Vervynckt & Romero, 2017, p. 5). Considering the scale of investment, the report identified the key markets for the PPP projects as developing countries including

Turkey, India, Brazil, South Africa and Peru. Yet, PPP arrangements were not applied merely in these countries, advanced industrial countries such as Canada, Australia, the UK, Denmark, the Netherlands have also employed PPPs to finance their development projects of social and economic infrastructure. The report presented PPP as a policy paradigm enabling the more private sector investment into the public sector through elimination of the risk factor, since the government came in as a partner with offering diverse options of subsidies, tax incentives and guarantees of demand to the private sector (pp. 13-16).

As far as the economic instability of developing countries and their high fiscal deficits are taken into consideration, it should be underlined that large-scale infrastructure investments necessitated for them to collect funds from the donor international institutions or governments, which meant increasing redirection of public resources to the credits and high interest rates. The model of private finance initiative, in this sense, emerges as profitable investment of international finance institutions, multilateral development banks and governments, but rising costs for receiving government budgets in the medium term. Figure 1 shows the extent and changes of PPPs applications across the globe.

As shown in Figure 1, the recourse to PPP in the public infrastructure finance has gradually increased throughout the years. The impact of 2008 global economic crises and recession on the PPP market can be monitored from the slight decrease of total investment value between 2008 and 2010. For the short time, the total volume of investment in the PPPs fell after the 2008 financial crisis, as the cost of private finance increased and as the questions have been raised over the efficacy of these investments. Correspondingly to the findings above, in 2010, among the OECD countries, only Mexico and Chile have applied PPP above the ratio of 20 percent out

of their all the public infrastructure projects. Canada, Denmark, the Netherlands, France, Norway are the ones between the ratio of 0-5 percent, while Italy, the UK, Ireland has 10-15 percent PPP ratio (Burger & Hawkesworth, 2011, p. 7).

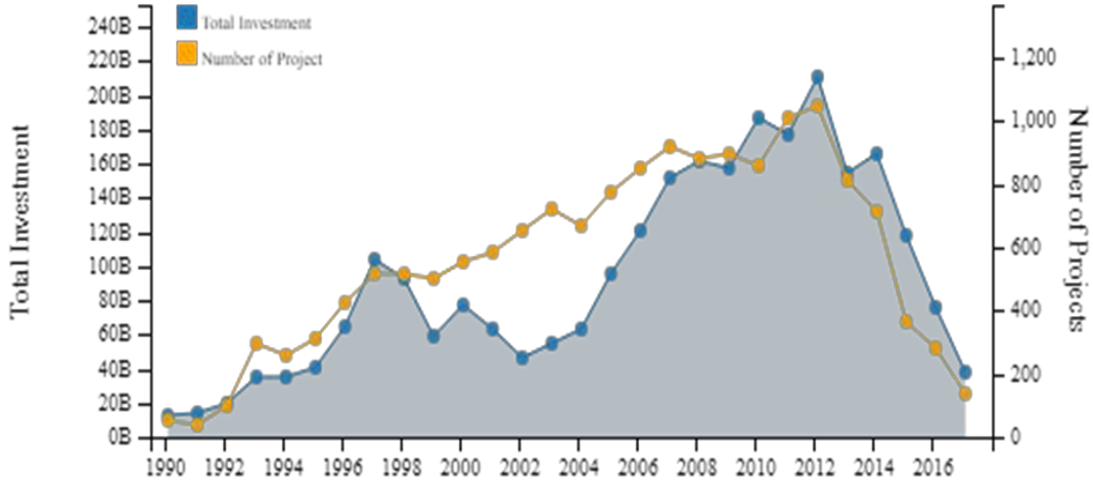

Figure 1. Number of PPP projects and amounts of total investment, 1990-2017
Source: Private Participation in Infrastructure Database, n.d.

Before going into deeper analysis of the political dynamics behind the PPPs regarding the power relations between the actors or the problems pertaining the transparency and accountability of the partnership, I would like to note the historical context from which PPP arrangements have emerged in order to grasp the main rationale behind the emergence of such policy. As a well-established financial center of the world, the UK has been the most active country in the PPP applications. It has originated from the idea of instrumentalizing the private money in the public procurement projects, meaning that main infrastructural projects will be developed through the method of private financing. Named as Private Finance Initiative in 1992, it is proposed as an alternative policy choice of the 1980s in which Thatcher government has transformed the structure of the welfare state through the extensive direct privatization (Krumm, 2016). First, private finance was thought to be very

instrumental in by-passing the budget constraints in full-scale development projects that would ignite the economic development of the country through renovation of the physical and social infrastructure and would provide a fund for financing the large-scale infrastructure investments that the public sector was not able to provide in an adequate level. The ideology of the time that assumed the private funding and private project management essentially more efficient and increased public budget deficit as a sign of inefficient public bureaucracy, along with the reputed risk transfer by the private sector paved the way for consideration of this option among the UK's public officials.

As soon as the Labour government came into power in 1997, the party rhetorically presented PPPs to the public as an economic development strategy and expanded the extent of PPP application since the supporters of the party are against the direct privatization of the infrastructure projects carried out extensively in the Thatcher government. Thus, most privatization projects began to be initiated in the form of partnerships "as an element of third way" (Krumm, 2016, p. 70).

In addition to these domestic developments, the UK has proved to be important actor in the global policy area in promoting and transferring the PFI model to other countries. Having experience in many PPP projects with both its private sector financial institutions, legal corporate firms, consultancy firms and construction/maintenance business groups and with its public sector in policy implementation process, the UK has been major actor in the diffusion of PFI contracts across the world. With the backing of the international institutions, most specifically the World Bank Group, many European countries as well as developing ones have drawn on the guidance of the UK's PFI in their various social and physical infrastructure projects.

Initially the UK and later many other governments following its lead have established a specific division in their government departments for these partnership projects with the aim of developing the standardized contracts, establishing the institutional link with the private sector agents and operationalizing the project management. Particularly the World Bank group and the EBRD have become the leading figures in the process of institutionalization of PPPs through enabling the project developments, carrying out the value for money analysis for the accounting techniques of governments with respect to analyzing which option is more efficient (traditional public procurement or PPP) and advising on the process of policy implementation.

The policy proposals of these financial institutions appraised the fiscal discipline across the world through suggesting that high budget deficits of the countries were supposed to be indicative of the weak-public management mechanisms. Therefore, private finance accounting has generated a somewhat false incentive for the budget deficit problems of countries through PFI/PPP. Relying on this model, governments could "keep PPP projects and their contingent liabilities 'off-balance sheet,' meaning the true costs of a project is hidden" (Vervynckt & Romero, 2017, p. 5).

Considering the negative implications of such government strategy on the fiscal balance, the Eurodad report indicates that "many projects have been procured as PPPs simply to circumvent budget constraints and to postpone recording the fiscal costs of providing infrastructure services – practices which end up exposing public finances to excessive fiscal risks" (p. 5). In addition, the EPEC (2016) warned the countries about the "affordability illusion" of the PPP and the detrimental effects of excessive recourse on the financial sustainability of the countries. The report

suggested that “an excessive focus on off government balance sheet recording [could] be at the expense of sound project preparation and value for money and [might] push public authorities to use PPPs where not appropriate” (p. 15). In that regard, one may suggest that the governments seeking to strengthen their popular appeal among society with the short-term interests through initiating large scale-infrastructural development projects such as bridges, railways, hospitals, may end up with the excessive use of private finance model within the interim period of two elections without considering the long-term future impacts on the financial resources of the country. This short-term thinking is indicative of the structural limits to electoral democracy and welfare expansionism in the age of neoliberalism. For example, Canada has abolished the use of PPP after realizing the negative fiscal implications of the PPPs by arguing that they lead to unnecessary flow of public sector resources to the private sector. Despite this domestic policy shift, the Canadian government goes on promoting the PPP projects out of its jurisdiction and particularly to the developing countries, considering the interests of its established PPP market (Infrastructure Canada, 2017).

Another important aspect of financing in the PPP projects is their capital structures. To start with, PPPs usually operates with the SPVs which are financed by both debt and equity. Usually three or four large companies including the financial institutions, construction groups, and maintenance firms establish a consortium “to raise capital, to share and to minimize the risks among different investors and to operate the contract” (Vervynckt & Romero, 2017, p. 10). To be more precise, it is this consortium that collects the debts for the project from the local or international development banks, constructs the facility such as hospital or bridge and operates it during the contract time.

As financing and expenditures are handled by the contractor and not by state agencies, the expenses and liabilities of the projects do not appear on the balance sheet of governments. Yet, one may ask the question of how the private sector collects such money. In this regard, there are two kinds of PPP projects. For the first one, namely the 'user-funded PPPs', private sector may charge the patients or introduce the public fees with the backing of government subsidies. It may lease the government merely for the cost of the building and the operation of the facility. When the contract is over, usually at the end of the 20-30 years, private sector has to revert it back to the government. For the second type, namely the 'government-funded-PPPs', government both pays for the investment value of the project and the services provided in the facility, as well as the foreign currency denominated private debts. Generally, private sector operates and maintains the facility in a given period in return for the annual rent from the public, and transfers it to the state when the period is over. Yet, the government has the right to regulate the service quality through contractually binding the private sector. The PFI hospitals in the UK are example of this type (Vervynckt & Romero, 2017, p. 10). As the private sector establishes such partnerships in return for making a high profit on their investment, the kind of return differs in these two kinds of PPPs: guarantee payment of government, and cost of capital.

First of all, as the private sector takes the risks of exchange fluctuation rates or the changing demand from the public for the projects, governments tend to offer various guarantees to attract the private investors, mostly in the times of economic downturn in a given country. The guarantees generally intend to make project more 'bankable' for the private firms, including 'loan repayments, guaranteed rates of

return, minimum income stream, guaranteed currency exchange rates and guaranteed compensation" (Vervynckt & Romero, 2017, p. 6)

Here, it is important to highlight that, particularly considering the case of developing countries, the issue of weak government capacity comes forward. First, due to issues of commercial confidentiality, the contracts are not disclosed to the public scrutiny, meaning that the contract negotiations lack the rigorous analysis from the civil society and other actors of public expertise, which does not conform to democratic policymaking processes. When it is added up to the weak institutional structure, lack of professional bureaucrats on the issue and unstable economic conditions of developing countries, private sector may demand excessive public guarantees or try to manage the projects solely according to their short-term profit interests without taking into account the future policy prospects.

The issue of unavailability of the expertise in the public sector is highly relevant here that needs to be further discussed. Due to the complex structure of contracts and projects, governments generally need help from the private agents including financial advisors for the finance structure, legal corporate firms for the adoptability of these project contracts to the national framework, and consultancy firms about the service management, which again comes up as another source of transactional cost for the government budgets. For example, in Portugal, the government provided the demand guarantee for the PPP motorways at the preparation phase of the contract, yet when the project began to operate it was understood that the traffic volume is overestimated, leading to rising pressures on the government shoulders with the growing compensation expenditures. That is why; the transparency is of high importance in order to make a rigorous analysis of whether there is a strong necessity for PPP without obscuring the real costs and benefits of

PPP application. The Eurodad report again designated the importance of the lack of transparency and lack of engagement with the public stakeholders: “This makes fiscal policy decisions less informed and encourages governments to go ahead with projects even when they can create fiscal problems in the future. It also means that citizens are left in the dark about their government’s real fiscal vulnerability” (p. 9).

The last point that is considerably discussed in the literature regarding the cost issue of PPPs is the relatively higher ‘cost of the capital’ in the PPP arrangements compared to traditional public procurement model. As the governments can borrow money at the lower interest rates due to the low risk factor, the private finance has turned to be more costly, which in turn exacerbating the fiscal pressures on government. Regarding this issue, the opponents of PPP generally argue that this ‘buy now, pay later’ model lead to more expensive and less accountable public service provision through obscuring a simple fact: “they leave an enormous legacy of hidden public debts” (Jubilee Debt Campaign, 2015, p. 2). For example, the investigation of National Audit Office of the UK concluded that private finance cost at least twice as much as if the government had borrowed to build the hospitals itself. Crucially, report also argued that increased costs of hospitals were a major contributor to the NHS crisis and noted, ‘‘This ‘NHS debt’ was a major contributor to the record £2.45 billion deficit faced by NHS hospitals in England in 2015/16. Cash-strapped hospitals are even more hard up while profit-making companies benefit” (Walden, 2017).

Therefore, the body of literature covered above suggests that governments, incentivized with the off-balance sheet premise, will likely to face huge financial burdens in the long run as they may end up paying significantly higher for the projects compared to the amount they would pay if they had used the traditional

public procurement model. While the language of change suggests the efficiency gains, value for money and the benefits of strong collaboration with the private managerial techniques, there is lack of accurate analysis demonstrating such positive implications in the literature, which is actually beyond the scope of this thesis. The cost issue in the literature has been reviewed due to the fact that it is mostly referred advantageous aspect of the projects during the policymaking process of governments, international organizations and the private sector.

What is more crucial here is the strong collaboration of the advanced countries, especially the UK, international finance institutions and development banks in transferring the PPP model to developing country contexts, due to the low risk of investments with the presence of numerous government guarantees and potentially high returns of profits for private contractors. On this subject, the network of civil society organizations across the world have launched a manifesto as a political critique of the PPP model, asserting that "the World Bank and other development banks stop prioritizing PPPs over traditional public borrowing to finance social and economic infrastructure and services" (Nelson, 2018).

3.3 Turkey's PPP experience

As extensively covered above, there are various conceptualizations of PPP. For the purposes of this thesis, it can be conceptualized as the long-term contractual arrangements between the public and private sector in which private actors finance and provide services that are traditionally provided by the state, including railways, prisons, hospitals, schools, motorways, bridges, waste collection and the like.

The regulatory framework pertaining to the PPP model in Turkey have been shaped initially by the neoliberalization process in the 1980s and its consolidation in

the 1990s, in line with the global PPP trends. Without explicit reference to the term, legislative amendments in the 1980s on private provision of infrastructure projects and services provided ground for the introduction of PPP methods. The first change in this direction was opening of a sector that was previously a state monopoly, i.e. the electricity production, transmission, distribution and trade, to the private sector -including foreign investors- with Build-Operate-Transfer model (Republic of Turkey, 1984).

A more significant change in this direction was made in 1999 in the form of a constitutional amendment. Previously, state contracts with private actors were subject to administrative law, and thus two parties of the contract were not equal in power, as the state bore a superior position with its mandate to protect 'public interest'. In addition, these contracts were subject to the approval of the Council of State, and the authority of conciliating disputes was the Council of State. This led to a reluctance of entering contracts with the state by domestic and foreign private actors, as there were numerous cases in which judiciary declared such contracts unlawful and repealed them (Ataay, 2003, pp. 226-7; Ministry of Development, 2014, p.27). In 1999, a constitutional amendment made the legal framework for PPPs -and private involvement in public service provision in general- more appealing for the private actors with the following provisions:

- Privatization became a constitutional practice for the first time (Republic of Turkey, 1982, Article 47).
- It became possible to make by law certain types of investments and services provided by private actors or state economic enterprises subject to private law instead of administrative law (Republic of Turkey, 1982, Article 47).

- Domestic and international arbitration was recognized as a dispute resolution mechanism regarding contracts (Republic of Turkey, 1982, Article 125).
- The practice of Council of State's approval of concession contracts was converted to a process of presenting opinion (Republic of Turkey, 1982, Article 155).

These changes prepared the basis for the legislation governing PPP projects, including that of city hospitals, as will be discussed in Chapter 5.

According to the Presidency of Strategy and Budget data presented in Table 1, the total contract value of 243 PPP projects that have been contracted out since 1986 is about 139 billion USD, while the total investment value is slightly above 60 billion USD and the value of TOR is about 76 billion USD as of 2019, adjusted in real terms. In each value term, airports, energy facilities and motorways occupy the top three places.

Table 1. Consolidated Table of Turkey's PPP Inventory

	Contract Value, Million USD	Number of Projects	Value of TOR, Million USD	Investment Value, Million USD	Average Contract Value Per Project, Million USD
Year					
2015-2019	13,860.23	39	4,175.73	9,684.51	355.39
2010-2014	94,219.52	86	55,468.68	38,750.84	1,095.58
2005-2009	17,982.67	35	15,923.19	2,059.47	513.79
2000-2004	2,297.82	26	107.42	2,190.41	88.38
1995-1999	8,544.36	44	535.85	8,008.51	194.19
1990-1994	2,149.50	11	0.00	2,149.50	195.41
1986-1989	20.61	2	0.00	20.61	10.30
Sector					
Airport	71,502.47	19	52,809.77	18,692.70	3,763.29
Energy	28,862.21	92	19,457.35	9,404.86	313.72
Motorway	20,151.70	42	23.13	20,128.57	479.80
Health Facility	11,235.84	20	0.00	11,235.84	561.79
Port	2,801.85	23	2,670.80	131.04	121.82
Other	4,520.64	47	1,249.81	3,270.83	1,309.60
PPP Model					
Build-Operate-Transfer	87,441.52	109	41,598.59	45,842.93	802.22
TOR	36,056.75	109	34,612.28	1,444.47	330.80
Build-Lease-Transfer	11,235.84	20	0.00	11,235.84	561.79
Build-Operate	4,340.60	5	0.00	4,340.60	868.12
Total	139,074.71	243	76,210.87	62,863.85	572.32

Source: Presidency of Strategy and Budget of Turkey (n.d.) and own calculations

In the Preliminary Report of the PPP Special Expertise Committee for the Eleventh Development Plan (2019-2023), the delegation of duties between the public and private actors in the PPP model are outlined as in Table 2. Even though this is in line with the general practices, it is noteworthy, since it reflects the perception of public-private delegation.

Table 2. Delegation of Duties between the Public and Private Actors in the PPP Model

Public	Private
• Planner: Determination and prioritization of projects • Coordinator: Co-development of the project • Supervisor: Performance monitoring and assessment	• Financier: Provision of financing • Coordination actor: Co-development of the project • Contractor: Establishment of infrastructure for service provision • Project implementer: Provision and administration of the service

Source: (Ministry of Development, 2018, pp. 10-11)

Besides the contractors, subcontractors and consultants, the main stakeholders taking part in PPP projects are as in Table 3.

Table 3. Actors Involved in Turkish PPP Projects

Public Institutions	Private Sector Institutions	International Organizations
• High Planning Council • Presidency of Strategy and Budget • Ministry of Treasury and Finance • Privatization Administration • Implementing Authorities: Ministries, Institutions, Municipalities	• Banks and Banks Association • Professional organizations • TOBB • Turkish Contractors Association • Union of Chambers of Turkish Engineers and Architects • Union of Municipalities of Turkey • Universities • Non-governmental organizations	• European Investment Bank • EBRD • WB and IFC • UN Economic Commission for Europe • UN Economic and Social Commission for West Asia • Other relevant organizations under the UN system

Source: Report of the PPP Special Expertise Committee for the Tenth Development Plan (Ministry of Development, 2014, pp. 81-83)

Changes due to the restructuring of the public governance body are applied.

The PPP Special Expertise Committee provides an assessment of the accumulation of PPP expertise in the public sector in their preliminary report. They note that since 2008, the Turkish public and private sectors have gained impressive amounts of expertise and knowledge in PPP through 'learning by doing' by taking part in all critical processes (Ministry of Development, 2014, pp. 49-50).

3.4 Power distribution within the PPP contracts

The literature on PPPs has focused mostly on the technical aspects with non-ideological language including typologies of contractual relationship, value for money analysis by the economists and managerial difficulties of PPP projects. Yet, beyond the managerial aspects of the partnering arrangements, it should be underlined that the main context of these projects is public service provision. Thus, considering their political and social implications, these projects should not merely be analyzed as for-profit projects. In addition, this new nature of relationship between the public and the private as 'contract partners' has strong implications in terms of the role of the state in public service provision. Therefore, it should be indicated that the nature of this relationship is a political one that needs to be taken into consideration.

Realizing this gap in the literature, Miraftab (2004) came with the study that elaborated on the power relations between the private and public agents. She argued that private firms had asymmetrical power over the public agents and thus the welfare-driven community interests in the PPP arrangements of public services were overwhelmed by the profit interests of private business. In line with the findings of Eurodad report by Vervynckt & Romero (2017), she also posited that government resources were targeted to the private sector strategies of market enablement in the

public services, meaning that private sector actors demanded greater support of the state.

In order to establish horizontal relations between the state, the private sector and communities, Miraftab (2004) addressed that the essential discrepancies between the agents with respect to access to resources should be looked more closely. Since the large private corporations that are able to participate such large-scale PPP projects more easily reach the financial and legal institutional resources, along with it, since they are highly experienced with contractual relationships in the marketplace; they have determining power over the basis of the conditions of contract. Through "applying management by contract further into policymaking and public service delivery", PPPs for public service provision changed the nature of the interaction between the public and private sectors and the role of private and public agents (Froud, 2003, p. 567). Therefore, the state's regulatory capacity to ensure the equitable distribution of resources for the society, to provide public services and to determine the long-term direction of policies are replaced with these increasingly contractual-based public service delivery. This is mainly because the state lacks the necessary experience in the contractual relationships and have difficulty in interpreting the content of complex contracts and monitoring the outcomes.

In line with the premises of the NPM, the contract has become a primary tool of rendering competition and efficiency in public service provision. As a result, over the long term, public side bounded by the contracts may meet with increasing transactional costs arising from excessive fragmentation within the services and increasing range of actor in the every step of delivery and concomitant monitoring challenge in every stage of the provision (Grimshaw, Vincent, & Willmott, 2002).

Furthermore, the name of 'partnership' bears some implicit clues for the changing of power and concomitant political relations between the two parties. More precisely, the term partnership seems to indicate the equal power status between the state and non-state actor, meaning that the traditionally special status of state with its political legitimacy and authority has been equalized with the previously weaker political role of private actor (Richter, 2004, p. 47).

Besides, the literature highlights that private agents in both national and international arena emerge as powerful actors in these partnering arrangements, which have affected the autonomy of the governments in policymaking process for public service delivery. As Buse and Harmer (2004) noted, "Partnership has also created new opportunities for the private sector to exercise power and influence over domains which were once the preserve of public-sector organizations, for example, in establishing norms and standards in specific issue areas" (p. 50). At this point, they pointed out global governance mechanisms that included private actors, and the fears of subordination of national priorities and policies of low- and middle-income countries. In this regard, they noted, "the political impacts of public-private partnership on the health sector are ubiquitous and may be far reaching", meaning that limits of private actors and their policy directions were not clear (p. 50). Drawing on this argument, one may suggest that healthcare services previously dominated by the public sector have become a domain in which commercial private agents have begun to elicit increasing impact on the direction of policies through the public-private partnerships. Therefore, the PPP represents marketization and commercialization of welfare, rather than simply being a form of the direct shift from public sector to private (Aldred, 2008, p. 32).

3.5 PPPs for healthcare services

Although it has been a widely used strategy for the infrastructure development across the world, the public-private partnership (PPP) model is a relatively new route for the services of welfare provision. The report issued by the World Bank can be regarded a tangible sign of the gradual interest on the subject, as it noted (Independent Evaluation Group, 2016):

> Originally confined to the traditional infrastructure sectors of transport, water, or energy, PPPs are increasingly applied also in social infrastructure sectors, particularly for delivery of health services. PPPs and other forms of private sector involvement in health are now also an important element of the World Bank Group's response to country health challenges, as reflected in the 2013 World Bank Group Strategy, the 2008 World Bank Group Health Development Strategy, and the 2015 joint World Bank Group. (p. vi)

As the World Bank also posited, the PPP application in the healthcare sector was a novel one and bore diverse characteristics that needed to be discussed with a special emphasis on the particularities of healthcare provision. Healthcare diverges from the physical infrastructure projects such as motorways or bridges as the PPPs are likely to have directly observable impacts on the provision of healthcare services and the healthcare spending of the countries. Beyond being the sole domain of investment policies and infrastructure-building projects, healthcare constitutes a substantial part of social policy agendas of governments, having a direct effect on the well-being of the societies.

Budgetary constraints, weak infrastructure and the limited availability of skilled health personnel in the public healthcare systems of developing countries such as India and Malaysia have rendered the rapid growth of private sector in these countries (Leon & Walt, 2001; Bloom & Standing, 2001). In such an unequal context of healthcare provision, the PPP is discursively constructed as a strong collaboration between the actors that strengthens both of them through mutually beneficial ways.

Its proponents have argued that PPPs will improve the physical infrastructure of public health provision, leverage the managerial skills of private sector and bring the health services to the underserved regions of the countries, thus delivering the public health goals of societies in a strong collaboration.

There are various models of partnership arrangements suggested in the healthcare policy literature. Raman and Björkman (2015) classified the PPPs in healthcare under the four categories based on their scope and characteristics, namely the service delivery PPP, financial protection PPP, infrastructure PPP and other PPP models. First, regarding the service delivery PPP, they identified the outsourcing and contracting-out strategies that had been widely used in the ancillary service provision in the public hospitals since the 1980s. Second, under the heading of financial protection PPPs, authors pointed out the ways that governments offered incentives to the private providers through policies of subsidies, tax incentives or they cited the arrangements such as public purchaser reimbursement of the services of private providers. Third, they referred to infrastructure PPPs as the activities that contributed to the physical presence of facilities, ranging from design, building and financing to operating, leasing, owning and/or transferring. Other partnerships include capacity building networks, alliances, and research/training activities (p. 380).

Increasing application of the PPP in healthcare has also led to changing mode of governance and incorporation of wide range of actors in healthcare policymaking processes. The distribution of power among the public and private actors is of high importance today as healthcare policymaking becomes more complex with the inclusion of different actors, thereby "simultaneously reshaping relations of power, authority and legitimacy" (Buse & Harmer, 2004, p. 50). In this respect, scholars argued that PPP had become a vehicle for the powerful private actors to exert much

more influence on the healthcare policy agenda of governments in two ways. First, private actors tend to control the policymaking processes through setting the standards on both global and national level. Second, they tend to shape the perception of public officials and senior health policymaker about 'the best options' in health care. This increased influence of private actors furthers the neoliberal restructuring of NPM reforms on the healthcare systems. In this regard, Buse and Walt (2000) argued that these partnerships empowered businesses to participate actively in policymaking processes at both global and national levels, to benefit from direct financial benefits in the form of tax breaks and concessions, and to enjoy elevated levels of global recognition and legitimacy (p. 556).

Here one should indicate that the discursive construction of healthcare PPPs in the literature again bear the non-ideological language of win-win solution, value for money for the public expenditure and increased quality of healthcare services (Bloom & Standing, 2001; Barrows, MacDonald, Supapol, & Harvey-Rioux, 2012). This framing, in a sense, depoliticizes the health policymaking with a strong authority on the knowledge and legitimacy of 'economistic language', obscuring the differences between the national contexts, changing necessity of state intervention into the healthcare needs of communities and problematic implications of PPP for healthcare service provision.

The critical literature on the PPPs propose that private sector motivated by the commercial interests is not likely to concern the issues such as equity or equal access to healthcare services. Following the footsteps of Bennet and Tangcharoensathien (1994), the main points of concern are: unethical methods of private sector in maximizing the profit, ignorance of the long term public health goals of private sector and short-term motivated health care intervention, increasing

brain drain from public to private providers, commitment on ambulatory care services rather than the preventive ones, direction of government resources to specialist care services and lack of regulation in their healthcare practices.

Bearing in mind such pitfalls of private provision of healthcare, Raman and Björkman (2015) underlined that public-private partnership in healthcare might lead to the transfer of such inefficiencies of private provision to the public healthcare provision. They pointed out that the probable consequences of PPPs in healthcare included the loss of autonomy in the public sector over deciding the additional services to be offered, determining the quality of healthcare service provision and monitoring the performance of subcontracted healthcare staff (p. 87). The authors furthered their arguments by underlining that the use of contract in healthcare service delivery might hinder the ability of government to monitor, determine and respond the future healthcare spending due to the high-costs associated with these large-scale health infrastructure projects and rising transactional costs of these complex multi-agents contracts. Some empirical research exemplified such an argument in the UK NHS crises (Evans & Bowman, 2005). Therefore, it would be crucial to highlight that without the effective capacity building in the government regulation and monitoring, the partnership with the for-profit private sector may have detrimental effects on the healthcare systems and may hinder the ability and autonomy of public sector over determining long-term healthcare policy prospects.

3.6 PPP contracts for hospitals as a last chain of privatization in healthcare provision

Public hospitals operate within different organizational structures in different healthcare systems. However, the literature on the healthcare reforms suggests that through the NPM reforms such as the purchaser-provider split, the granting of

financial autonomy to hospitals and decentralization of governance procedures, operation of public hospitals in different contexts have increasingly converge each other, likening the public hospital management to those of private hospitals with the introduction of similar interests among them such as efficient resource allocation and becoming financially sustainable over the years (Durán & Saltman, 2015). As I discussed previously, with the growing use of outsourcing in the ancillary and maintenance services such as cleaning and catering or sometimes in clinical services such as radiology, public provision has been in company with private sector for many years. This alignment with the private sector has led to the following changes that affected the healthcare provision: rapid technological improvements in medical technology along with the rising expectations of patients about the quality of clinical and non-clinical hotel services in hospitals and political pressures of various private agents on public sector to restructure the hospital organization and finance in order to expand their role in the public service provision (Durán & Saltman, 2015, p. 443).

The application of the UK's PFI model in healthcare provision further altered healthcare service provision and policymaking. Similar to its application in the other public services areas, PFI hospitals are projects financed through the private sector loans with the model of design-build-finance and operate within a contract-term of 20-30 years. Through the life of contract, public sector pays the cost of capital, cost of borrowing from the financial institutions and cost of services including the maintenance of hospital and non-clinical ancillary service provision. A further set of contracts is embodied in the contracts between the SPV and the companies providing the soft services (outsourcing strategies). These hospitals introduce new forms of medical service provision, in which state takes part only in clinical service provision through the medical personnel it provides; yet the delivery of assistance and non-

clinical services and the operation of commercial spaces within buildings are transferred to private sector (McKee, Edwards, & Atun, 2006).

In that regard, it is necessary to make distinction between the traditional contracting-out and PPP. The traditional outsourcing model was different from this PPP model as they are usually short-term contracting for single service provision and there are relatively high number of commercial actors competing to provide such services. In the case of contracting out the support services in public hospitals, the power of private sector to determine the conditions of service provision and to decide upon additional services is restricted compared to PPPs. This is because the former is short-term contracts and public healthcare authority is less dependent on a single service provider considering that there are large number of competing providers in the market. Moreover, different from contacting-out, PPP hospitals are managed by the consortium that include senior private and public sector managers who manage the hospital collaboratively, which in turn raise the above-discussed issue of asymmetrical power of private and public over commercial contracts and over the private sector management strategies.

Furthermore, it is elucidative to indicate that the PPP contracts for hospitals distinguish the core services from the support services with the reservation that the distinction is commonly flexible. As the boundary between these two types of services is not easy to draw, the core services may increasingly be targeted by the private sector penetration, which is exemplified in the case of the radiology. While the core services constitute the work carried by the most professional health personnel such as physicians and nurses, the support services generally include the ancillary service provision. The empirical literature analyzing these PFI hospitals in the UK and Canada provided similar results on that issue. The literature suggested

that the quality of support services tend to be poorer in PPP hospitals as the private consortium members begin to cut costs by starting from the non-clinical service provision and can easily attempt to degrade the working conditions of the workers of support services for the sake of increased profit Gaffney et al. (Gaffney, Pollock, Price, & Shaoul, 1999a; Whiteside, 2009; Barrows, MacDonald, Supapo, & Harvey-Rioux, 2012).

According to Gaffney et al.'s study (1999b) on the impact of PFI on the British healthcare system, the extra high costs of PFI hospitals had caused the redirection of NHS funds from the clinical budgets to the debts for private sector. Therefore, their empirical study succinctly found out that PFI/PPP neither generated value for money, nor improved the quality of service in the healthcare context of the UK. The authors noted, "Under the private finance initiative the NHS pays more for less; paradoxically, the largest hospital building program in the history of the NHS is being funded by the largest acute hospital closure program [sic]" (p. 51).

In line with the findings of Gaffney et al.'s study (1999b), some other scholars argued that the PFI represented the neoliberal welfare state reconfiguration because of the fact that it enabled the transfer of public resources to the corporate healthcare businesses (Aldred, 2008; Holden, 2005b). Being the large-scale hospital projects, PPP hospitals allow both multinational and national health businesses including the construction companies, ancillary service companies, maintenance sector, medical device industry, financiers and consultants increased access to public service provision without necessarily introducing the direct private provision of services per se. The literature discussed below provided several reasons to clarify why PPP was another form of privatization in the public health service.

Public-private partnerships operate as an important tool to pave the way for the privatization of healthcare services and appeal the patient demand, especially in the contexts where this kind of transformation is unlikely to happen. Here, one should remember the insights of Holden (2005a) in explaining why in the developing world privatization could not be rendered easily. First, he argued that the lack of capital accumulation in these countries and large capital requirement for the private sector's development hindered the privatization process. The PPP, in this sense, provided the necessary capital through instrumentalizing the public resources, public funds and government guarantees to lower the risk of private sector investment. Second, Holden raised the issue of low demand for the private healthcare provision, as most of the population in developing world could not afford to purchase such highly expensive services. Again, PPP came into play through resolving the low-demand issue as the PPP hospitals were still identified as 'public hospitals' and the service was free at the point of utilization with the reimbursements of central/state or public insurance schemes. Third, Holden asserted that the unavailability of medical technology, physical capital and source of finance were other reasons for the lack of private provision. The PPP model took away these problems through attracting the foreign capital and source of finance, being riskless for private sector with the compensation payments, government-backed, profitable projects. Forth issue was the scarcity of high-skilled medical personnel in the developing world contexts. Through the supply of the professional healthcare personnel for the core services provided in the PPP hospitals, governments stepped in again to solve this problem of privatization. The last and probably the most profound pitfall of privatization that Holden suggested was the high resistance of public to direct privatization of healthcare service provision, especially in the context of national health care

systems. By legitimizing the partnership in the eyes of society as a form of strong collaboration for leveraging value-added, high quality, equitable healthcare service for all and private sector finance, the PPP reduced the potential social protests against these projects. Finally, it is also important to underline that the complex structure of the PPP arrangements that were extremely difficult for the society to comprehend made PPP acceptable in the eyes of citizens.

Given that the PPP model sets the foundation of different form of privatization in healthcare, another theme that should be discussed emerges when PPP develops to a certain extent in a country. The first and maybe the foremost issue is the consequent growing autonomy of the private agents over the healthcare service provision. Through binding the state by the long-term contractual agreements, private sector consolidates its inclusion in the healthcare service provision, especially for the support services for a long period. Through the course of these contracts, firms are awarded by the management of public buildings and healthcare service provision, and long-term guaranteed government backed cash payments.

Here, it would be useful to remind Holden's (2003) classification of health-related commercial private sectors. Excluding the direct private providers and private health insurance companies, all kinds of health-related private sector considerably benefits from the PPP model hospitals (p. 293). Corresponding to the main premise of this review, the complex configurations of finance and provision may pave the way for increased private involvement without the necessary growth of direct private hospital provision. Private sector, through increasing the power over the public service management, public infrastructure building and the direction of services provided in different steps of provision, may acquire much more interests than it would in the direct private provision (p. 292) . The following international and

domestic corporate actors draw advantage from PPP arrangements: the financial institutions and consultants during the financial phase of contracts; construction sector in building the infrastructure; medical industry in supplying the necessary and mostly over-supplied technological equipment; maintenance and support services firms through the all life of hospital management; health consultancy groups in giving advice to public or private consortium side in carrying out such complex structure of both financing/managing and corporate legal firms in standardizing the contracts and making the local legal framework compatible with the international standards and resolving the contractual disputes between the parties. All these commercial groups are added up as actors to the health policymaking processes and they gain extensive profits from the growing application of PPP contracts, where profits of private sector translates into augmenting costs of public sector (Holden, 2005b, p. 203). Considering that construction sector has proved to be main stimulator of economic growth across the world and increased market activity and investment, renovating public building and infrastructure such as hospitals through PPP can be regarded as best option for long term private accumulation strategies. As for the healthcare projects, given these hospitals are officially entitled as 'public hospitals', private sector finds a chance to increasingly penetrate into the healthcare provision without undertaking the demand risk from society or risk of going bankrupt as public cannot easily let their bankruptcy and, if this is the case, tend to bail-out with the concerns over public health issues (Holden, 2003, p. 298).

In this respect, one may possibly raise a question of what the main rationales behind private sector investment in such PPP arrangements are. In order to respond such a question, the aspect of strong government transfers should be discussed here. Especially the governments of developing countries provide several step-in-rights for

attracting the private sector investment into their lacking infrastructure development projects to rejuvenate the economic growth through guarantees including shadow toll or revenue guarantees, exemption from VAT, stamp duty and charges, free use of state-owned immovable assets and expropriation and international arbitration. States prefer to generally provide such step-in-rights with the intention of attracting foreign-direct-investment, supporting the emergence and growth of the private sector in health care provision and subsequently stimulating the economic activity and growth in the country. Here, it seems enough to suggest that all these developments indicate that the legitimizing discourse of PPPs in bringing forth the risk-transfer to private sector, value for money and efficiency for the use of public resources is deeply flawed due to the fact that it is mostly the public side that assumes the risks such as crucial financial risk of currency rate fluctuations in paying the leases or bailing-out in the case of bankruptcy. To situate these developments in broader neoliberal reconfigurations, scholars argue that in today's highly globalizing, subsequently competitive and highly unstable world, market needs the governments much more than ever to 'step-in' in order to enhance their operations. This argumentation per se might infer that the state enters PPP contracts without seeking its own or public interests. However, while the discussion of keeping PPP projects off-balance sheet, their contribution to the development discourse and their promises of public appeal holds in many cases, PPPs create new types of relationing between the public and private parties, which vary among different national contexts. In fact, this is among the main motivations of this thesis; it tries to investigate the motivations of each party to enter PPP contracts, and what the (expected) results have been or will look like.

Considering the fact that it is usually very difficult to invest in such a complex large-scale project, the consortium investors in PPPs including the ones such as construction companies or catering firms tend to be oligopoly in the market. The most probable outcome of this situation is suggested in the literature as: 1) the relatively low number of private actors competes in the tendering process and subsequent growing costs of the project for the government. Bearing also in mind that the competition occurs only at the beginning of the contract-making, over the 20-30 years, the public sector is highly bounded to the one main company in the consortia, 2) One may also argue that this will lead to growing reliance of government on small numbers of private firms over providing healthcare services, paving the way for their growing voice over the policymaking process (Hellowell & Pollock, 2009). Once bounded by the contract, government has no choice but to collaborate or even bailout these hospitals in the case of the bankruptcy. The hospitals covered by public-private partnerships provide essential public healthcare services and governments must assume responsibility for service provision in the event of contract failure so that the patients can continue to access public hospital care. This means government always holds a residual risk. This situation is not unlikely to happen as public-private partnerships for hospitals have a very high failure as the examples of Australia and the UK demonstrated (Duckett, 2013; Blaiklock, 2018).

Another focal point of change in PPP hospitals requires further discussion: the centralization of capital in healthcare sector. Building on the idea that only a few firms are able to invest such complex projects and only such firms can enjoy the benefits of economies of scale, Aldred (2008) argued that this situation would lead to redistribution of resources not only from the government to private but also from

small firms to the favored large corporate ones. In this respect, it is possible to suggest that PPP will presumably lead to contradiction between not only the labor and capital, but also between the small and large businesses. Here, it is worth directly quoting from her, as she explained bluntly:

> future neoliberal welfare is likely to mean a greater concentration of finance-led corporate power in alliance with the state, and the aggravation of systemic crises in service provision, which are likely to be blamed on their victims. PPP scarcely represents a new stable settlement in which free trade achieves unproblematic hegemony, but rather a constant battle for power between capitals, labor forces and users. [sic] (p. 54)

Other two examples of centralization of capital in the PFI model are the following. With the elevated utilization of economies of scale and the practice of granting PPP hospital contractors the right to operate commercial spaces in the hospital campuses, small pharmacies have had difficulty in competing with corporate pharmacy chains. Second, a process of de-professionalization and proletarianization of health professionals has taken place thanks to the lack of corporate culture of the large contractors and the strive of governments to abolish the basis of their traditional power over the health service provision (Aldred, 2008, pp. 43-45; Haug, 1973, pp. 205-206).

Another point that is emphasized in the literature about PPP hospitals is the process of decision making about the organization of hospital management. The process tends to be far from being democratic and accountable, mostly because of commercial confidentiality issues. Aldred (2009), on this issue, suggested that the UK PPP hospitals were structured by top-down elite decision making without any collaboration from the staff, service users, patients and physician in chief (p. 549). The author explained that hospital environment dominated by the private sector managers thoroughly excluded the voices of physicians and patient representatives, which in turn might bring about the clash between the private managers and public

physicians (p. 546). The joint decision making between the managers and other health personnel is very crucial for the sake of hospital operation considering the importance of immediate and efficient intervention for the healthcare issues. The contestation between the public employees and private managers is the potential factor of problem for hospital management. Therefore, the inclusion of private sector in the public health service planning does not seem possible without the embeddedness of 'shareholding logic' within the public managers' decision-making. Yet, this embeddedness in turn would consolidate the market logic in the public service provision and configuration of public health service in the image of the market (p. 549). While this is not peculiar to PPP hospitals, it supplements the internalization of the market logic in this context.

One should suggest here that because of such transformation, public hospitals are tilted in favor of the private sector at the expense of health equity concerns. Operating through the principles of market and under the control of corporate firms, 'customer satisfaction' is given precedence over the necessities of qualified examination and treatment. Following that, the luxury hostel services replaced the importance of necessary clinical intervention, which in turn might have also affected the quality of healthcare provision.

Pollock (2004) mentioned another crucial observation about the implications of the PPP model in healthcare for health personnel. Operating under the principle of market, PPP transforms the public hospitals where public health personnel begin to work increasingly longer hours within the shorter time-constraints for clinical examination and where the public sector ethos for equitable, high quality health is diminished with the financial interest of private managers for more profitable, efficient management. Moreover, Ball et.al (2001) in their empirical study regarding

the PFI hospital of the UK, found that the length of the stay in the hospitals was reduced as the PFI hospitals require increased number of patients in order to sustain themselves financially. These findings show that public sector moves to work like the private sector, in line with the proposals of the NPM paradigm including efficiency and value for money.

3.7 The politics of healthcare

Health care policy is also a political domain that is highly shaped by the power relations between the actors. As health policy scholars Freeman and Moran (2000) contended: "Health care policy arenas are populated by dense networks of institutions, all representing complex constellations of actors" (p. 35). Building on this fact, this thesis scrutinizes the political underpinnings of the introduction of the PPP model in healthcare provision in Turkey.

The policy area is not independent from national as well as international dynamics in a sense that health policymakers have to comply with the changing needs of citizens in terms of healthcare along with pursuing the international health care arena that provides 'best practices' to the problems. In that focal point, one should also posit that the determination of both problems and solutions is not nationally bounded, meaning that healthcare policy arena is unprecedentedly populated by global policy actors who have a considerable influence on the local actors and their rationality on the policymaking processes. Freeman and Moran (2000) explained the influence of growing importance of international economy on healthcare policies, as he noted:

> fiscal pressures push policymakers in the direction of cost containment; industrial imperatives push them in the direction of expanding the demand for healthcare goods and services. And decision now facing health policymakers

> can only be taken with reference to international economic considerations. (p. 36)

In this context of increasingly globalized health-policy arena, states turn to be under the pressure of managing and regulating the internal and external factors and thus concomitant inclusion of numerous actors in the health policymaking process. Therefore, although the state bureaucrats and role of governments are still very influential as they choose one among the diverse set of health policy options, it becomes impossible to understand the common policy trends without the careful analysis of global health policy circles.

Against this backdrop, this thesis focuses on the recent diffusion of the PPP model in the healthcare sector in Turkey. Even though it seems at first glance that there is a considerable convergence among the countries in their adaption of PPPs, it requires a further analysis in order to understand deeper how this policy agenda manifests itself in different country contexts. For the scope of this thesis, I will specifically elaborate on the processes how the PPP is learnt from abroad and through what global as well as national actors it is localized in Turkish health care context. I aim to take into account the global dimension of policymaking, especially within the context of increased dissemination of knowledge and ideas between the actors, international and national institutions and governments. The objective of this aim lies at the preceding discussions around the issues of growing privatization, commercialization and marketization tendencies in the health sector and subsequent increase in the power of non-state -both for-profit and non-profit- actors within the policy circles. Drawing on the idea that the methodological nationalism falls short of explaining the actual policy dissemination among countries and the weakness of academic insistence on the importance of bureaucratic state power in explaining the policymaking mechanisms, I will try to employ a critical position towards the

interrelations between the global policy networks, international and national institutions and state bureaucracy in transferring and diffusing ideas, policies and institutional designs. Yet, before going into deeper analysis of the actors and processes, one should make the necessary conceptualization in order to be more precise about the terms used here such as ‘policy diffusion’, ‘policy transfer’ and ‘global policy networks’. I suggest that only with this perspective, we can understand the introduction or change in the health policy agendas.

3.8 Policy transfer framework

Especially over the past decade, technological advances and the subsequent easiness of the communication between the policymakers have entailed explicit increase in the occurrences of policy transfer/diffusion. Marsh and Sharman (2009) defined the distinctive features of the policy diffusion and policy transfer, yet at the same time underlined the importance of building an integrative research framework benefitting from the changing interactions between the mechanisms involved in both concepts. What is important in their discussions was the observation that the notion of diffusion tended to emphasize the structure, the notion of transfer tended to focus more on agency (p. 270). Stone (2001) also suggested that rather than dealing with the content of policies, diffusion approaches focused on the process and the mechanisms of transfer, which generally lacked an analysis of policy context and direction. Its focus is limited on broad historical, spatial and socio-economic reasons for a pattern of policy adoption neglecting the politics involved.

Moreover, Marsh and Sharman (2009) underlined that researchers had to recognize the dialectical relationship between structure and agency and their mutual interaction that produced policy diffusion/transfer. They defined policy transfer as a

process by which "knowledge about policies, administrative arrangements, institutions and ideas in one political setting [was] used in development of policies, administrative arrangements, institutions and ideas in another setting" (Dolowitz & Marsh, 2000, p. 5). On the other hand, the authors presented the policy diffusion as a more passive process through which policy choices in one country affected those in another country. In the arguments of policy convergence, the agency almost disappeared in the process and convergence resulted from not because of specific transfer and learning mechanisms but commonly due to various structural developments operating at the international level. However, the authors also alerted that these classificatory schemes might sometimes have overlapping conceptual cores and complementary interests.

The literature on the policy transfer/ diffusion is mostly dominated by the discussions around the roles of agency and structure in these processes. Marsh and Sharman (2009) criticized the diffusion literature by suggesting that it fell short of analyzing the role of agents in the diffusion process while overemphasizing the role of structural factors. Given that agency effects were fundamental in the analysis of policy diffusion, authors argued that the meanings agents, leaders and high-level bureaucrats attached to these structural developments were the determining factors in the policy transfer (p. 274). They contended that transfer literature tended to further acknowledge the role of agency while neglecting the structural developments to a certain extent. Authors highlighted the importance of sophisticated approach to the structure/agency problem in order to come up with patterns and explain how and why they came about, as the relationship between them was dialectical, that is, "structures provide[d] the context within agents act and they constrain or facilitate[d]

the agents' action. However, agents interpret[ed] those structures and, in acting them, change[d] them" (p. 275).

Stone (2012) also argued that policy transfer studies should encompass both structure and agency, that is, both the opportunities and constraints to transfer and the role of agency in these structures, as she put: "Agent-centered approaches do not dismiss structural forces but suggest that in varying degrees, states and organization can mediate these dynamics" (p. 548). She proposed that agency was also decisive in the policy transfer processes and researchers should consider the logic of choice in selection of policy ideas, the interpretation of circumstances or environment and bounded rationality in adaptation. Here, it is fruitful to define the concept of bounded rationality as it has crucial role in determining the position of actors towards the policy options and it highly affects the rationality of policymakers. Regarding this concept, Dolowitz and Marsh (2000) argued that many actors involved in policy transfer were not perfectly rational. By drawing on the concept of 'bounded rationality', they clarified that actors were influenced by their own perceptions of decision making situation rather than real situation and it might sometimes be based on incomplete or mistaken information about the nature of the policy (p. 14).

Furthermore, there are various mechanisms of policy transfer/diffusion that simultaneously affect the nature of policy outcomes. Marsh and Sharman (2009) classified four major mechanisms, namely learning, competition, coercion and mimicry. *Learning* was defined as a rational decision of governments to emulate foreign institutions and policies that were believed to produce efficient and effective results in borrowing countries. It took place generally through transnational problem solving in international policy network or sometimes on a bilateral basis. *Competition* was commonly employed by policy diffusion scholars, who suggested

that increasingly globalized capital had obliged countries to adopt more investor-friendly regulations including deregulation, privatization, low inflation and strong property rights that helped states to remain competitive in global markets. *Coercion* might come from transnational place through the international organizations' conditions attached to their lending or from other powerful states via various forms of threat risks. *Mimicry* or emulation was the process of copying foreign models in terms of symbolic or normative factors, rather than a technical or rational concern with functional efficiency as governments believed that adopting a given policy promoted by international organizations or more 'developed' country would make them being advanced, progressive and praiseworthy (p. 277).

These above-mentioned policy transfer mechanisms may involve both voluntary and coercive elements. Dolowitz and Marsh (2000), in their holistic framework, conceptualized policy transfer as a continuum between the lesson-drawing to direct imposition of program, yet indicating that many cases of policy transfer might involve both coercive and voluntary elements (p. 6). At this specific point, they gave the example of the role of international organizations such as IMF and World Bank and underlined that when such international organizations were involved in the policy transfer process, they generally recommended some specific consultants to be hired, which blurred the distinction between the voluntary and coercive transfer for the researchers (pp. 10-11). These organizations might influence the decision maker bureaucrats directly through their policies or loans conditions or indirectly through the information and policies spread at conferences and reports, generally sold as 'best practice' elsewhere (p. 11). Therefore, it is important for researchers to respond the questions of 'who are involved in the policy transfer?' and

'with what motivations they are involved in the process?' in order to reach more insightful conclusions about the object of research.

In order to analyze and explain the whole policy transfer process, Dolowitz and Marsh (2000) came up with a broader conceptual framework organized around six main questions: "Why do actors engage in policy transfer? Who are the key actors involved in the policy transfer process? What is transferred? From where are lessons drawn? What are different degrees of transfer? What restricts or facilitates the policy transfer process?" (p. 8). Given the interlinkages between the abovementioned questions, the policy transfer should be studied as a multi-layered process that involves several inter-organizational networks. In their methodological study, Evans and Davies (1999) pointed out the multi-layered structure of policy transfer by opposing a kind of methodology that restricted the transfer to action-oriented intentional learning that took place consciously and results in policy action (p. 366). This understanding takes policy transfer as causal factor leading to policy convergence. However, authors distinguished policy transfer from policy convergence in that the latter might occur unintentionally due to harmonizing macroeconomic forces or common pressures or processes (p. 368). The element of intentionality and agency was crucial in authors' definition of policy transfer. Their primary concern was the analysis of those structures and processes that could shape the behavior of international, state and non-state actors and thus facilitated process of policy transfer. That is why they accepted the importance of state actors as well as non-state transnational actors in policymaking process of all levels of governance (p. 365).

Evans and Davies (1999) pondered upon the global changes and transnational structures in order to explain the context within which policy transfer found a way

out. Relatedly, they proposed that the literatures on globalization, internationalization, trans-nationalization and policy transfer could be linked in three major ways. First, through increasing opportunity structures for policy transfer, globalization processes could act as facilitator of policy transfer. Second, policy transfer enhanced the process of globalization through the creation of further opportunity structures such as the EU economic development program. Third, it was further suggested that international regimes played a key role in processing policy ideas through epistemic communities with an attempt to use their knowledge resources to promote global awareness and similar perceptions of certain policy problems and options (p. 371). Therefore, structural global changes in economic, technological, ideological or institutional space should be analyzed in order to grasp their function as facilitator of the space for policy transfer and affecting the nature of the process itself (p. 373). That is why; Evans and Davies gave particular importance to the policy networks and complex interdependencies characterized by 'governance without government' in order to provide insights for external and internal processes of policy transfer (p. 374).

In the inter-organizational level of analysis, Evans and Davies (1999) offered tools for analyzing how decision makers and bureaucrats acquired and utilized knowledge in multi-organizational setting, where some level of autonomy independent from structural forces was attributed to actors in the processes of option analysis and implementation (p. 383). In doing so, these authors integrated the literatures on policy transfer, policy networks and epistemic communities into heuristic notion of *policy transfer network* that might comprise representatives of epistemic communities, other forms of policy entrepreneurs, key bureaucrats, politicians and privileged groups (p. 374). By integrating Marsh and Rhodes' (1992)

concept of a policy community and Adler and Haas' (1992) notion of an epistemic community, authors developed their own conception of a policy transfer network. The notion of a policy transfer network evaluated the cognitive dimension of decision making, that is, how decision makers acquired knowledge. Thus, through the emphasis on structural (organization rules and imperatives) and interpersonal relationships (information and communication exchange within networks), policy transfer network enables us to understand complex policymaking in inter-organizational setting. In these engagements within the networks, different levels of government gained certain essential skills and knowledge resources (p. 376). The thesis will instrumentalize this theoretical framework of policy transfer network in order the find out the emerging patterns involved in the relations within the public-private partnerships in the healthcare sector, which in turn shape the consequences of policymaking process.

On the other hand, Beyeler (2004) defined the ways in which epistemic communities influenced policymaking processes as diffusing ideas and acquiring bureaucratic positions. With the former, they affect the stances of policymakers and the public, while with the latter, they become able to exercise a direct influence on policy design (p. 4). In this respect, Lee and Goodman (2002) highlighted the 'global' characteristic of the epistemic community taking part in healthcare financing reforms, "in the sense that, it ha[d] encompassed a broad range of state and non-state actors across higher, middle and lower-income countries" (p. 103). This was a process that lasted for decades, starting as a disorganized group of institutions "with a shared concern about the inadequacy of resources for health development", and having transformed into close partners with projects, individuals taking part, and policy proposals (p. 112). Lee and Goodman argued that this process operated via

rotation of individuals between this global network, prominence of expertise in -mainly- economics and public health with strong academic affiliations and production coupled with consulting roles, different approaches US- and UK-based institutions embrace, and support of students of these institutions from lower-income countries to become policymakers in their countries or international health organizations (pp. 112-115).

Stone (2001) is another scholar who also argued that transfer was a process that was often facilitated within networks. However, she gave a particular importance to the non-state actors without obscuring the role of key actors of bureaucrats and politicians. Her work focused on the roles played by non-state actors who acted as 'policy entrepreneurs' interacting with officials in government and international organizations in the international spread of ideas and information. She mainly discussed soft form of transfer and policy entrepreneurship undertaken by think-thanks, consultancy firms, foundations and the university sector (p. 3). The author defined network as a structural framework for policy-oriented learning within which such knowledge institutions provided crucial information sources for the decision maker and bureaucrats, which could be utilized for spreading of ideas and reforms. Networks are encompassed by several independent actors who come together to exchange resources (for example, money, authority, information, expertise) and to achieve their objectives (p. 7). Building on this conceptualization, Stone viewed network as a unit of analysis that provided insights on how joint policy was constructed and how public and private interdependence was built simultaneously beyond the hierarchical control of governments. Therefore, the agents of policy transfer are not solely politicians, bureaucrats or state agencies; individuals, experts, networks and organizations have also begun to organize as

agents of transfer (p. 8). What was relatively absent in the policy transfer literature, she argued, was this role of transnational networks and non-state actors in global and regional fora and she filled this gap through directing analytical attention to the role of transnational and global actors in policy transfer.

Stone (2001) identified two-fold problem in the policy transfer literature: first was that the literature focused on lessons and policy transfer between nation states with an implicit tendency to assume a bilateral relationship, second problem arose from methodological nationalism (pp. 18, 20). This is in line with the argument of Marsh and Sharman (2009) which read "most contemporary work on diffusion and transfer springs from dissatisfaction with the previously conventional notion that states are self-contained, isolated units whose institutions and policies can only be explained by reference to domestic variables" (p. 278). That is why; Stone (2012) asserted that multiple and more complex transfer agents that were not identified with either exporting or borrowing nation might initiate and facilitate the transfer. International organizations, think tanks, consultancies, law firms and banks are examples provided by the author. These transfer networks and knowledge producers constitute the major part of global governance mechanisms that creates new opportunities and 'agenda-setting influence' for policy transfer (p. 550). These 'policy transfer entrepreneurs' helped transfer the intellectual matter that enabled policymaking, as she bluntly recognized:

> They can be co-opted into such processes in partnership with development agencies and international organization. In these policy communities, they potentially becoming involved in the indirect coercive transfer of policy ideas and practice. A variety of organizations constructs the intellectual infrastructure for cross-national learning and creates justifications for transfer. [sic] (Stone, 2001, p. 21)

In that specific point, Stone gave the example of the World Bank by arguing that the Bank had recently begun to present itself as agent of learning and facilitator

of a learning dialogue among policymakers in order to provide an environment for so-called sustainable development goals for the countries (p. 19).

Scientific associations, foundations, training institutes, consultants and other knowledge oriented non-state actors may also stimulate the spread of policy ideas through persuasion and advocacy but also through cooperative engagement with official actors, that is, networking around governments and international organizations. These bodies have interacted with other agents of transfer and have used their intellectual authority or market expertise to reinforce and legitimate certain forms of policy or normative standards of 'best practice' (p. 13). Stone's work is influential in a sense that it drew attention to "the extent of close interaction, extensive co-operation and growing institutional integration" between the third sector policy networks and official actors in the transfer of policies and ideas (p. 33). Yet, it also recognized that non-state actors could not bring about policy transfer alone. They are mostly dependent on governments and international organizations to see policy transfer instituted in policies and programs. Furthermore, the process is highly reconfigured by the internal factor which is specific to the local contexts 'such as the changing dynamics of political interests and the socio-historical make up of a polity' (Stone, 2012, p. 547).

Stone's (2004) analytical categorization of actors involved in the policy transfer process is three-fold: namely "the states, international organizations and non-state sector" (p. 545). While analyzing the role of states, the author distinguished the developing countries from the developed ones. She did so by suggesting that the former was more likely to subject to direct imposition and 'one-size-fits-all' approach from other exporter countries as well as international organizations since they lacked the necessary expertise and knowledge to comprehend the technical

characteristics of policy and possible future implications of that policy for the country.

Under the heading of the transfers from international organizations, Stone (2004) gave the examples of the OECD, the UN, the World Bank and the WTO. These institutions help the emergence of similar policy responds to the differentiating and contextually bounded problem areas. The medium of transfers may vary from spreading academic publications about the 'best practice', organizing conferences for dissemination of ideas to assigning officials in the local contexts with an objective of creating suitable revenues for the networking around the state bureaucrats. Career changes from public official positions to the employee of international organizations is also a common practice in many countries, which stimulate the impact of bounded rationality among actors and enhance the local knowledge of international organization about the specific dynamics and organizational bureaucratic structures of importer countries. They also function as a facilitator of the emergence and dissemination of common perceptions and knowledge sharing among the public bureaucrats about the solutions and problems. Again, the process may involve both coercive and voluntary form of policy transfer mechanism. For example, the financial institutions may force countries to adopt the specific kind of policy which is the case in "the conditionality tied to loans" (p. 554). Transfer might also proceed through more consensual and implicit mechanism, as Stone succinctly suggested:

> Institutions such as the World Bank, the WTO and the International Monetary Fund (IMF) have set up research departments or hold conferences and consultations to advocate the 'scientific' validity of their objectives, and have engaged in various outreach activities, data-gathering and monitoring to promote awareness and educate the public. In this way they can become one institutional junction for epistemic communities. (p. 554)

Within the category of non-state actors, Stone (2004) scrutinized the commercialized mode of transnational policy advice that encompassed agents such as international banks, law firms, transnational think tanks and consultancy firms. Author underlined the rising appeal to the consultancy by arguing that these companies had unprecedentedly gained a respectable status in the transfer of policy ideas, management principles and social reforms of public sector from one setting to another. Especially developing countries that are eager to learn 'best practices' have proved to be important customers for such consultancy companies. In global policy networks, consultants operate as both advisers and implementers through their important source and authority on the knowledge about actual practices for the governments that increasingly turn them for acquiring the knowledge of best practice. In order to be more precise, the author provides us with an example of the object of policy transfer that is disseminated successfully across the globe with the inclusion of consultancy firms as important agents. The New Public Management reforms, for example, are transported to numerous countries through the consultancy networks of various firms such as the 'big four' companies including PwC and the KPMG. These companies promoted the inclusion of managerial techniques of private sector into the public sector, outsourcing strategies and adoption of market economies into various under-developed and developing countries through "growth in the use of external consulting services by government" (p. 557). All these actors form networks and collaborate with each other to initiate policy transfer process as well as operate to implement the policies into the local contexts and to "project their ideas into policy thinking across states and within global and regional forums" (p. 560).

Given this theoretical framework on the policy transfer network so far, it needs to be mentioned that very few scholars employed this analytical framework in order to explain the healthcare policy transfer across the world. The literature is widely dominated by the studies that focused on the role of each agent separately, rather than analyzing their organic interdependence. The position of each agent is intertwined within the policy circles and they generally tend to pursue the paths that are likely to pave the way for more rapid and accurate policies in the end. Yet, one should here emphasize that there are structural differences between the public and private agents even though the former is increasingly likened to the latter through organizational reforms of NPM and PPPs. Yet this process is not independent from neoliberalization period in which market ideology and actors amplified their influence on the health policymaking processes, usually in exchange for the knowledge, experience, expertise and loans they provided for the governments.

The literature investigating the transfer/diffusion of contractual PPPs through the lens of policy transfer network is unconventional and very limited (Appuhami, Perera, & Perera, 2011; Siemiatycki, 2013; Shaoul, Stafford, & Stapleton, 2007).

One study that analyzed the diffusion of contractual PPP arrangements from the industrial countries to the developing country contexts attributed the underlying reason of this trend to the "coercion from international aid granting organizations (IAOs) through conditionalities attached to financial assistance" (Appuhami et al., 2011, p. 431). Through drawing on the policy diffusion literature, scholars traced the roots of extensive adoption of PPPs in the public service provision of Sri Lanka and found out that IAOs such as the World Bank, the IMF and the Asian Development Bank operated as interlocutors through affecting the developing countries to adopt PPPs that had previously been implemented in more industrial countries such as New

Zealand, the UK, Australia and Canada. Yet, they suggested that if the diffusion occurred especially from the industrial contexts to the developing ones, it generally tended to be a more coercive process including "fiscal force, financial or moral authority, trade practices, economic sanctions and monopolization of information or expertise" (p. 433). In that regard, what scholars mainly argued was that IAOs usually worked for the interests of the industrial countries as large part of their financial resources came from those countries. Scholars rightfully underlined that "transfer agents' control[led] financial resources sought by developing countries, including FDIs, aid, grants, loans and securities. Thus, industrial countries, such as the USA, [could] coerce developing countries through transfer agents by giving financial assistance" (p. 433). The main emphasis was given to the World Bank Group in the promotion of PPPs as an efficient strategy for service provision. Here, the following quotation from the World Development Report 1994 explains well the new role of the government as envisioned by the World Bank:

> Public-private partnerships in financing have promise . . . Government will have a continuing, if changed, role in infrastructure. In addition to taking steps to improve the performance of infrastructure provisions under their direct control, governments are responsible for creating policy and regulatory frameworks that safeguard the interest of the poor, improve environmental conditions and coordinate cross-sectoral interactions – whether services are produced by public or private providers. Governments are responsible for developing legal and regulatory frameworks to support private involvement in the provision of infrastructure services. (International Bank for Reconstruction and Development, 1994, p. 2)

Another research that merely focused on the PPPs in the transportation sector such as the projects of roads, bridges, railways, subways and airports suggested that the global production of this infrastructure strategy originated from the excessive promotion of "small numbers of highly globalized construction contractors, engineering firms, financier, accountancies and consultants from developed countries" (Siemiatycki, 2013, p. 1254). The crucial finding of the research was the

suggestion that the implementation of PPPs was happening without necessary consideration and control from the public sector and thus process tended to be dominated by the private sector interests at the expense of welfare interest of society and taxpayers. Furthermore, the authors underlined that the geography of the PPP application was changing from industrial countries to developing and underdeveloped contexts. International institutions, law firms, consultants operate as facilitators in this transfer process through preparing standardized legal frameworks, advising governments for necessary regulations, competitive tendering processes and dispute resolution mechanisms, that are of crucial for the attraction of increased number of investors (p. 1259). Research posited that similar processes were undergoing in the numerous developing countries such as Brazil, India, Egypt, Russia, Turkey and Poland with the mechanisms including:

- "Establish[ing] policy and legislative framework
- Initiat[ion of] central PPP policy unit to guide implementation
- Develop[ing] common deal structures and procurement protocols
- Develop[ing] public sector comparator models
- Use [of] government institutions to build domestic marketplace for PPPs" (p. 1260).

These processes involved in the implementation of PPPs in the developing world generally emerge from the leadership of the World Bank Group which provides advisory support and financial resources to the governments seeking the expertise for building capacity in their official units. There are also other advisory channels such as the divisions of experienced countries in project management of PPPs. Among them, the UK and Canada are most referred ones that provide paid consultancy to other governments outside of their jurisdictions (Shaoul, Stafford, &

Stapleton, 2007). Additionally, Shaoul, Stafford and Stapleton added up another crucial unit of network, namely the 'supportive civil society organizations' like industry trade associations, which tended to be sponsored largely from the big PPP-related companies, consortium leaders, investors and financiers. Examples of such organizations include the Canadian Council for Public Private Partnerships and PPP Forum in the UK, whose duties may be summarized as follows: advocating on the efficiency of PPPs, sharing global and national specificities between the agents involved, delivering conferences, publications, mobilizing public support via media and distributing awards to the successful PPP projects across the globe in order to promote and attract other governments' interests.

The analysis of Shaoul, Stafford and Stapleton (2007) included the following non-state private sector actors: first was the main consortium leaders, which were generally the construction companies that benefited extensively from PPP policies as they boosted the construction sector, while second was the main advisory institutions both for the public and the private and the last was the financial firms that collected funds for the financing of the projects. The consortium leaders tend to be a few numbers of large multinational companies that are able to collect credits at low interest rate, initiate high capital-intensive private investments and employ large workforces. Therefore, advanced industrial countries such as the UK are recognized as more advantageous in PPP market due to their highly experienced and settled mega companies. The second important non-state actor is the commercialized advisory and legal firms that provides consultancy services during the implementation of PPPs and service delivery. At this point, it needs to be realized that the partnership is built not only between the private and partner agents but also within the private sector, which is the case among PPP-related Anglo-American legal

firms and financial institutions. Shaoul, Stafford and Stapleton (2007), on this issue, commented that:

> Anglo-American legal, contractual, and regulatory frameworks towards PPPs have increasingly become the industry convention worldwide, providing strong property rights and dispute resolution protocols that have made emerging markets attractive to international investors. This spread of Anglo-American legal and regulatory treatments towards PPPs has been led and supported by the dominant role of Anglo-American financial and legal advisors in the PPP production process. (p. 1265)

Related to the global developments, Shaoul, Stafford and Stapleton (2007) clarified the important role of 'big-four' consultancy firms including KPMG and Deloitte whose functions included networking with the government officials and advising them in their evaluations of the PPP projects. The most crucial aspect of this findings, authors argued, was the fact that these growing multinational legal and advisory activities in the implementation and transfer of PPP policies was the emerging pattern of delocalization and deterritorialization of the legal frameworks and signified rising autonomy of market actors on the crucial processes of law creation, which might have detrimental implications for the embeddedness of the public service provision within the local contexts (p. 491).

Overall, Shaoul, Stafford and Stapleton's (2007) research has proved to be very inspirational for the research design of this thesis, as it took into account the three-fold policy transfer network including states, international organizations, market and civil society actors and their strong interdependence during the PPP policy implementation and provision. Yet, its scope was limited to the transportation sector and thus the research fell short of being an important source for the analysis of healthcare-specific characteristics and subsequently excluded health-related actor analysis.

To fill this gap in the literature, Holden (2009) came up with a research design that paid attention to the role of commercial interests in the healthcare policy transfer. His main object of analysis was the healthcare industry of the UK that exported PPP projects in health to developing and Eastern European countries. The research applied three-level analysis of policy transfer including the actors from international institutions, states and non-state domains. Author argued that the British government, with its well-established market in PPP applications in the healthcare sector, tries to influence other countries "in order to lay the basis for the winning of consultancy, construction and other contracts by British firms" (p. 313). What is crucial in his arguments is that despite the efficiency gains of PPP in British healthcare is not proven, the government of the UK, within the partnership from financial institutions, multinational firms and international knowledge institutions, exports PPPs to developing countries. The responsible official unit of the export strategy in the UK is the Department of Health's international department, DHI, which plays an indispensable role "in liaising with other government departments and with industry interests to facilitate the export strategy, including conducting scoping report in order to identify priority markets to be targeted in both developed and developing countries" (p. 314).

Arguing that the literature on the material interests motivating the policy transfer of different actors was very underdeveloped, Holden (2009) pointed out that the material benefits might be the main stimulator of the organic relationship between the international institutions, states and non-state market actors. For example, for the case of PFI health project transfer from the UK to other countries, author proposes that The UK DFID routinely gives funds for consultancy firms provided that they advise developing countries to adopt PPPs (p. 316). However,

what was distinctive for the health-related PPP projects, author posited, was their "primarily social and equity-oriented goals", rather than merely economic goals (p. 316). In order to explicate the main rationale behind the UK's health PPP projects, he investigated the British healthcare industry and found out that the medical devices industry, pharmaceutical industry (health care goods), health consultancy firms (500 active British health consultancies across the globe), and medical support services (services) lied at the basis of British export strategy and trade relations (p. 317). He suggested that in 2005 the British government launched a program to expand the market for its medical industry and the UK-based health companies in international trade. Through this program, British government has begun to utilize the NHS as an engine and support for economic growth, rather than as a social policy area for the universal health care for all citizens. Here, it is worth directly quoting from Holden, as he succinctly explained the contradiction between the economic and social policy and the simultaneous subordination of the latter for the sake of the former, not only in the area of healthcare but also for other social policy issues such as education, labor market and social security policies:

> This is in line with wider contemporary thinking on economic and social policy, in which competitiveness in the global economy is seen as being based on innovation, skills and knowledge. In this view, synergies should be found between economic and social policy so that they work together rather than against each other, and where necessary social policy is subordinated to economic policy in the attempt to enhance competitiveness." (p. 318)

As bluntly suggested above, the explosion in the high value-added medical industry and services, due to unending demand and technological innovations, has begun to be seen as a favored tool for the competitive advantage of states in the global economic environment. This situation reminds of Moran's arguments again that are extensively discussed in the first part of this review, that could be summarized as the tension between goals of welfare state and primacy of industrial

goals of the state in the context of healthcare. Holden (2009) suggested that tensions could exist between each other if the governments gave precedence to industrial economic goals over the health policy targets, which was the proven case for the pharmaceutical industry all over the world (p. 318). Holden provided another example for this tension by discussing the situation of medical devices technology in Eastern European countries. In order to support the medical devices industry, those governments backed investors extensively through certain guarantees and subsidies. The result is that the radical upgrade in the medical technology has resulted in the hospital's budget crises to sustain the operation of these supplies and repairs. Similarly, PPP hospitals being high-technology mega hospitals may come with detrimental impacts on the governments' budgets to sustain such high-cost medical technology and services, which are generally imported from other countries.

In order to promote the UK standards in health, value for money and efficiency of PFI systems, the UK Department for International Development organized many meetings with the UN agencies, the WHO and the World Bank to demonstrate the promises of the PPP policy to these knowledge agencies and in turn to make them transfer this strategy to another countries (Holden, 2009, p. 319). In this respect, Holden found out that beginning from 2005, many advanced industrial countries as well as the developing ones had been established as the top priority PPP markets including the USA, Japan, France, China, India, Saudi Arabia, Hungary and Turkey (p. 320). In order to attract their attention for PPPs and make them adopt it to their healthcare systems, the UK Department of Health accepted delegations from other countries such as Finland, Portugal, Canada, Chile, Mexica, Hungary and Turkey. Along with these delegations from other countries' influential healthcare officials, the British government have organized several PFI forums and carried out

various promotion and lobbying activities such as inward-outward missions to other countries, sponsored visits to the UK and numerous health-related seminars. India, China, Chile and Malaysia were the ones that launch a large-scale hospital modernization program with the application of PFI. Many consultancy firms, management companies such as PPP Solutions Ltd, financial and legal advisory companies and the UK DFID have provided fee-based advisory services for many countries. As a result, many developing and eastern European countries have begun to initiate PPP program and establish legal frameworks that thoroughly affect their health systems and healthcare budgets. Numerous development banks from all over the world have turned to be major financiers of these programs and the institutions such as the World Bank has provided loans to many countries attached to the PPP implementation in their hospital system (p. 326). All in all, Holden's work offered rich empirical material that demonstrated us that the material interests were the key factor that bound policy transfer agents. He rightfully noted, "international institutions, donor governments and private consultancies, therefore, all act[ed] as conduits for policy transfer rather than simply as neutral advisors" (p. 328).

Aldred's (2007) research on the scope of the UK's PFI application on the health sector via the policy networks including private and public actors revealed similar findings to preceding studies. The major finding of the study was that the policy networks of PPP were constituted by mostly private interests that were prone to disregard the general welfare interests of the public actors that made policies work in micro contexts such as the physicians. In line with Holden's suggestions, she also contemplated that the social policy goals of countries were increasingly reconfigured under the dictates of the economic policies. Her methodology was built on a network analysis through several interviews with key actors, observations and documentary

analysis. What she mainly observed was that PPPs instilled the commercial interests and market imperatives into the organization of British health system and thus paved the way for the blurring the boundaries between the public and private both for their managerial aspects and their future prospects. She underlined, "…where the private sector help[ed] plan welfare services, and the public sector [thought] 'commercially' (p. 144). She argued that PPP was carried out by policy networks that were shaped primarily by the interest of banks, construction sector and private service managers. Aldred further suggested that the long-term contracts of PPPs consolidate the interests and cash flows of such networks within the public health service provision and decrease the governments' radius of action through bounding them in complex contractual arrangements.

3.9 Conclusion

In light of the findings discussed in this chapter, one should emphasize that this discussion over the policy transfer network does not imply a diminishing role of the state in policymaking. Rather, it suggests that there is an increasingly emerging pattern of state in network with other political agents including non-state market actors and international institutions.

Within unprecedentedly globalizing world, any research that studies the shifts in policy changes and transfers should take into account both internal and exogenous factors shaping the relations, interdependences and interlinked motivations of actors within these policy circles. Building on this idea, I first focused on the new public management reforms directed at the healthcare policies as a response to the 'welfare state crisis' and some contingencies of the healthcare systems departing from the broader context of welfare state. I demonstrated that the reform initiatives spread

across the globe through similar policy agendas with the influences of the knowledge institutions and the leading governments. These so-called 'contagious' reform agendas have proliferated the inclusion of private sector in both publicly and privately dominated healthcare systems, differing according to the path-dependent institutional contexts and different regulatory attempts of governments. Increasingly globalizing world, changing patterns of world trade regimes and growing influence of international and regional institutions were also major factors in shaping and determining the evolution of healthcare policies across the globe. Beginning from the 1980s, given that healthcare has proved to be very profitable sector for capital accumulation due to the rising trend of commercialization and marketization, the economistic language and the market ideology have shaped the perceptions of senior healthcare officials of governments and other important health policymakers.

In the abovementioned process, commercial actors investing in medical technology, pharmaceutical industry, support services, direct providers and health insurance companies have searched for the ways to influence the reform agendas to pursue their interests. Public-private partnerships have come to the scene in this context, which in turn furthered the interests of the market actors in the public health systems without a need for direct privatization.

What PPP brings forth cannot be explained simply as rising influence of private actors on the public sector. As the preceding literature has suggested that it is the changing organization of welfare and healthcare provision that consolidates the private interests and their voices on the public policymaking.

Against this background, the next chapter scrutinizes the context within which PPP has been added on the agenda of Turkish healthcare policymakers and through what political processes it is transferred and implemented into the Turkish

health political context. Next chapter traces the roots of the emerging links between the private and public sector in the healthcare provision in order to lay the basis for the implementation of 'the PPP city hospital project' that have arrived in the Turkish scene very recently with much fanfare. The research tries to shed light on the following questions: First, through what kind of policy network and what motivations of the actors involved in this network, PPP paradigm is transferred to Turkish health care provision? Second, what are the political dynamics behind the introduction of public-private partnerships in healthcare provision in Turkey and how do different actors perceive, contribute or resist the introduction of public-private partnerships in health care provision? The thesis will draw mainly on Evans and Davies' (1999) comprehensive research framework of 'policy transfer network' along with Stone's (2004) threefold actor analysis within these networks: states, international institutions and non-state actors.

CHAPTER 4

TRANSFORMATION OF TURKISH HEALTHCARE: FROM 1945 TO THE HTP

In the previous two chapters, I have discussed the main elements of the implementation of the PPP model in healthcare in general. From this chapter on, I will focus on the Turkish context. As a start, this chapter will examine the Health Transformation Program that was implemented as the major first step of the promises of the JDP in the field of healthcare. In doing this, the chapter will start by the neoliberal transformation, along with economic, social and political developments and developments in healthcare from 1945, the beginning of the post-World War II era, to 2002, the year the JDP won the elections and formed a government. This will provide the background that paved the way for the introduction of the HTP, which contained elements that were very similar to the decades-old proposals of reforming healthcare. These will be followed by the exploration of the content of the HTP and its results. The chapter will then move on with the policymaking processes, including the included and excluded parties, the government's strategy in successfully implementing the reform package, and the impact of international actors in the reform process. The chapter will be concluded by the presentation of different viewpoints about the content and results of the reform as well as how it was implemented.

4.1 Setting the frame for the HTP: From the 1945 to 2002

Turkish political and economic context in the aftermath of the Second World War was reflected in the developments in the Turkish healthcare system. As indicated by the policymakers and can be observed from the developments in the stated period,

the Health Transformation Program has its roots in the general political environment concerning Turkey and changes in the country's healthcare system since 1940s.

Turkey established three-pillar occupational status-based social security scheme in 1945, 1949 and 1971 respectively. In addition, starting in 1946, the Ministry of Health and Social Affairs undertook an active position in healthcare provision, which was extended to cover administration of public hospitals in 1961. The policy stance that gave way to these developments were reflected in the FYDPs starting in 1960s (Atun, et al., 2013, p. 68). On the other hand, one of the most important developments pertaining to healthcare policy is the 'socialization' of healthcare services. In this regard, the constitutional basis for socialization was provided by recognizing provision of healthcare services as one of the main duties of the state in 1961 Constitution (Republic of Turkey, 1961a, Article 49). Starting from this, the scope of socialization was expanded to cover universal access to primary healthcare services, and integrated provision of preventive and curative care services (Republic of Turkey, 1961b). Günal (2008) argued that socialization of healthcare services was a decision informed by the global practices at that time, including developments in Europe in terms of healthcare provision and welfare state (p. 203).

Approaching the 1980s, the ISI policy of Turkey was raising concerns. The economy's dependence on foreign exchange inflow to sustain the ISI policymade it vulnerable to external shocks and required the country to seek loans from abroad. The IMF and other international financial organizations provided loans in return for a series of stabilization programs. The failure of the 1978 Ecevit government to undertake the program worsened the state of the economy (Orhon, 2009, p. 53). After the Justice Party's electoral victory in 1979, high-ranking bureaucrat Özal negotiated a new loan agreement with the IMF and the World Bank. As a result, a set

of structural reforms, referred to as the 'January 24 decisions', were declared, transforming the country's economic policies towards a neoliberal approach. As part of this approach, the state imposed budgetary cuts on social services, and encouraged private and non-governmental organizations to take part in the provision of social services, believing that emerging market structure would bring competition, and thus higher levels of aggregate benefit.

These developments were followed by the 1980 coup and the military administration assumed government. However, this event did not change the economic route of the country, as the framer of the January 24 decisions, Özal, was appointed Deputy Prime Minister for Economic Affairs in the interim government and led the economic program, including carrying out the stabilization program agreed with the IMF. During his two years of incumbency, which was followed by his election as the civilian Prime Minister, policies of marketization were implemented, including trade liberalization, reformation of state economic enterprises and loosening of the strong state regulation over the economy (Öniş, 2004, p. 119).

The healthcare services, which "began to be referred to as 'the health sector' after the 1980s" were directly affected by this shift in economic policies in Turkey (Yılmaz, 2017a, p. 203). The wave of liberalization which introduced bits of privatization, deregulation and decentralization in search for 'efficiency' founded a place in public healthcare provision (Orhon, 2009, p. 54). In this respect, the state started further supporting the development of private sector in healthcare in 1980s. In 1981, certain types of private healthcare investments were provided with customs tax exemptions, coverage of financing costs and investment deductions (Temel, 2003, p.

13; Orhon, 2009). The private sector was already present in the healthcare sector before 1981, but the introduction of significant incentives was a novel development.

Another paradigm shift in healthcare policy in this period was embodied in the formulation of the 1982 constitution. While the 1961 constitution gave the state the mandate to provide basic healthcare services as explained above, the 1982 constitution placed the state as a regulator and a supervisor in the provision of healthcare (Republic of Turkey, 1961; Republic of Turkey, 1982; Orhon, 2009, p. 57). As was the case in 1960s, this new approach regarding healthcare policy was reflected in the Fifth FYDP issued in 1984. In this FYDP, improving the efficiency of public healthcare institutions, expanding the coverage of social security, reformation of social security administrations and recovering of the actuarial balance of social security institutions were explicitly mentioned. In this document, support of privatization in healthcare was also declared as a policy objective notably with the following clause, which marked the first instance of a declared financial deregulation of private healthcare institutions:

> Private health institutions and hospitals will be encouraged. The fees charged in return for the services these institutions provide will be liberalized. On the other hand, healthcare services will be developed via service procurements by the public through contracts with self-employed doctors. (State Planning Organization, 1984, p. 152)

In 1987, the Basic Law on Healthcare Services was passed. With this law, the public hospitals were converted into public enterprises and their revenue models were redesigned to include the establishment of revolving funds. Revolving funds were composed mainly of the collection of direct payments from patients. The establishment of revolving funds aimed at granting financial and administrative autonomy to public hospitals. This was in line with the Ministry of Health's move in

1983 of extending the use of revolving funds and placing them as compensation of the cuts of MoH shares in the public budget (Kartal, 2009, p. 40).

Secondly, with the General Health Insurance, the Basic Law presented a change in financing of healthcare services with a social security system based on premiums collected from citizens, or social assistance organizations for the ones who are unable to pay the premiums (Orhon, 2009, pp. 59-60). Lastly, the law put forth the conversion of the status of health personnel to a contractual one, constituting a pay-for-performance incentive mechanism as an additional source of income for medical doctors.

While having brought critical changes, the provisions of this law were mainly not implemented until the HTP. This is due to challenges by high courts and delays in drafting by-laws for implementation. The most important challenge by courts was the decision of the Constitutional Court (1988) a year after the law was passed, which repealed a number of main mechanisms introduced by the law. In this regard, two of the repealed articles are relevant to our case. First, the Court declared unconstitutional the introduction of the pay-for-performance model (p. 116). Second, while the Court did not repeal the establishment of the General Health Insurance, it declared unconstitutional pooling of all funds in the existent pillars of social security without appropriate limitation on the executive power (pp. 112-113). As for the delays in implementation, with regard to the Constitutional Court's decision, Sarp, Esatoğlu and Akbul (2002) point out the lack of implementing necessary legal changes following the decision. Secondly, they note that the structure of autonomous public health institutions was not effectively realized due to non-issuance of necessary documents of framework, and financial and accounting infrastructures and plans, as well as the absence of a study on total quality management (p. 17).

However, this law is a vital legal source that has envisioned the main features of the HTP as an effort to increase efficiency in resources, decrease the burden of public hospitals from the public budget, and make the public hospitals market actors in the 'healthcare sector' competing with private actors (pp. 52, 70). Orhon argued that this was the expected end result of the liberalization policies of the Özal era in line with the demands of international financial organizations, particularly the IMF, and it "paved the way for the commodification of health care … during that era" (p. 58). This was also partially in line with the developments outside of the country; in 1980s, the concerns of inefficiency of state enterprises and the role of healthcare provision in increasing budget deficits led many governments change the balance between the public and the private actors in healthcare provision in favor of the latter (p. 70). This trend was driven by the impact of budget deficits with the lessening of cash inflows from international lenders, which then would result in applying to intergovernmental agencies such as the IMF and the World Bank. This path would lead to cutting social service budgets in an effort to fulfill the conditionalities of loan agreements with the IMF and the World Bank, which asked for spending cuts in return for the loans.

Turkey's experience of increased private activity in healthcare was different from 'direct privatization', and as Orhon (2009) put, was an instance of commercialization, including the public institutions in the market competition as autonomous enterprises (p. 71). The commercialization trend observed in Turkey mainly followed the New Public Management paradigm, which was described in the literature by Bailey and Davidson (1999), Aldred (2009), and Le Grand (1999).

The shift in Turkish economic policy and in particular healthcare policy have been highly influenced by the approach of the international financial institutions.

From the 1980s onwards, with the restructuring of the delegation of duties between the World Bank and the IMF, the World Bank started to actively engage in the Turkish social policymaking. The January 24 decisions were designed to meet the expectations of the World Bank and the IMF, and helped the government secure loan agreements with both institutions. Orhon (2009) argued that even though these loan agreements did not have healthcare-specific articles, the proposed changes in the economic environment constructed the link between changing economic policies and healthcare policies, as it was exemplified by the 1987 Basic Law on the Healthcare Services (p. 69). The policy advises and dictations of the World Bank and other international organizations resulted in their more active involvement in Turkish health policymaking in the following decades.

In 1989, the Turkish government signed the Health Project Loan Agreement with the International Bank for Reconstruction and Development, which included proposals such as further inclusion of the private sector in curative healthcare services -which happened to be more profitable than preventive services-, further autonomization of public hospitals, shifting the burden of social security premiums to employees, and privatization and marketization of social security funds (Soyer, 2003, p. 312). This agreement was indicative of the developments in healthcare in the 1990s.

The 1990s was an important period for setting the frame for the transformation in the healthcare system in the 2000s. This was a difficult decade for Turkey, during which it suffered from continued economic and political instability. The wave of liberalization in the 1980s were not supported by structural reforms, which rendered the economy vulnerable to external shocks generated by the international economic and financial turmoil in the 1990s (Macovei, 2009, p. 32).

Thus, the 1990s was a decade of turbulent macroeconomic indicators, and ended with the 2001 financial crisis that stemmed from the unregulated and insolvent banking sector. In addition, the continuous changes in governing coalitions, as well as the strength of policy disagreements between coalition parties, did not help but aggravated this situation. An example related to our case would be that the Minister of Health changed for nine times during the decade. Additionally, the 1994 financial crisis and its aftermath resulted in further dependence of Turkey on loans from international institutions, and the subsequently increased impact of these institutions on the economy and policymaking. This increase in the impact of these institutions provided the platform for budgetary cuts especially to decrease the "'burden' of social transfers" (Ağartan, 2008, p. 214). Thus, the increased impact of the bad economic outlook on the citizens' lives was supplemented by the decreased social spending.

Making a comparison between the actors involved in processes of social policymaking in the 1980s and the 1990s, Ağartan (2008) states that in the 1990s, while civil society input was strengthened, civil society actors was mainly the "political elite who initiated reform attempts with the growing support of international policy actors, most notable being the World Bank and the IMF" (p. 221). In terms of healthcare policy, one of the most prominent civil society actors was the Turkish Medical Association. The limits of its organizational and financial capabilities, its involvement in social issues including the ones untied to the medical profession, and its unpopular image among the medical professionals and the society at large are coupled by the political institutional setting and limited its prospects of being involved in policymaking (p. 226).

The preparation and signing phases of the Health Project Loan Agreement, as well as feedbacks received from both the World Bank and the World Health Organization set the tone of the attempts of healthcare reform by the Ministry of Health and State Planning Organization in the early 1990s. Especially the milestone event in the formation of Turkish healthcare policy, the First National Health Congress, convened in 1992 to discuss the "draft document which was prepared by integrating the committee reports, various options, policy experiences of other European countries, and the advices of the WHO" (Ağartan, 2008, p. 253). In this event, the TMA (1997) voiced its concerns about the government's approach to the problems on which the association agreed, and questioned the intentions of the MoH to solve the existing problems in the system, which led to the worsening of the already tense relations between the two parties (p. 254). In addition, preparation of the Master Plan Study on Health Sector in 1989 by Price Waterhouse Company, contracted by the State Planning Organization, and the consequent preparation of a 'National Health Policy' document by the Ministry of Health in 1993 created the environment that shaped the content of discussions and policy documents (p. 251).

Even though the newly drafted health policy framework did not result in a policy reform at the time, the recommendations listed as part of this framework had important insights that affected future policies, including:

- Establishment of a GHI by the merger of the existent social security institutions
- Creation of the family medicine within the primary healthcare services
- Granting of administrative autonomy to hospitals
- Establishing a purchaser-provider split, mandating the Ministry of Health mainly with regulation and supervision, as well as providing preventive

healthcare services (Ministry of Health, 1993, pp. 47, 52, 59, 64; Bump, Sparkes, Tatar, & Çelik, 2014)

These proposals were in line with the principles of the New Public Management paradigm promoted by international actors. In addition, the pro-market ethos of these proposals largely resembles the Health Transformation Program, which will be discussed in the next chapter. Regarding the attempts for reform stated above, Kartal (2009) argued that they did not contribute to finding a solution to the problem of inequality in social security provision due to the basis of the existent social security scheme on occupational status (p. 41). The Green Card system was established in response to this problem of inequality as a safety net for the people who were not enrolled in the existing social security institutions. As explicitly stated in the law, the Green Card scheme was an attempt to offer a temporary solution to the uninsured citizens:

> The aim of this law is to cover the healthcare expenses of those citizens who are not insured by any of the social security institutions and who do not have the means to cover such expenses by the State until a General Health Insurance practice is established, and to specify the procedures and principles to be followed in this respect. (Republic of Turkey, 1992)

The scheme initially included only inpatient services; outpatient services were excluded. As of 2003, inefficient enrollment mechanisms resulted in the enrollment of about 3.77% of the population, while 9% of the population actually met the eligibility conditions (Aran & Hentschel, 2012, p. 7). Kartal (2009) argued that the Green Card scheme, as a means-tested program, was "far from the universalist citizenship based understanding", making visible the gap between the Green Card beneficiaries, the poor and the informally employed citizens, and the formally employed citizens (p. 94). On the other hand, Tatar et al. found that Green Card holders were making a significant amount of informal payments -higher per

capita than the rich and the employed- to physicians and for drugs due to the limited coverage the scheme offered. They also asked the beneficiaries about their reasons of interrupting treatment, and found that insufficient means was the main reason for 93.3% of the Green Card holders, while it was for 73.3% of the population enrolled in other social insurance schemes (Tatar, Özgen, Şahin, Belli, & Berman, 2007, p. 1038).

Another important step in the 1990s was the 'Social Security Reform Initiative' of 1999. This proposal included provisions such as universal coverage of social security, purchaser-provider split, introduction of family medicine, reconsideration of public healthcare service procurement from private providers and the like, which are in line with the reform attempts including 1987 Basic Law on Healthcare Services, 1989 Master Plan Study on Health Sector and 1993 National Health Policy. These ideas were in circulation for over a decade, and many of the proposals concerning healthcare were already included in the 1987 Basic Law. Although not implemented due to challenges by courts and non-implementation of necessary regulatory framework, the discussion process included a number of professional organizations including Union of Chambers and Commodity Exchanges of Turkey (TOBB) and TÜSİAD, and this action plan proposal and the discussion outcomes provided novel contributions to the Health Transformation Project (Ağartan, 2008, pp. 261-262).

In addition, Turkey implemented two major health projects with the World Bank in the 1990s, both of which had an aim to improve healthcare services delivery in rural regions through "restructuring the services provided by the Ministry of Health." In these projects, the World Bank emphasized the importance of repeatedly

stated three reform areas: “integrated health care system, family medicine and general health insurance” (Orhon, 2009, p. 88).

Until the early 2000s, private hospitals had limited capacity, were operating in large cities, and serving mainly to affluent people (Yılmaz, 2017a, p. 203). On the other hand, the relative boost of the private actors in healthcare in the 1990s should be duly noted, in line with the approach of the Turkish governments, as well as the advices of international organizations. Furthermore, at the wake of the new millennium, Turkish healthcare system had several deficiencies.

First, while the private sector had occupied a small portion of the healthcare provision sector, it had a significant role due to dual practice of medical doctors. Dual practice, as it was practiced in the Turkish context, referred to the practice of doctors employed at public hospitals to work part time in the private sector -at private hospitals or their own clinics-, which was a common practice, and was allowed by the state due to the inadequacy of compensation for medical doctors in the public sector (Erkoç, 2012, p. 21; Bump, Sparkes, Tatar, & Çelik, 2014, p. 2). While this practice indicates problems in compensation scheme of doctors, its implication of increased out-of-pocket payments had an important impact on the beneficiaries of public health institutions (Stokes, Gurol–Urganci, Hone, & Atun, 2015, p. 2). Secondly, the healthcare financing system was fragmented due to the multi-pillar social security framework based on occupational status. This was a source of inequality, as different pillars provided differential levels of access and quality of services for different premium and co-payment policies (Agartan, 2008, pp. 240-1). Furthermore, unequal regional distribution of healthcare facilities and human workforce, inadequacies in emergency service organization, insufficient levels of primary and preventive services and programs, increasing levels of drug

prices without necessary state supervision, problems in terms of placement policies and motivation of healthcare personnel, and lack of institutionalized patients' rights were crucial issues that paved the way for the formation of the discourse favoring the Health Transformation Program in the following decade.

4.2 The 'New Millennium' and Turkish health policy: 2000s and the HTP

> Until today, numerous studies and projects prepared with domestic and international participation have been put forth, and these projects were called as 'reforms. Though with different names, we are aware that this institution has hosted various projects with the same objective. That we do not speak of a reform comes from our awareness that we have not put forth a completely new idea. We, as the Ministry, need to assess the practices and quests of the civil world, and our expedient legacy. However, the failure of the previous studies that were presented with the aim of reformation to find an application ground has shaken the public's confidence. It is also not realistic to entirely terminate the existing structure and start transition to a new system. In order to realize the long-awaited change, the existing structure should be transformed towards the goal without harming it. We are committed to achieving this transformation. Therefore, by resuscitating the public's desires that have been reshaped as hopelessness, we hereby start a sequence of actions with a wide participation, in which all parties will embrace and take active role, and call it as the 'Transformation Program'." (Ministry of Health, 2003, p. 24)

In 1999, having suffered from high unemployment and inflation rates, the Turkish government signed a stabilization agreement with the IMF. The points of focus of this agreement, which shaped the economic policy of the country even after the governing parties changed in 2002 general elections, was restructuring of public finance and social security, as well as privatization. Hit by the outbreak of the financial crisis in 2001, a new economic program was prepared with the support of international financial institutions with an emphasis on reforming the public sector, encouragement of the private sector as the driver of growth, and the provision of social relief for the population segments that the financial crisis hit the most (Kartal, 2009, p. 41). This is the time when the New Public Management discourse became

more effective in Turkey, with the economic policies in line with the World Bank's policy recommendations for efficiency and value for money. Here, social security and health care were the budget items at stake.

When the calendars hit the year 2002, Turkey was in the process of a general election. With the popularity fall of the parties in the Turkish parliament and the rise of new parties, the general election in November was concluded with a parliament with two parties with a single party majority. The Justice and Development Party (JDP), the new governing party, was elected out of the discourse of the financial crisis and the need for change deeply felt within the society. With the adverse impact of the financial crisis especially on the poorer segments of the society, changes in healthcare system had a major potential for appealing to the masses. Thus, healthcare reform was one of the key topics of the JDP's electoral promises. Shortly after the JDP took office, an Urgent Action Plan was released, outlining the action plan of the new government within the first year of office vis-a-vis the enduring problems of the country. This plan included a recap of the healthcare reform attempts of the previous years:

- MoH will be restructured,
- All public hospitals will be united under a single umbrella, and public hospitals will be granted administrative and financial autonomy,
- Provision and financing of healthcare services will be split,
- General Health Insurance System and Institution will be established,
- The family medicine system and a sound referral system will be established, and maternal health, child health and preventive care will be on primary focus,
- Private investments in the health sector will be promoted,

- An integrated social security network will be established, different practices leading to inequalities will be eliminated, and
- The Social Assistance and Solidarity Fund will be strengthened in terms of financial and administrative capacities. (State Planning Organization, 2003, p. 11)

These vague provisions constituted the main framework of the Health Transformation Program. Here, the restructuring of the MoH, autonomization of public hospitals, purchaser-provider split, encouragement of private investments, and implementation of a pay-for-performance remuneration model for state doctors were key elements that set the foundations of the HTP around the general principles of the New Public Management paradigm. In this regard, Kartal (2009) argued that the policy stance of the government especially concerning the HTP were "formulated … not with social concerns, but with imposed managerial logic" (p. 42).

An OECD (2009) report suggested, "the HTP's objective [was] to make the health system more efficient by improving governance, efficiency, user and provider satisfaction, and long-term fiscal sustainability." (p. 44) The same report listed down key features of the program as follows:

1. Redefining the role of the MoH as a steward, or a planning and supervising authority,
2. Establishing single and separate institution for healthcare purchasing and a separate union of public hospitals, responsible for provision,
3. Establishing a single institution for financing, namely Universal Health Insurance, that is a merger of the existing three social security institutions as well as the Green Card scheme, with an aim to cover the entire population,

4. Improving delivery, accessibility and service quality of healthcare, enrollment in quality and accreditation programs to ensure these,
5. Developing personnel motivation and qualifications,
6. Creating institutes to support the new health system,
7. Introducing mechanisms to ensure rational use and management of drugs, materials and devices,
8. Establishing Health Information System to support decision-making (p. 12).

The HTP offered solutions to a wide range of aspects that the health sector and its beneficiaries suffered beforehand, ranging from financing and provision to administration and human resource management. The HTP transformed the financing aspect of healthcare services by moving from a dispersed framework to a centralized financing mechanism, in an effort to solve the coordination problem. In this regard, the previously low coverage rates of the former social security system were solved with the introduction of the GHI, which extended coverage to the entire society. Lastly, problems of access to and quality of healthcare services were addressed within the HTP (Memişoğlu, 2016, p. 65).

Improving access to healthcare was an important aspect of the HTP's promise of universalism. In this regard, the provision of free healthcare at public hospitals or facilities to children under the age of 18, as well as for primary care and pre-delivery maternal services was introduced. In addition, an incentive mechanism was designed to attract those who had standing debts to the insurance funds to pay these and return to the enrollment to the GHI.

A notable feature of the HTP is the practice of co-payment, in which patients pay a fee for the healthcare services they receive at public health institutions in kind of out-of-pocket payments. In addition, while the GHI covers certain medications, in

many cases generic drugs are entirely covered, while 'more expensive' licensed drugs require payment of a partial contribution by the patient. This raised questions about the extent of universalism envisioned by the HTP, which was pointed out by Ağartan (2012) as "the financing dimension, especially the scope of co-payments, should be examined more closely to assess the extent of universalism" (p. 464)

Ağartan further explained the second main component of the HTP besides universalism, i.e. marketization. The HTP, she argued, transformed the boundaries between the public and the private actors. With the gradual drop in the MoH's involvement in the healthcare sector with the autonomization of public hospitals and the purchaser-provider split, the transformation of the MoH into a regulatory and supervisory body, the HTP brought a certain degree of marketization to the healthcare sector (pp. 466-7). Another feature of the HTP that supported the move towards marketization was the introduction of a pay-for-performance remuneration scheme. While it was voiced for decades, even in the 1983 Basic Law on Healthcare Services, it had not been implemented due to court challenges and regulatory delays. As part of the HTP's initial phases, this scheme was implemented in 2004, and has been argued to have introduced private sector managerial techniques and profit orientation to public healthcare institutions, which is a major component of the NPM proposals (Pala, 2018, pp. 107-110; Özkal Sayan & Küçük, 2012, p. 188). This scheme has restructured the remuneration model such that health professionals, mainly doctors, will earn according to the number of cases they deal with and other quantitative metrics.

While out-of-pocket payments were among the problems that the HTP was supposed to address, the top-up payment scheme -explained below- seems to have led to a drop in out-of-pocket payments, from 29.94% in 1999 to 17.38% in 2017

with an increasing trend in the recent years, as can be seen in Figure 2. While this drop of 12.56 percentage points in 18 years is significant, it remains high considering the premises of equality in access to healthcare services and the GHI with universal coverage.

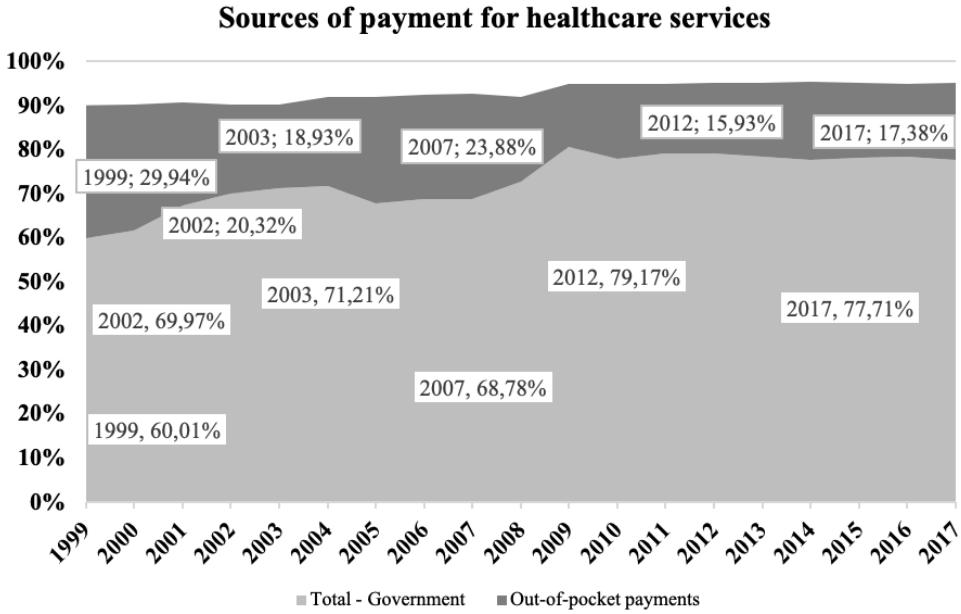

Figure 2. Sources of payment for healthcare services

Source: TURKSTAT, n.d.

There are two components of the HTP that are worth mentioning in detail, i.e. restructuring of the MoH, and the establishment of the GHI with coverage of private hospitals.

With the aim of transforming the MoH into a regulatory and supervisory body, two autonomous bodies were formed. First, Public Hospitals Institution was established in 2011 as the umbrella organization of the public hospitals, which were granted administrative and financial autonomy. This was coupled with the establishment of public hospital unions (Republic of Turkey, 2011, Article 26). This governance structure was to ensure the financial accountability of the autonomous public hospitals. Six years later, as a setback from the autonomy-accountability duo,

the autonomous umbrella organization was replaced by a dependent directorate called the General Directorate of Public Hospitals (Republic of Turkey, 2017, Articles 184-194). Secondly, Turkish Pharmaceutical and Medical Device Agency was formed as the regulator and supervisor of the pharmaceutical and medical device markets, in response to the problem of market-dependent floats in drug prices (Republic of Turkey, 2011, Article 27; Bump, Sparkes, Tatar, & Çelik, 2014, p. 3).

With the second component, the government included visits and treatments in private hospitals in the coverage of the GHI, which was the realization of the government's ambition to promote private involvement in healthcare provision. The enrollment structure of private hospitals is open to all volunteering hospitals and other private healthcare institutions. As part of the enrollment, the SSI annually decides on and declares fees set for each operation, and pays that amount for the visit of an insured citizen. In addition, the hospitals are allowed to charge top-up payments within the cap determined based on the ranking of the facility by the MoH (Yılmaz, 2017a, pp. 204-5). While this practice of top-up payments resembles the co-payment scheme at public hospitals, they have created different implications. While the latter was, as Ağartan (2012) pointed out, was an area that does not conform with the stated intent of universalism in the HTP (p. 464), the top-up payment scheme for private healthcare provision expanded the target population of these private providers, and have had a significant impact on the design of private healthcare institutions. This structure, Yılmaz (2017a) argued, had created a private health market with two main groups of actors: those enrolled in the GHI and mainly serving the population under this scheme, and those having decided not to enroll and thus serving to affluent sectors of the society (p. 211). He highlighted the dependence of the first group of hospitals on the GHI, which allowed for power asymmetries and

cases of discontent when the government attempted to impose limits to their growth and revenues (pp. 221-6). In addition, he argued that this scheme led private hospitals to seek further benefits from the economies of scale, having resulted in the proliferation of large domestic and foreign hospital chains and a series of mergers and acquisitions within the sector (pp. 212-3).

Both of these trends, i.e. the restructuring of the MoH as a regulatory and supervisory authority, and the coverage of private hospitals in the GHI, contributed to an increasing trend in private sector involvement in healthcare provision. As can be seen from the Figures 3, 4 and 5, from 2002 to 2013, the number of private hospitals doubled and the number of hospital beds in private hospitals tripled, while the same metrics for public and university hospitals did not go through such a boom. In addition, the number of qualified beds in all types of hospitals significantly increased.

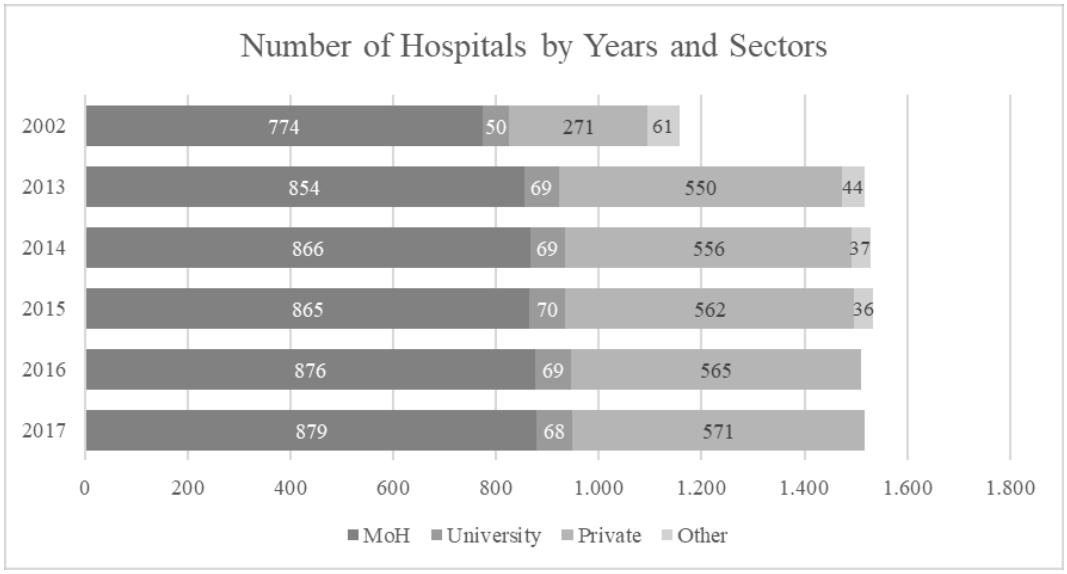

Figure 3. Number of hospitals by years and sectors

Source: Ministry of Health General Directorate of Health Information Systems, 2018, p. 113

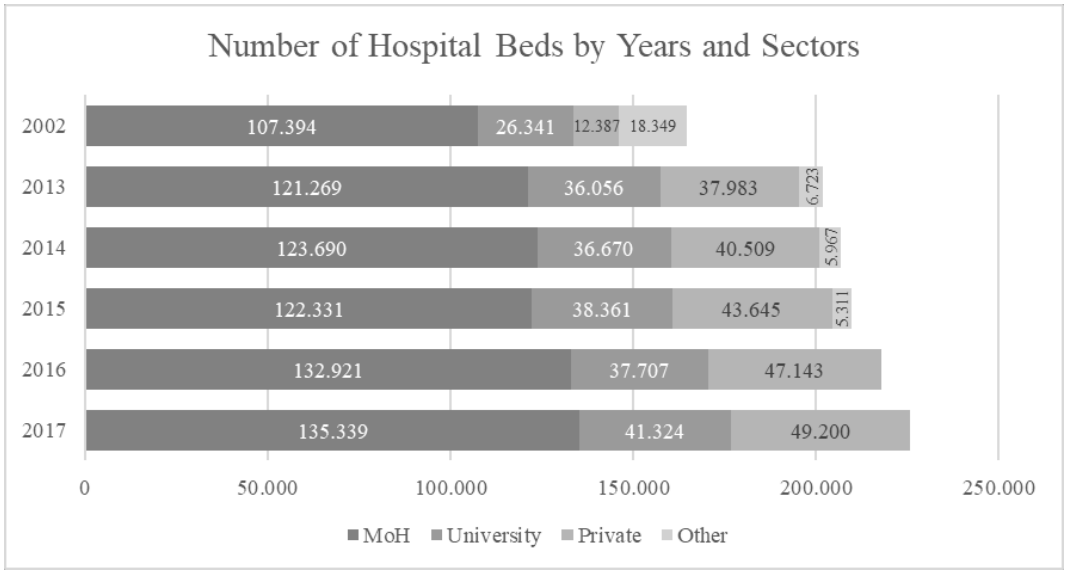

Figure 4. Number of hospital beds by years and sectors

Source: Ministry of Health General Directorate of Health Information Systems, 2018, p. 113

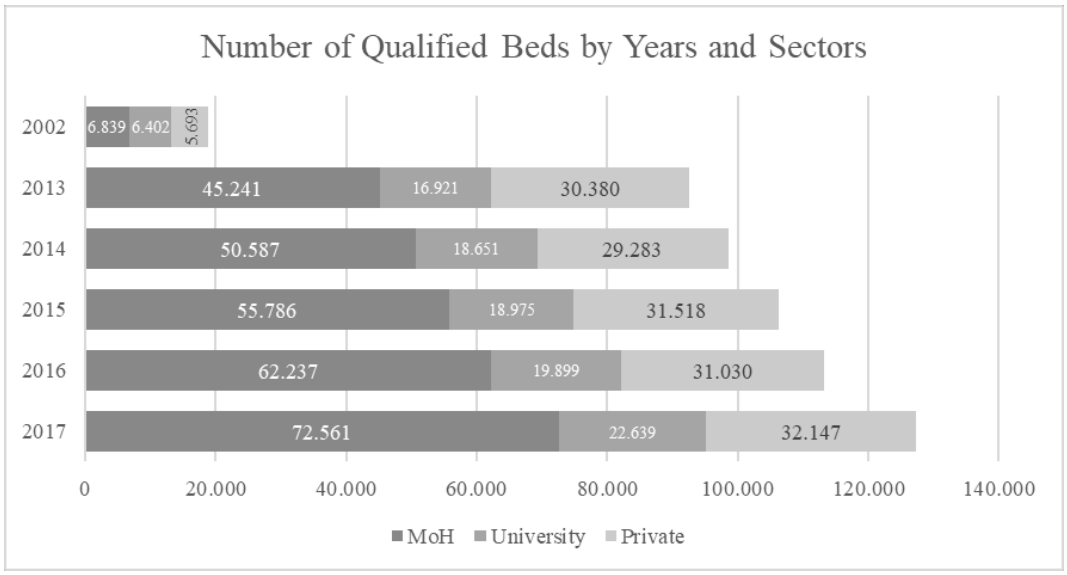

Figure 5. Number of qualified beds by years and sectors

Source: Ministry of Health General Directorate of Health Information Systems, 2018, p. 114

When we consider the ownership of medical equipment that could be taken as an indicator for the technological investment in hospitals, we see in Table 4 that the numbers of equipment per hospital are not significantly different between public and

private hospitals. An interesting result is the same metric for university hospitals, which is more than double of public and private hospitals. Considering that the category 'university hospitals' includes hospitals affiliated both to public and foundation universities, this might mean that the number of equipment per hospital is high at university hospitals because i) their training mission requires such an investment, and/or ii) the revenue from providing monitoring services using such equipment is worth the investment.

Table 4. Hospital Equipment Figures Based on Hospital Types

	MoH-affiliated	University-affiliated	Private	Total / Aggregate
Total Number of Equipment	8,520	1,721	5,572	15,813
Percentage of Number of Equipment for Hospital Types	54%	11%	35%	100%
Total Number of Hospitals	879	68	571	1,518
Number of Equipment per Hospital	9.69	25.31	9.76	10.42

Source: Ministry of Health General Directorate of Health Information Systems, 2018, pp. 114, 127; own calculations

One aspect of the rise of private healthcare provision is the liberalization route that Turkey has been undertaking since 1980s. Especially with the membership to the WTO and the signing of the GATS, Turkey committed itself to opening its healthcare market, along with other service sectors, to foreign investors.

Another aspect of the rising availability of private hospitals is the parallel rise in their accessibility. Once facilities serving mainly to the affluent population, private hospitals have now been affordable for a larger portion of the population with the coverage of the GHI. In addition, the figures above should also be considered in line with the patients' demands for the adoption of new medical technologies, which Ağartan (2008) noted as a potential reason for the shift towards private healthcare facilities (p. 82).

Defining which type of privatization this rise of the involvement of private actors in the health sector is a form of privatization has widely been discussed among scholars. Among these scholars, Soyer (2007) considered the program as a privatization project with regard to the GHI's coverage of private hospitals and subsequent transfer of public resources to the private sector (pp. 90, 105). Differentiating between the strategies of 1980s and 2000s, Orhon (2009) classified the HTP as a form of privatization as opposed to the wave of commercialization in the 1980s (p. 127). In this classification, Orhon referred to two trends: i) the build-lease-transfer model envisioned in the law on transferring SII facilities to the MoH, and ii) the rise of private investments in the health sector (pp. 116, 127). On the other hand, Yılmaz (2017a) considered the privatization that the HTP adopted as a form of 'passive privatization', which referred to allowing the private sector to invest further in healthcare provision mainly to serve larger segments of the population through the GHI. He also argued that treating the private actors in the health sector as a homogeneous body was misleading and limited the scope of analysis, as this disregarded the divergences among the private actors and the conflicts that they had with the government (p. 218). These discussions are also relevant in an analysis of the city hospitals, which refers to a public-private partnership (PPP) model in establishing new healthcare facilities and healthcare provision. The next chapter will provide an extensive analysis of the city hospitals.

4.3 The policymaking process of the HTP

On the side of the JDP, a number of factors drove the formation process of the HTP. First of all, the 'conservative liberal' rhetoric of the party that brought together the elements of universalism and marketization aligned well with the wave of

liberalization in the previous decades, and the party stated its intention to continue with the economic principles set by the IMF agreement, and even move further (Ağartan, 2008, p. 282). Ağartan (2016) noted that the HTP was an effective implementation of examples from other countries and policy ideas of multi- and international actors. These lessons were utilized by the political leaders and the reform team in the process of the discourse formation (p. 13). On the other hand, the arguments that contribute to the electoral success of the party in 2002 were based on the failure of previous governments in providing welfare to the public. In this regard, healthcare was among the most prominent aspects of the party's electoral promises. Bearing in mind the government's alignment with the guidelines of international organizations and the prominent role of healthcare in JDP's electoral victory, the policymaking process should be analyzed for domestic and international actors respectively.

The domestic part of the policymaking process was driven by the established policymaking culture. As was the case for many decades, the policymaking process of the HTP happened without active involvement of the related civil society actors and political opposition, except for professional organizations such as TÜSİAD, TOBB and OHSAD, and without taking their concerns into consideration when they are involved. Even though the civil society, particularly the TMA, offered their standpoint during the discussions on the related draft law in the parliamentary committee, their opposition towards many of the main components of the program, with a vocal stance against shifting the burden towards the citizens and commercialization of healthcare, were not taken into consideration (Ağartan, 2016, pp. 7-8). The cleavage that the World Bank argued to be "'ideological' in nature, taking the form of state-centered vs. market centered", in fact, led to a deterioration

of the relationship between the main representative organizations of the health professionals and the JDP government (Rossetti, 2004, p. 6; Ağartan, 2015, p. 1623).

Bearing in mind the top-down nature of the policymaking process, Sparkes et al. (2015) argued that the "key explanatory variable in determining Turkey's outcome was not how institutional veto points structured interest group influence", but "was how these institutional veto points structured the strategic actions of Minister Akdağ to promote the adoption of his desired policies" (p. 272). In this regard, Akdağ and the reform team utilized the political and economic discourse that had recently led them to a novel electoral victory.

First, Akdağ focused on getting quick-win solutions via administrative acts in coordination with other ministries, which helped him overcome possible parliamentary and presidential opposition, and rapidly aggregate popular support for the reform with elevated levels of satisfaction from healthcare services in the initial years (Turkish Statistical Institute, 2003). When it came to needing legislative acts, he made sure that the legislation would enable flexibility through administrative decisions in major topics. Secondly, he extended this inter-ministerial coordination into cooperation via a working group with the participation of high-level bureaucrats from relevant ministries, and laid out group principles based on solution-orientedness, in an effort to eliminate possible bureaucratic resistance and display his emphasis on a solid technical design of the reform instead of political discussions. Thirdly, he agreed to amend some provisions such as the retrospectivity of the increase in retirement age so as to eliminate legal challenges by the Constitutional Court. Lastly, he leveraged the power and support of Prime Minister Erdogan in making sure to overcome the residual risk of bureaucratic or in-party resistance (p. 273).

Unlike domestic actors other than the government, international organizations had a large level of influence over the design and implementation processes of the HTP. In designing the HTP, JDP administration, government and bureaucracy have explicitly stated their commitment to the principles and guidance of international organizations, which seems to be in favor of the existence of the influence of epistemic communities as Adler and Haas (1992), Beyeler (2004) and Goodman (2002) conceptualize.

A very strong evidence of Turkey's alignment to epistemic communities can be found in the guide prepared by MoH on the Program in December 2003, where the MoH (2003) stated that it would take into account the WHO's 'Health for All in the 21st Century' policy, the EU's Accession Partnership Document for Turkey, the need for amendments to the Turkish health regulations in compliance with the EU health regulations, and other international lessons (p. 26).

The influence of epistemic communities on the Turkish reform was also seen in the documents of international organizations. First of all, as an external party that had been actively providing funding and guidance to Turkey on matters concerning health policy, the World Bank (2005) indicated that the emergence of the will to reform in Turkey resulted in development in matters that the World Bank prioritized for Turkey (p. xi). The World Bank especially praised the will of the JDP government in reforming healthcare and embracing the previous reform proposals as their own reform project (p. 48). In another report that focused on assessing the health sector in Turkey, the World Bank (2003) offered an extensive review of the problems of the Turkish healthcare system and a comprehensive framework for reform, providing the World Bank's view and lessons from similar attempts in other countries.

Secondly, the profiles and backgrounds of the key members of the HTP reform team and the World Bank team are important to consider in such an analysis. Rifat Atun, Meltem Aran, Ipek Gurol and Sarbani Chakraborty took active part in the Health Transformation Program on both sides, namely the MoH and the World Bank. Atun served as a consultant and an advisor, Aran and Gurol served as analytical consultants, and Chakraborty served in the World Bank team. Their educational backgrounds and academic affiliations, as well as the novel article that they published along with then-Minister of Health Recep Akdağ and former MoH deputy undersecretary Sabahattin Aydin aligns with Lee and Goldman's description of the epistemic communities in health policy. Here, Atun and Chakraborty's assignments in the World Bank, as well as Atun's assignments in the WHO and the UK Department for International Development supports this description.

4.4 Considerations about the outcomes of the HTP

Such an impactful transformation in the Turkish healthcare system has received major scholarly attention. A team of people actively involved in the HTP process, i.e. Atun et al. (2013), published an article on the Lancet Global Health, a reputable journal on health policy, where they assessed the HTP extensively. They gave credit to the previous efforts and desires that had dated back 60 years, which they argued to have facilitated the HTP's capacity to achieve its targets. At a point in time when most of the reforms envisioned by the HTP were achieved, they highlighted the importance of focusing on sustaining the achievements especially of the GHI. The article seems to be prepared as a 'project closure report' as used in business projects. The report was concluded with a 'lessons learned analysis' with the following key points (pp. 95-96):

- With the creation of a “receptive context”, the reforms were perceived by the society as appropriate and timely interventions.
- The legitimacy of and public support to the HTP was furthered with the program’s emphasis on right to health vis-a-vis the demands of the public for development in fundamental rights.
- Political stability via the governing party’s holding a majority of seats in the parliament, strong leadership of Prime Minister, the Cabinet and Minister of Health, and the presence of a dedicated team of bureaucrats within the MoH helped the project be rapidly executed and have a corporate backing.
- Economic growth and stability provided public funds necessary to invest in social areas, which allowed the government to extend the coverage of the Green Card scheme and establish a GHI system. Also, the decrease in unemployment resulted in an extended coverage of the mandatory insurance.
- The success of the program owes to the 10-year-long service of the dedicated reform team.
- Rising figures of satisfaction from healthcare services resulted in an increased legitimacy of the project, a strengthened MoH within the Cabinet, and resulted in subsequent electoral gains.
- An effective feedback mechanism based on continuous inputs from the field, focus group studies and surveys, coupled with a flexible approach in the project scope allowed the implementation of strategic and structural developments along with tactical developments with immediate results in beneficiary satisfaction.

- Rapid implementation of the policies had been a key success factor, not allowing organized reactions and making it easier to overcome bureaucratic challenges.
- Comprehensive changes implemented in the healthcare system as part of the project were instrumental in increasing access to healthcare services, especially for the disadvantaged segments of population.

A group of TMA members published responses to this article, criticizing the prevalent optimism in the report. Aksu, for example, argued that the working conditions of doctors worsened with the HTP, with significantly lower remuneration with the performance-based pay scheme, skyrocketed number of patient visits per day, and increased work hours (Aksu, 2014, p. 28). Elbek (2013) focused on the outcomes the performance-based pay scheme. He mentioned that from 2005 to 2010, while the numbers of inpatient and outpatient visits, diagnostic tests, and other procedures substantially increased, academic studies dropped by 44%. He evaluated these trends as indicators of erosion in professional ethics, acting for profit in service provision, invasion of the right to receive qualified health service while consumption of health services scaled up (p. 414).

On the other hand, Ağartan (2012) considered the HTP as an instance of a major transformation in the state's role in a service line where the state had previously enjoyed near monopoly. While the state maintained an active position as a regulator and supervisor, Ağartan mentioned the JDP's "faith in markets to deliver services more efficiently", which resulted in the encouragement of private involvement in the provision of healthcare services (p. 467). This encouragement did more harm than good to the regional inequalities in healthcare provision, thus rendered the program unsuccessful in establishing universalism in access (p. 468).

Yılmaz (2013) brought forward another perspective about the impact of reform on access. He argued that the changes that were implemented with the HTP did not eradicate inequalities, but changed their source. The previous social security system was based on the occupational status of the citizens, which defined the hospitals they could visit, the amount of contributions they needed to pay, and the amount of coverage they received in return. With major reforms in healthcare financing, provision and market regulation, Yılmaz argued that once based on occupational status, the inequalities were transformed to be income-based. With the unification of all public hospitals under the MoH, as well as the establishment of a single social security institution and merging the preexisting four schemes under that institution, the discrepancies in coverage and service quality were eradicated (pp. 65-67). However, five features of the HTP that Yılmaz referred to introduced the transition of the basis of inequalities from occupational status to income.

> 1) continuity in social insurance-based health care finance structure and the introduction of stringent income means testing; 2) the introduction of contributory payments for hospital visits in both public and private hospitals and medications; 3) the introduction of additional payments for private hospital visits; 4) the establishment of link between the quality of health care services and levels of contributory and additional payments, and; 5) the definition of a basic benefit package for public health insurance alongside the introduction of supplementary (private) health insurance (p. 67).

Dorlach (2015) provided another insight on inequalities emerging with rising privatization in healthcare provision. While he argued that public healthcare services improved in an egalitarian way, he highlighted that private services skyrocketed in the reverse way. Thus, he considered the Health Transformation Program and the general health policy of the JDP as having created a new form of dualism. Previously, the problem with healthcare was the occupational status-based inequality, embodied by the existence of different social security institutions and the provisions of each institution. With the HTP, this was transformed into inequalities

in coverage and quality of healthcare provision: “egalitarian provision of basic public health services of low-to-medium quality coupled with inegalitarian access to private health services of medium-to-high quality” (p. 529).

4.5 Conclusion

Bearing in mind the role of healthcare in Turkish political arena, a discussion of policy transfer in the city hospital program should start with the discussion of the prior policies on healthcare provision and its commercialization. Turkey has attempted to establish and then reform its healthcare system in every decade, especially since the 1960s. Post-1980s neoliberal economic transformation fundamentally shaped the healthcare policy trajectory in the following years. The loan agreements with international financial institutions and related economic shifts towards marketization and liberalization directly affected the country’s approach to healthcare.

The problems of inequality and the generally low level of service provision in healthcare system were major policy issues that governments and bureaucrats faced in those times. Coupled with the global economic turmoil and the financial crises the Turkish economy underwent, the discourse of ‘welfare state crisis’ emerged as a driving force towards the New Public Management reforms in healthcare provision. Despite not being implemented, the healthcare reform proposals in the 1980 and 1990s repeatedly included restructuring the MoH as a regulator and supervisor, granting of autonomy to public hospitals, and establishment of the GHI with the merger of the existing social security institutions. These proposals emerged out of the interplay of the state, international organizations and non-state actor, as outlined by Stone (2004) as the main actors involved in the policy transfer process, and also

marked the preliminary instances of the policy transformation that has led to the city hospitals (p. 545). In this regard, the state followed the discourse of 'welfare state crisis' in its effort to initiate neoliberal economic transformation vis-a-vis the financial volatility present. This position of the state is deeply tied to the stances of the other two groups of actors. International organizations such as the IMF, the World Bank and the European Union offered recommendations in both coercive and voluntary forms. While the European Union's recommendations were part of the accession negotiations, and thus were in a relatively voluntary form, that of the IMF and the World Bank were presented in a coercive form as conditionalities for the loans offered. Loans and attached structural adjustment programs were these forms of coercive transfer. Moreover, major health projects with the World Bank especially in the late 1990s were significant in this regard.

Increased private activity is relevant here with regard to the policy transfer approach. The encouragement of the private sector involvement in healthcare provision gained momentum in 1980s with the 1982 constitution, the Fifth FYDP issued in 1984, the 1987 Basic Law on Healthcare Services, and the elevated relationship and communication with the IMF and the World Bank. The emphasis of the governments in the post-1980 period until the introduction of the HTP was to commercialize the health sector by involving public health enterprises into market competition, in line with the development of the New Public Management paradigm. The Master Plan Study on Health Sector published in 1989 exemplifies the prominence of international financial institutions in domestic policymaking. In addition, the inclusion of non-state actors provided significant input to this transition, with PwC's preparation of the 'Master Plan Study on Health Sector' of 1989 and contributing to the health policymaking process in that period. This role of PwC was

an instance of the Turkish bureaucracy's lack of necessary expertise and knowledge for framing their health policy reform. The content of the proposals of PwC, which were in line with the guidance of the mentioned international organizations, indicates the applicability of Stone's (2004) argument about the commercialized mode of transnational policy advice played by the non-state actors (pp. 555-7).

The global economic outlook and the vulnerability of Turkish economy rendered 1990s a hard decade for the country. Concluded with the 2001 financial crisis, the World Bank actively guided Turkey towards their new approach to healthcare provision, which was centered on universalism and marketization –as Ağartan (2008) observed-, ensuring embeddedness of healthcare in the market economy. Informed by the policies of international institutions including the World Bank and the World Health Organization, the 1993 'National Health Policy' was drafted. With provisions covering the establishment of the GHI, creation of the family medicine system, provision of administrative autonomy to public hospitals, establishing purchaser-provider split and restructuring the MoH as a 'steward', this policy draft contributed to the main themes of the Health Transformation Program. The introduction of the Green Card scheme in 1992 was an exception to the abovementioned trend, as it was created as an attempt to extend social security coverage to the segments of the society that were previously excluded from the social security system.

The late-1990s hosted the proposal of the 'Social Security Reform Initiative', which was an attempt to realize the 1993 'National Health Policy'. Although the initiative was not implemented, the discussion process it created helped civil society actors to get involved, and provided novel contributions that later informed the Health Transformation Program. Furthermore, major health projects with the World

Bank and signing of the GATS involved Turkey in the process of marketization of healthcare.

The Turkish healthcare system arrived the new millennium with problems including compensation of health professionals, multi-pillar framework of the social security system, unsatisfactory levels of social security coverage, mismatches in regional distribution of healthcare facilities and the like. The financial crisis in 2001 and its impact on the poor contributed to the elevation of the JDP to government and aggravated access problems in the healthcare system. In this regard, first, sharp devaluation of Turkish lira dramatically slumped the purchasing power of the population, which increased the burden of out-of-pocket payments of uninsured segments of the population. Second, the austerity policy adopted in an effort to overturn the adverse trend in the economy included severe cuts in public expenditures in social services, thus directly affecting the poorer segments (Dufour & Orhangazi, 2009, pp. 104, 119).

With healthcare as a top electoral promise, the JDP prioritized the issues in healthcare immediately after it took office. Building on the previous policy drafts and the ideas communicated by the international financial institutions, the Party commenced the Health Transformation Program in 2003, which was a revitalization of the long-awaited reform package. The Program mainly included restructuring the MoH as a regulatory and supervisory authority, granting autonomy to public hospitals, splitting the purchaser and the provider, establishing a General Health Insurance scheme with the merger of the existing multiple social security frameworks, creating the family medicine system, and taking measures to promote private investment in the health sector. Particularly with the restructuring of the MoH and including private hospitals in the coverage of the GHI, the market share of the

private hospitals rapidly elevated. This was followed by the trend of mergers and acquisitions in the sector as well as establishment of large hospital chains and a rise in the FDI inflow in healthcare. This also created a new form of relationship between private providers and the state, given that a significant part of the private providers has started to depend on the payments from the GHI. This rise in the private share in healthcare provision, on the other hand, has led to a 'passive privatization' in the Turkish healthcare sector (Yılmaz, 2017a, p. 218). On another note, the combination of a neoliberal approach characterized by increased private activity in healthcare provision, and popular appeal of the programs that appeal to the public's pain point of inclusiveness fits well the concept of 'neoliberal populism' as Akçay (2018) employs in explaining the general policy stance of the JDP.

On the other hand, as a prominent example of the main propositions of the New Public Management paradigm, this Program symbolized the strengthened ties between the Turkish government and the 'epistemic communities' in healthcare policy. The policy transfer network, as conceptualized by Evans and Davies (1999), that was active in the program management included individuals linked to the 'epistemic communities', while having international organizations -most prominently the World Bank- in direct advisory and financing role (p. 376).While the domestic actors other than the government were not actively involved in the policymaking processes actively, international actors such as the World Bank have had a central role in the HTP through loans and policy advises. In addition, the inclusion of individuals linked to the 'epistemic communities' to the core team conducting the reform supplemented the alignment of the resulting reform with the NPM paradigm.

The HTP has brought massive changes in the Turkish healthcare system and healthcare sector, and thus it has received major scholarly attention. In line with the

conception of epistemic communities, the members of the reform team were engaged in academic debates with extensive articles that were supportive of the Program and were published in respectable journals. These attempts were challenged by several actors, including a group of TMA members, emphasizing the adverse impacts of the Program in terms of the working conditions of health professionals and the invasion of the right of the patients to qualified health service.

Another line of scholarly attention was around the access inequalities the Program has brought. In this respect, Ağartan (2012) challenged the promise of universalism in access, which she argued to have failed. Secondly, Yılmaz (2013) argued that the Program did not eradicate inequalities, but inequalities changed form from occupational status-based to income based. Lastly, Dorlach (2015) highlighted the widening of the gap between public and private provision of healthcare in terms of inequalities; he argued that while the discrepancies between different public hospitals had been eradicated, a new form in inequality had emerged in terms of coverage and quality of healthcare provision.

The changes that the HTP has brought are substantial not only with their impact on the country's healthcare sector, but also with the restructuring of the dynamics of the relationship between public and private actors. The trend of privatization –though sometimes contested in the literature- has allowed for the introduction of public-private partnerships in public healthcare provision, embodied in the form of the city hospitals. At this point, moving forward with the PPP model was not the only alternative that the government had. It could also contract out the construction of new hospitals or renovation of existing ones, as done in cases such as the renovation project of Okmeydanı TRH. The private involvement is limited to the conduct of the project, and the hospital will still be operated by MoH (Taşyapı, n.d.).

The reasons why the PPP model was preferred for the majority of public health investments will be elaborated on in the next chapter in line with the new relationing of the public and the private and the process this new form of relation was formed. The next chapter will extensively examine this new model of hospital construction and healthcare service provision, while analyzing it from the point of view of the literature on New Public Management, changing public policymaking and policy transfer.

CHAPTER 5

THE MAKING OF THE TURKISH CITY HOSPITAL MODEL

The previous chapter examined the last brick in the wall placed right before the city hospital program, i.e. the Health Transformation Program. From the prominence of populist discourse to the policymaking process and the involvement of private and international actors, the HTP offered critical lessons to the city hospital program. This chapter tells the main story that emerged out of the foundations touched upon in the previous chapters. In doing so, this chapter will extensively describe the city hospital model, the projects under this model and the legal framework governing these projects and the program in general. Then, the financing scheme of the projects and hospital operations, as well as the risks incurred by the public sector will be examined. These offer valuable insights about the city hospital program, as they shed light on the policymaking processes, power distribution, the expected impact of this instance of public policymaking and the financial and operational sustainability of city hospitals. These aspects place financing and risk distribution in the very center of criticisms. The examination of these aspects will be followed by a discussion of the policymaking process, analyzing the passive role of the bureaucracy, dominant role of the private stakeholders, and the exclusion of certain stakeholders from the process. The chapter will be concluded by the discussion of the empirical findings in relation to the relevant literature and the research questions.

At this point, I would like to recall the research questions of this thesis in order for the reader to follow this chapter from this lens: 1) Through what kind of policy networks and with what motivations have the actors been involved in this network of transfer of the PPP paradigm to Turkish health care provision? 2) What

are the political dynamics behind the introduction of public-private partnerships in health care provision in Turkey, and how do different actors perceive, contribute or resist the introduction of public-private partnerships in health care provision?

5.1 The second phase of the HTP: City hospitals

The Health Transformation Program has brought about significant changes towards privatization in healthcare, especially with the extension of GHI coverage to include services provided in private health facilities. After the realization of the failure of the autonomous public hospital system and the consequent restructuring of the system towards re-centralization, a new system was put forth, that is city hospitals. This new system is based on the public-private partnership model, where the private builds public infrastructure and provides public services, while the financial risk remains mainly on the public. In such a partnership, the aim was not to privatize public-owned hospitals, but to include private actors in the management of public hospitals with a for-profit and market-oriented approach in public healthcare provision. As stated frequently by public officials and other stakeholders, the city hospital program aims to increase bed quality, and a significant quantitative improvement in beds is not a primary aim (Tükel, 2018, p. 215; PwC Turkey, 2015, p. 12; Yolcu, 2017). The context of city hospitals has shown that providing assurance for the future profit of private healthcare businesses was a priority for the Turkish government. This can be understood the recent statement of President Erdogan in one TV program: “The number of *customers* coming to city hospital will increase soon” (soL, 2018). The statement of Erdogan also clarifies that the Turkish government has begun to accept its patients as ‘customers’ in order to sustain the guarantee of private sector and the

prominence of curative healthcare policies over preventive public health interventions will be strengthened.

5.1.1 The model and project details

The city hospital program has been introduced as the second phase of the Health Transformation Program. In a speech in a symposium that took place in 2016, Akdağ, the former Minister of Health that led the HTP's first phase and the initial phases of the city hospital program, emphasized that the implementation of the PPP model to public healthcare provision would bring efficiency, effectiveness, easy access and high-quality service (Ministry of Health, 2017). Koca, the incumbent Minister, recalled the motives of starting the city hospital program as the inability of making extensive health investments using the public budget, gaining management dynamism from the private sector, enjoying an effective corporate financing mechanism, and sharing the costs and conduct risk of these investments with the private actors involved (Grand National Assembly of Turkey, 2018, p. 152).

The general framework of the city hospital program has been drawn with Law No. 6428 of 2013 and the related By-Law No. 2014/6282 of 2014, with which the MoH has begun to instrumentalize PPP strategy for large-scale hospital investments and established the Public Private Partnership Department in order to regulate and pursue the developments within the implementation of PPP projects in health sector (Republic of Turkey, 2013; Republic of Turkey, 2014). This law and its related by-law authorized the MoH and its affiliates to establish partnerships with private companies in building new facilities, renovating existing facilities, and transferring provision of certain services and administration of commercial facilities, subject to the preliminary project designs, feasibility reports and process standards.

The PPP model used in these projects is called 'Build-Lease-Transfer' model, in which "the right of building a facility on the land of the state is given to the private sector and the risks are distributed between two parties. Private sector operates and maintains the facility in a given period in return of the annual rent from the public, and transfers it to the state when the period is over" (Ministry of Development, 2016, p. 14). The 'land of the state' referred to in this definition is Treasury-owned lands, which are assigned for the projects at no charge (Republic of Turkey, 2013, Article 2).

Preliminary feasibility reports and general project design is prepared or contracted out for preparation by MoH, and presented to President for approval.[1] Tenders take place upon the necessary approval by the President. On the other hand, renovation projects and service procurements -including procurement of consulting services- do not follow such an approval process (Republic of Turkey, 2006, Articles 6-7). The preliminary feasibility reports, and details of the expected costs of projects are not disclosed in tender documents and preliminary qualification announcements, while they are included with details in the tender approval document, which is not available to the public (Republic of Turkey, 2006, Article 8).

The investment period was determined as 2-3 years and the operations period as 25 years. In most cases, they are designed as oversized, very costly, mega hospital projects. For instance, Ankara Bilkent Integrated Health Campus -as 1.1 billion US dollar project- is being built on the 1.285.798 m^2 area and expected to have 3.660 beds capacity (Ministry of Development, 2016, p. 38). The Social Security

[1] Previously, the approving body was the High Planning Council. However, as part of the transition to the presidential system and reorganization of the public body, the Council was dismissed with Statutory Decree No.703 (Republic of Turkey, 2018, Article 17) issued on 2 July 2018, and its authority of project approval was given to the President with Presidential Circular No. 2018/3 (Republic of Turkey, 2018, Annex List Article 1) issued on 1 August 2018.

Institution persists as the financial provider of the medical expenses of patients, yet the state guarantees certain volumes of use of each service provided by the contractor, and pays the gap in the case of deficiency (PwC Turkey & Garanti Bank, 2017, p. 4). All in all, the government buys the operational and infrastructural services that the private sector offers, takes the risk of the probable debts, pays annual rents, and guarantees the demand and use volume. Therefore, it will be meaningful to argue that the state preserves the interests of the business groups, by closing down the previous public hospitals to increase demand for recently opened city hospitals.

The legislation sets a limit of 30 years for the contract period excluding the fixed investment period (Republic of Turkey, 2006, Articles 6(1), 6(4) and 50). That the details of the services allowed to be transferred to the contractor are not outlined in the legislation and left to the MoH as the party responsible for the project design and feasibility studies have resulted in a limited role for MoH in city hospitals. As an example, the tender notice for Antalya City Hospital outlines the mandates of the contractor as well as the services it will provide as follows:

- Mandates: Project finance, final and as-built projects, construction, medical devices and other equipment, as well as furniture and equipment necessary for the health campus
- Services to be provided: Property and plant maintenance and repair, extraordinary maintenance and repair (renovation), management of common services, pesticide control, parking lot, cleaning, hospital information management system, security, patient guidance and companionship, reception and help desk, transport services, laundry, catering and dining hall,

laboratory, medical visualization, sterilization and disinfection, rehabilitation and waste management services

- In addition, the contractor will undertake the construction and operation of facilities excluding medical service, in compliance with healthcare services and subject to the approval of the MoH's PPP Department (Press Advertisement Agency, 2017)

In fact, MoH has an extensive definition of medical services that includes laboratory, visualization and sterilization services. However, these services are categorized as 'medical support services' instead of medical services, and thus are transferred to the contractor. Therefore, the boundaries between the mandates of the MoH and the contractor based on the medical and non-medical distinction are not clear when it comes to implementation (Akdağ, 2012, p. 311).

The city hospitals introduce new forms of medical service provision, in which the state takes part only in clinical service provision through the medical personnel it provides; yet the delivery of assistance and non-clinical services and the operation of commercial spaces are transferred to private sector. The division of areas of responsibility is determined by the contract the contractor signs with the state, which is transferred to the SPV established for the project. The contractor, then, generally sub-contracts -and sometimes sub-sub contracts- assistance and non-clinical services; such as security, maintenance, food supply and cleaning; to medium and small-scale ventures. The sub-contracting mechanism is explained by Murad Bayar (2017), Board Member of CCN Holding -contractor of three projects- in his presentation at OHSAD Conference in April 2017 using the case of Mersin City Hospital. As shown in Table 5, contractors subcontract to numerous different firms in the planning, implementation and operation phases (p. 16).

Table 5. Business Model Partners

Business Development	Investment	Administration
Finance Corporations • Domestic banks • Foreign banks • Investment banks	Sub-contractors • Manufacturing • Electricity • Mechanical	Technology Suppliers • System integration • Software development
Investment Firms • Equity • Organization • Project management	Material Suppliers • Construction materials • Furniture	Equipment Suppliers • High-technology medical equipment
Contractors • Construction companies operating in Turkey and target countries	Advisors • Architectural • Legal • Environmental	Administrative Support Firms • Clinical and general support services

Source: (Bayar, 2017, p. 16)

In addition to the subcontracting relations between the main contractor and smaller firms, the administrative structures of the main contractors are also organized to address the needs in the city hospital model. For example, in a presentation in 2017, Vahap Dogan (2017), the Chief Operating Officer of SPVs of Mersin and Ankara Bilkent City Hospitals, explained the corporate structure of CCN, which comprised of companies handling investment and operation, construction, services and technical procurement and biomedical procurement.

As mega hospital projects, city hospitals are effectively health campuses hosting multiple hospitals and other types of health facilities. The management structure of city hospitals has been determined by Presidential Decree No.28 in January 2019 as containing a coordinating physician in chief, physicians in chief for each hospital, and departments in charge of medical services, administrative and financial affairs, and other support services (Republic of Turkey, 2019). The managers and officers from the SPV that actively participate in the operation of the hospitals are not included in the organizational structure of the hospitals. However, the extent of the services provided by the SPV show the part personnel of the SPV plays in daily operations. Ökten (2018) and Yerlikaya (2018) referred to the help desks established by the SPVs in city hospitals that coordinated the services needed

for the continuation of medical service and provided by the SPV. The effective organizational structure was, as repeatedly mentioned in all the forums that I attended, discussed for a long time with an aim to find an optimal solution that would balance the public and private stakeholders in managing the city hospitals.

While there are no official disclosures about the organizational structure, a report by Sağlık-Sen Strategic Research Center published in July 2018 provided the number of employees of the contractor firm in the Mersin City Hospital, which can be seen in Table 6.

Table 6. Employees of the SPV Operating Mersin City Hospital

Service Line	Number of Employees
SPV Administration	32
Technical Services	236
Cleaning	230
Security	579
Companionship, Reception and Transportation of Patients	354
Catering	234
Waste Hauling	25
Pesticide Control	5
Parking Lot	23
Hospital Information Management System	265
Laboratory	30
Visualization	61
Total Parental Nutrition and Medicine Preparation	9
Rehabilitation	14
Laundry	30
Sterilization and Disinfection	80
Other Technical Firms	38
Total Number of Employees	2,245

Source: Atasever, et al., 2018, p. 73

These numbers become meaningful when we consider the number of MoH personnel employed at the same hospital. As mentioned by the former Acting Physician in Chief Serkan Kılınç in February 2018, there were 1,770 health professionals including 445 doctors, and 764 administrative personnel employed at Mersin City Hospital, which totals 2,534 (Medimagazin, 2018). Even when taken at face value, these numbers and functional breakdowns highlight the share of private

employees in Mersin City Hospital and implies the extent of the impact the SPV is expected to have. Besides this single instance and the pieces of information provided above, however, how the structure has been designed at the city hospitals that are operating has not been publicly disclosed yet.

Currently, there are 21 projects for which the tender processes have been concluded and the contracts have been assigned between the Turkish government and the business sector (Ministry of Health, 2019). Table 7 gives the bed capacities and investment amounts for each project. Nine out of these 21 projects have been completed and started operating, while 12 of them are still under construction. On the other hand, 11 projects are being prepared by MoH, which will make the total number of city hospital projects 32. The nine projects that have been completed have a total capacity of 12,062 beds, while the ones under construction have a total capacity of 18,747 beds. The projects under construction are planned to be completed by 2021 lastly with the opening of Şanlıurfa City Hospital. In total, 21 projects cost 11.7 billion USD in terms of investment amount, as reported by the MoH (2019). These figures show that while the number of beds will not significantly change, the city hospital projects require high amounts of investment capital.

Recently, the Medium Term Program for 2019-2021 was published by the Ministry of Treasury and Finance (2018), which contained breakthrough measures for the future of the projects. The program declared that;

- Pre-tender project plans and tendered projects that had not been started would be suspended,
- New and longer-term business plans would be structured for ongoing projects with suitable financing conditions, and

- Mega infrastructure projects would be implemented by FDI and international financing (pp. 5-6).

Table 7. City Hospital Projects, Project Statuses, Bed Capacities and Investment Amounts

Project Name	Bed Capacity	Investment Amount, Million USD
1. Completed		
Adana City Hospital	1,550	669.06
Mersin City Hospital	1,294	374.43
Isparta City Hospital	755	309.78
Yozgat City Hospital	475	178.96
Kayseri City Hospital	1,607	485.09
Manisa City Hospital	558	212.18
Elazığ City Hospital	1,038	380.54
Ankara Bilkent City Hospital	3,704	1,254.95
Eskişehir City Hospital	1,081	390.82
Total, Completed	12,062	4,255.81
2. Contract signed/Under construction		
Ankara Etlik City Hospital	3,577	1,135.98
Bursa City Hospital	1,355	389.02
Physical Therapy and Rehabilitation, Psychiatric, and High-Security Forensic Psychiatric Hospitals	2,400	678.21
Konya Karatay City Hospital	838	262.38
Gaziantep City Hospital	1,875	864.69
Tekirdağ Health Campus	480	245.20
Kütahya City Hospital	600	182.10
Kocaeli City Hospital	1,180	385.49
Turkish National Public Health Agency and Turkish Medicines & Medical Devices Agency Campus	-	797.39
İzmir Bayraklı City Hospital	2,060	597.80
İstanbul İkitelli City Hospital	2,682	1,518.77
Şanlıurfa City Hospital	1,700	394.70
Total, Under construction	18,747	7,451.74
Total, Completed and Under construction	30,809	11,707.54
Pre-tender projects	13,600	

*In million USD.

Source: Ministry of Health, 2019

These statements put the future of pre-tender and unstarted projects under question. Also, the explicit reference to ongoing projects with 'suitable financial conditions' might be interpreted to indicate that some of the ongoing projects are suffering from financing issues. Taken into account along with the currency fluctuations and devaluation of the Turkish lira, these statements raise suspicion for

the continuity and solvency of the city hospital program, which have been offered as institutions to replace many existing healthcare institutions that millions of citizens benefit from. Also, considering the financial turmoil the country has been undergoing, the burden of high amounts of investment for projects that are not designed to contribute to the bed capacity of hospitals might have been noticed. Such a shift in a short time span -less than a decade- shows the lack of planning, and prominence of interests of private actors and economic growth over welfare and public interests.

Closure of existing public hospitals as part of the demand guarantee provided to the contractors is an important component of the design of the city hospital program. The webpage of MoH's Department of Health Investments provides details of the completed and ongoing city hospital projects, which are given in Appendix. However, different amounts of details are disclosed in this webpage, some projects lacking the list of hospitals to be closed and other important details. Therefore, since a comparison from a single official source is not possible, different sources including non-public ones are used throughout the chapter. Another problem with the official data available is that the bed capacities of the hospitals to be closed (officially 'moved') are -with limited exceptions- not provided in the official webpages. This limits the researcher ability to estimate the actual volume of the demand guarantee. What is important to discuss here is the practice of public hospital closures, taking place in the form of closing down public hospitals in city centers, including the ones that have been recently constructed or renovated, and the ones that are very large hospitals with prominent specialists and training capacities.

As explained above, according to the city hospital model, the contractors are responsible for the construction, operation and related intermediate expenses of the

projects. On the other hand, MoH is obliged to pay the contractor rent for operating hospitals as agreed in the contract, as well as a service fee for the services provided at these hospitals. Table 8 provides the payments made by MoH to the contractors in the form of rent and service fees for city hospitals, along with comparisons to total expenses and city hospitals started operating.

Table 8. Payments of MoH to Contractors

Term	Rent*	Service Fee*	Total Payment *	MoH - Total Expenses*	Ratio of payment to total expenses	City hospitals started operating
Feb.17						Mersin
Mar.17						Isparta
Apr.17						Adana, Yozgat
May.17						
Jun.17						
Jul.17						
Aug.17						
Sep.17						
Oct.17	124.72	15.50	140.22	6,019.54	2.33%	
Nov.17	124.72	70.50	195.22	8,950.70	2.18%	
Dec.17	124.72	185.61	310.33	12,716.38	2.44%	
Jan.18	137.98	25.90	163.88	3,047.62	5.38%	
Feb.18	144.31	77.93	222.24	5,638.61	3.94%	
Mar.18	150.83	178.47	329.30	8,549.31	3.85%	
Apr.18	301.78	237.70	539.48	11,652.12	4.63%	
May.18	308.41	314.43	622.84	14,522.63	4.29%	Kayseri
Jun.18	324.49	381.99	706.47	17,256.58	4.09%	
Jul.18	501.31	451.82	953.13	20,615.56	4.62%	
Aug.18	507.73	523.39	1,031.12	23,693.13	4.35%	Elazığ
Sep.18	539.96	654.30	1,194.26	26,912.41	4.44%	
Oct.18	846.10	747.88	1,593.98	30,531.06	5.22%	Manisa, Eskişehir
Nov.18	1,049.37	854.75	1,904.13	34,044.83	5.59%	
Dec.18	1,152.65	1,047.95	2,200.60	37,039.05	5.94%	
Jan.19	488.17	96.95	585.12	4,411.89	13.26%	
Feb.19	507.70	241.82	749.52	7,923.01	4.68%	Ankara Bilkent
Mar.19	583.48	388.63	972.11	11,795.58	5.75%	

*These amounts are in million TL, and indicate year-to-date amounts, i.e. the total amount paid from the beginning of the year to the end of the given month.

Source: Ministry of Health Directorate of Strategy Development, n.d.

As can be seen in Table 8, while the first city hospital, i.e. Mersin City Hospital, started operating in February 2017, the rent and service fee payments started to be reflected on the monthly account statements of the MoH in October 2017. According to these account statements, from October 2017 to March 2018, the

MoH paid 2.85 billion TL as rent and 1.96 billion TL as service fee, totaling 4.8 billion TL in total. Given that the total amount of expenses of the MoH was 74 billion TL for this period, the payments to the contractors in the form of rent and service fee constituted 6.52 percent of the total expenses of the MoH. This ratio is significant, as it was 2.44 percent for October-December 2017, and it rose to 5.94 percent for 2018, meaning that the payments are likely to cover more of the MoH budget when the projects under construction will start operating. This conclusion is relevant when we consider it together with the demand guarantee provided by MoH by the practice of closing-down of existing public hospitals, and the lack of provision of ease in access due to the location of city hospitals relatively far form city centers. On a side note, these are capable of a demand shift in the middle class towards the private hospitals and clinics that GHI covers. While private healthcare provision has not been seen as a concrete alternative for public hospitals so far, this might result in emergence of such an alternative.

5.1.2 Legal framework

The formation and amendment of the legal framework is one of the aspects of the city hospital program that shows the lack of long-term planning by the state, and the state's passive role in the policy formation process. The first legal change was passed on July 3, 2005 on the Basic Law on Healthcare Services, which vaguely framed the fundamental aspects of PPP projects in healthcare with a focus on the construction of new healthcare facilities with BLT method. A related By-law No. 2006/10655 entered into force in 2006, and outlined the details of the model. Law No. 6284, which was special to the PPP projects in healthcare, was passed in 2013, repealing the Additional Clause in the Basic Law on Healthcare Services. This was followed

by the entry into force of the related By-law No. 2014/6282, which repealed the By-law No. 2006/10655. With these legal developments, the coverage of PPP projects in healthcare were extended from construction of new buildings to renovation of existing facilities and procurement of research and development, project services and consultancy and other services that require high technology and major financing. In addition, terms of revaluation of the rent in case of financing in foreign exchange, and establishment of an SPV after tender were major additions to the previous legislation.[2] This law and by-law, along with other related pieces of legislation have undergone significant changes since then.

First, several changes were made that applied to ongoing projects. The first example of this is the passage of Law No. 6284 and By-law No. 2014/6282 after some tenders had already been concluded. Another example took place in July 2018, when Statutory Decree No. 703 authorized President to allow changes in the project coverage in case unplanned needs emerge within the projects.

Second, challenges to the related legislation by courts upon the claims filed by non-governmental actors, most notably the TMA, a couple of legislative changes were made. Firstly, the Council of State made a decision of a stay of execution of the provisions that allowed transferring of Treasury-owned lands to the contractors as part of the city hospital projects in 2013. In response, an amendment to the law was made in 2013 that called for the non-implementation of terms of contracts that required transfer of such lands to the contractors, and that authorized the Minister to make amendments on the contracts made. The TMA argued that this contradicts the constitution and the court decision was for the benefit of corporations, as the relevant

[2] This type of payment is referred to as 'usage fee' in the by-law. However, the financial statements of the MoH refer to it as 'rent payment'. It is important to note that 'rent' was the term used in the repealed by-law of 2006.

provisions would require the cancellation of such contracts (Turkish Medical Association, 2017). Secondly, the Constitutional Court declared unconstitutional the practice of contracting out the duty of MoH to conduct audit of the ongoing projects on the grounds of the absence of mechanisms to detect possible cases of incompetency of the auditors or irregularities in auditing, as well as the sanctions to be applied in such cases (Constitutional Court of the Republic of Turkey, 2015, p. 84). In 2016, this practice was re-introduced along with the stated mechanisms and sanctions (Republic of Turkey, 2016b, Article 74).

In addition, project-specific changes in the legal framework have taken place. In 2017 and 2018, legislation on constructions and planning in coastal areas were changed and exceptional construction rights were granted to the city hospital projects in Trabzon, Zonguldak and Rize (Republic of Turkey, 2017a; Republic of Turkey, 2018a).

Lastly, another legal concession that was made in favor of contractors and financiers is noteworthy. This includes making the city hospital contracts subject to private law, and allowing the resolution of future conflicts to be handled by international arbitration. These provisions can be argued to not allow future changes in healthcare policy in case the proposed changes are less favorable for contractors, and in general favor the interests of capital holders at the expense of limiting the state's autonomy to protect its interests along the duration of the contract. The intention of contributing to the appeal of these projects was explicitly mentioned in the preamble of the draft law amending the Law No. 6428 that halted the requirement of arbitration hearings to happen in Turkey while preserving the requirement of application of Turkish law to the merits of the case (Grand National Assembly of Turkey, 2015, p. 9). This imbalance of power and limited autonomy of

the state should also be discussed in relation to the depolitization of healthcare and healthcare policies.

The projects being subject to private law has two implications. First, this change allowed an extensive level of participation by law firms, such as Clifford Chance and Elmadağ to tender and contract processes was present. These law firms are also leading participants and in some cases organizers of PPP-related conferences and forums, which provide a medium of idea exchange and policy transfer. Second, being subject to private law resulted in considerations of the contracts as 'trade secrets', and thus in non-disclosure of the terms of contracts. Tükel (2018) argued that this eliminated possible comparisons between the costs of projects and the costs if the projects were handled by the public sector (p. 221).

5.1.3 Financing and risks incurred by the public

Other country examples, as covered in Chapter 3, show that PPP projects in healthcare turn out to be more costly than projects undertaken by the public sector itself. In addition, in such a setting, states incur significant levels of risk that they might have difficulty in managing. In this regard, this section will provide an overview of the financing structure of Turkish PPP projects in healthcare, the financial concessions provided by the state to the contractors, and risks incurred by the state that might have detrimental effects to future generations.

For the case of city hospitals, which is the only group of PPP projects that follow the 'Build-Lease-Transfer' model, the SPV operating the hospital has the central role within the inflow and outflow of funds, as outlined in Figure 6. The SPV has four types of fund inflow, which are i) equity provided by investors, ii) senior debt lent by financiers, iii) payments made by MoH, and iv) revenues from the

operation of commercial areas. MoH makes two types of payment: i) availability payment, and ii) service payments. The former type refers to the rent paid by MoH to the SPV operating the city hospital, while the latter one refers to the volume and non-volume service payments, which are payments made for the services provided to patients and covered by MoH from the global budget composed of payments by central government and SSI (Ministry of Employment and Social Security, Ministry of Finance, & Ministry of Health, 2017). The distinction between volume and non-volume services derives from the terms of the city hospitals' contracts, which outlines the changing amounts of payment to be done for provided services based on the 'volume' of use of each service within a specified time span.

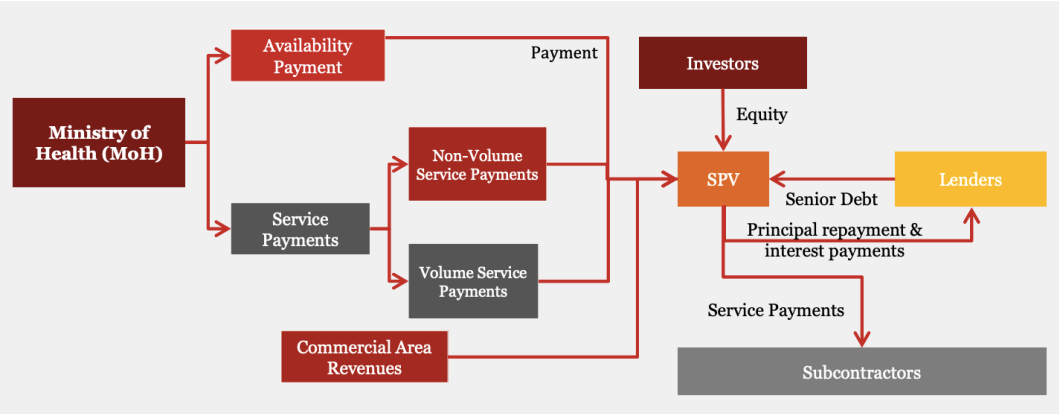

Figure 6. Main structure of BLT scheme in Turkey

Source: PwC Turkey & Garanti Bank, 2017, p. 4

As outlined by PwC Turkey and Garanti Bank's report (2017) financing of the projects is provided mostly in US dollars or Euros, and mainly through bank loans (p. 5). This is also verified by the officials in public speeches, as well as the media coverage of financing decisions (Dünya, 2015; Dünya, 2016). Alternative sources of financing are also utilized, with examples of Islamic finance in Konya and Manisa city hospital projects, and bond financing in Elazığ city hospital project

supported by EBRD and MIGA under a credit enhancement scheme (European Bank for Reconstruction and Development, n.d.).

In the 6th PPP Forum that I attended, Şule Kılıç, Deputy Country Director of EBRD, praised the bond issuance in Elazığ city hospital project, and declared support for the extension of this type of financing in other projects and other countries. In the same conference, Simten Öztürk, Project and Acquisition Finance Manager of Garanti Bank, stated that project bond issuance would be increasingly used in future projects and that Garanti Bank was working on enhancement of such mechanisms.

Financing in foreign exchange introduced exchange rate risk to these investments as a top risk, bearing in mind that the revenues of these hospitals are in Turkish liras. The impact of this type of risk has become more prominent with the fluctuation of Turkish lira's exchange rate since August 2018 (Tükel, 2018, p. 221). This risk puts not only the contractors and the project in general, but also the MoH, under pressure, as MoH has assumed the obligation to pay rent in foreign currency to the contractors throughout the operating period.

Lastly, as these are not publicly financed projects, they are kept off the balance sheet of the public accounts. Tükel argued that this allowed the government to hide the budgetary burden of these projects, thus eliminating possible further criticisms (pp. 221-222). Tükel's argument fits well with the general approach, as the possibility to keep these investments off the balance sheet was presented as an advantage of the PPP model that provide the option to postpone the recording of expenses and eliminate immediate burden (International Monetary Fund, 2004, p. 19; Vervynckt & Romero, 2017, p.5).

In terms of financing, which the private actor is mandated to provide, at least 20 percent of the investment budget should be financed with equity (Republic of Turkey, 2006, Article 54). This means, up to 80 percent of the investment budget can be financed with debt. Emek (2017) argued that this level of equity requirement enabled only large companies with strong equity structures to take part (p. 159). This seems feasible, considering that average investment values per city hospital contract is the second highest among all PPP projects, coming after airports. As can be seen in Table 9, the average investment value per contract is 983.83 million USD for airport projects, 561.79 million USD for healthcare facilities, and 258.70 million USD for the entire portfolio of PPP projects in Turkey.

Table 9. Comparison of PPP Projects Based on Sector

Sector	Number of Projects	Investment Value, Million USD	Average Investment Value Per Contract, Million USD
Airport	19	18,692.70	983.83
Health Facility	20	11,235.84	561.79
Total	243	62,863.85	258.70

Source: Presidency of Strategy and Budget, Turkey, n.d.; own calculations

On the other hand, setting a maximum limit on debt-to-equity ratio provides a safety belt to the government and society at large by giving a certain level of assurance in terms of financial solvency. This is especially important given the high levels of risk possible financing problems pose in healthcare facilities, as well as the Treasury guarantees granted to these projects (Sharma & Cui, 2009, pp. 3-4). Two aspects are crucial in considering the cost burden of the projects: i) the length of projects and the currency and interest rate risk this brings, and ii) the boost in return on equity -a central metric used in project finance decision making- debt financing creates. As for the latter aspect, while financiers take debt-to-equity ratio into consideration in assessing risk and determining interest rate, and thus a rational investor would determine debt-to-equity ratio at an optimal level that maximizes

their returns, this should not be left to the market to balance especially in healthcare projects.

Another implication of the possibility of financing these projects with up to 80 percent debt is the following. Scholars have argued that in general, as the default risk is significantly lower for governments, governments have higher financial credibility than private companies, and thus the risk premium of governments is considerably lower than private companies (Gaffney, Pollock, Price, & Shaoul, 1999a; Dawson & Maynard, 1996; Emek, 2018). With the prominence of debt financing, he argued that the higher risk premium of private companies will increase the cost of debt, and subsequently the cost of the project in general.

Another implication of debt financing at such levels is related to the consideration of PPP projects as 'trade secrets' (Pala, 2018, p. 124). This consideration implies non-disclosure of the details of these projects. Therefore, the preliminary feasibility reports that contain the calculations of the expected budget of the project including alternative financing scenarios (such as direct public financing) are not disclosed to public, and thus the public does not have the ability to hold the government accountable for possible higher burden on the public budget. This practice of non-disclosure was also recognized in the Report of the PPP Special Expertise Committee for the Tenth Development Plan, in combination with the emphasis on the importance of extensive and realistic preliminary feasibility reports (Ministry of Development, 2014, pp. 56-57). As a comparable case, the case of PFI hospitals in the UK might be considered. The discussions in the Treasury Committee of the UK House of Commons in 2011, as well as the Report by the Comptroller and Auditor General in 2018, stressed the issue of higher risk premium of the private sector in PFI hospitals, which added up to the burden on the public budget by 70

percent compared to the estimated costs of a publicly financed hospital (House of Commons Treasury Committee, 2011, p. Ev11; National Audit Office, 2018, p. 11).

For example, again on the UK debates, a report by Jubilee Debt Campaign (2017) emphasized the transaction costs to the discussion of higher costs introduced by PPPs. They noted that the involvement of consultancy, accountancy and law firms contributed to the burden on the public by increasing costs. According to their calculations, in total, the additional burden of PFI hospitals on the public might reach 550 percent in some cases (pp. 3-7). This risk of additional burden was also recognized by the IMF (2004). The IMF (2004) stated, "PPPs [could] be used mainly to bypass spending controls and move public investment off budget and debt off the government balance sheet, while the government still [bore] most of the risk involved and face[d] potentially large fiscal costs", while it also noted the non-contribution of governments to the initial cost of investment and the related opportunity cost of capital among the benefits of PPPs (p. 19).

The indispensability of inclusion of international investors needs special attention, as it was a major issue highlighted in the Report of the PPP Special Expertise Committee for the Tenth Development Plan. Firstly, the report noted that foreign partners were able to bring in financing packages from export credit agencies, and international organizations such as the IFC and the EBRD were effective in providing financing. This is desirable by the government, as foreign creditors could better provide large bulks of financing. Secondly, the report argued that Turkish banks were incapable of providing loans of large volume. The report noted that 1.5 billion US dollars was the optimal credit amount for Turkish banks, over which they required the participation of all national banks, thus eliminating competition, and funding with this method could only reach about 2 billion US

dollars. For volumes over 2 billion US dollars, the report noted, national banks required participation of international banks (Ministry of Development, 2014, p. 73). Therefore, international investors and foreign financiers stand as pivotal actors for the provision of financing to the PPP projects.

The discussion of the financing mechanisms and structure should be followed by the aspect of risk management, with respect to the risks incurred by the government in an effort to make the projects more appealing for investors and financiers. This is particularly prominent bearing in mind the government's placing the growth of the health sector as an engine of economic growth and aiming to attract more FDI, which have resulted in the government taking measures to minimize the risk of investors and offer various guarantees and incentives to attract more investors. These measures have appeared in the forms of revenue and demand guarantees, loan repayments, step-in rights for the creditors, exemption from VAT, guaranteed currency exchange rates and international arbitration in case of problem between the stakeholders, along with fee-free use of state-owned immovable assets and expropriation, which was mentioned previously.

In this regard, one of the major instances of risk sharing is the treasury guarantees governments provide to the debts of contractors, in an effort to make such projects appealing to investors and financiers. Currently, the ratio of debt assumed by Treasury is 85 percent for cases of the SPV's default, and 100 percent for other cases, which was proposed by the Undersecretariat of Treasury as a mechanism of risk sharing with the lenders (Republic of Turkey, 2014, Article 4). This risk assumption scheme also applies to Turkish city hospital projects. In addition, step-in and project take-over rights are generally granted to the financiers, which make sure that financiers can secure their loans in case of a default (Bueno, 2016, p. 321;

Hergüner, Tuncel, Sazcı Uzun, & Kaya, 2017, p. 5). On the other hand, the legal framework requires the establishment of an SPV for the undertaken project by the contractors in the form of a joint stock company (*anonim şirket*), which is a form of company that is "liable for its debts up to its assets and [in which] the shareholders are liable only towards the company itself up to the subscribed capital" as outlined in Article 329(1) of the Turkish Commercial Code (Okumuş & Atlı, 2019). After its establishment, the SPV is transferred the rights and responsibilities previously undertaken by the contractor. Neither the law nor the by-law specifies a minimum amount of equity for the SPV. Thus, this limitation on the liability of shareholders can be argued to provide investors a safety belt in case of a default, thus increasing the risk of loan repayment incurred by the Treasury.

Another measure that has strong implications for the health policy design of the country and its outcomes is the demand guarantee provided by the government. According the PPP hospital contracts, the government persists as a demand guarantor for the services private sector offers, through promising to close down some of the already established public hospitals within city centers and transferring the patients and medical personnel to these integrated PPP health campuses. Thus, the total number of the hospital bed does not change in a given city, meaning that the private sector would not take the demand risks for PPP hospitals. Here, it should be underlined that such a large-scale reorganization of healthcare providers and closing up the already existing public hospitals will not only aggravate the cost burden on public budget but also will organize the health service provision in the image of market that may have detrimental impacts on the healthcare policy prospects of Turkish government. As the critiques of the NPM paradigm suggested, increased involvement of private sector into the public healthcare service provision and

restructuring of public service in the image of private sector would decrease the regulatory capacity of the government to organize health services through bounding them in complex contractual arrangements.

Another form of government-provided guarantee is the volume guarantee for the use of non-clinical service provision. Based on my findings from the 6th PPP Forum, the government offers guarantees for the use of non-clinical service that private sector provides in PPP hospitals. This was also included in the explanation of the revenue model of the SPVs for city hospitals in the report by PwC and Garanti Bank. These services include the cleaning, imaging, food and parking area and other non-medical services. This guarantee again shows that government publicizes the risks of demand for private sector and guarantees the future revenue in the PPP hospital projects.

The government also provided exemptions from several fees and taxes, including full exemption from VAT in 2012, exemption of all papers and declarations from stamp tax in 2016, and exemption from all administrative fees in 2016 (Republic of Turkey, 2012; Republic of Turkey, 2016a). These were followed in 2017 by the exemption of SPVs bringing PPP projects funds through securities issued overseas from all administrative fees and stamp tax (Republic of Turkey, 2017b). These exemptions were granted in order to reduce costs of financing PPP projects (p. 53). Lastly, in January 2018, the government issued Communique No. 2018-32/51 that prohibited the use of foreign currencies in business arrangements including debts taken on by Turkish residents with no foreign exchange income (Republic of Turkey, 2018d). However, the contractors of PPP projects were held exempt from this prohibition, arguably due to the indispensability of debts in foreign exchange in PPP projects.

5.2 Policymaking process

The policymaking process of city hospital projects and the program in general, have taken place within a framework that resembles the one of the HTP: a top-down process that lacked long-term planning, excluded relevant civil society actors, and happened behind closed doors (Yılmaz, 2017b, p. 137).

In the first phase of HTP, the minister of health Recep Akdağ and his crew of health policy bureaucrats established strong bonds with the international policy circles and internalized the international health standards through regularly collaborating with many international actors including the World Bank, the WHO and the like. This has led the foundation of the introduction of PPP policy in the Turkish context. Being already attached to the international policy circles and participating in various transnational health policy networks in the first phase of transformation program, health bureaucrats in Turkey have already begun to increasingly look to other nations as an example to learn and transfer the suitable policies.

Within this context, Holden's (2009) analysis of the role of the UK in these international policy circles for promoting the PPP policy in health and the relationship it builds with other nations to transfer the this strategy, which is covered in Chapter 3, is highly relevant. Turkey has been one of the leading countries that participated in these forums and has built collaborative actions with the UK, international agencies and commercial firms.

On the other hand, similar to the first phase of the HTP, Turkey's attachment to the epistemic communities is not limited to the UK-based firms. The EBRD has been a pivotal partner for Turkey in city hospital projects. As explained by Kılıç, Deputy Country Director of EBRD, in the 6th PPP Forum that I participated, the

EBRD provides support in three roles: i) it serves as a consultant, providing evaluation mechanisms of PPP projects, working on improving bankability of projects, and providing technical cooperation for value for money methodology, ii) it provides loans to projects, and iii) it takes part in the contract monitoring process, helping the MoH in performance oversight. The EBRD's involvement has also served to attract foreign sponsors, including Astaldi and Salini (Italy), Meridiam (France), Samsung (Korea), Vamed (Austria), Sojits (Japan), General Electric (USA), as stated by Kılıç. The pivotal role of the EBRD has also been showcased by its participation to the PPP Special Expertise Committee for the Tenth Development Plan, and by the extensive inclusion of EBRD's assessment and suggestions to the Committee's report.

The IFC is another major international organization that contributes to the city hospital program. As stated in an IFC newsletter that covered IFC's role in Adana City Hospital project and the City Hospital Program, the IFC's contribution includes the following points:

- "Through its continued engagement with the MoH and the sponsors, IFC helped improve the Project structure and documents, which are now in line with international standards and best practices.
- IFC is providing and catalyzing long-term funds amounting to 45 percent of total debt.
- IFC is leveraging the World Bank Group's global healthcare knowledge, including IFC Advisory Services' expertise in PPPs, to ensure best practices are implemented.
- As a senior lender in the Project, IFC is complementing IBRD's continued support of the Turkish healthcare sector. This includes the potential for providing capacity building within MoH's relevant departments to effectively manage and implement the PPP Program.
- IFC is providing critical guidance and input to the implementation of best practices in the areas of environmental and social issues, including application of energy efficient technologies in the buildings" (International Finance Corporation, 2015, p. 4)

The IFC thus places itself as a major financier, as well as a consultant to the city hospital program, working to "contribut[ing] to the success of the wider Health

PPP Program" (p. 4). Turkey's being the second largest country of operations of the IFC, as well as hosting the largest office outside of its headquarters in Washington, DC, shows Turkey's close links to the organization. The works of the IFC are based on the Country Partnership Strategy documents prepared and agreed by the World Bank Group and the Turkish authorities, which outline the priorities of the Group in general and the IFC in particular. Similar to the inclusion of the EBRD in the Tenth Development Plan preparations, the recent Country Partnership Strategy recognizes Turkey's commitment to development as outlined in the Tenth Development Plan in line with the Group priorities (The World Bank, 2017, p. 9).

The IFC's role is praised by investors as well. The Chairperson of the contractor company of Adana City Hospital, Rönesans Holding, stated, "IFC's engagement at the corporate level [would] support our international expansion, garner recognition as a global contractor, and create significant value for our stakeholders by improving our corporate-governance practices" (International Finance Corporation, 2016).

Besides getting involved in the international policy circles and designing the city hospital program in line with the international rhetoric, Turkey also participated in the promotion of the PPP model in healthcare to other emerging economies. In March 2019, IFC and Johns Hopkins Medicine International organized a conference titled 'Making Global Connections: Leading Change in Emerging Health Markets' in Istanbul, Turkey. Bringing together private and public sector representatives, as well as representatives of international funds, the conference claimed to have offered "attendees the opportunity to forge collaborative relationships" (International Finance Corporation, 2013). The body of participants included representatives from 44 countries, three of which -Brazil, India and Turkey- included high-level

government officials as implementers of PPP model in healthcare (International Finance Corporation, n.d.). On the other hand, representation of MoH by Sarbani Chakraborty, MoH Advisor with World Bank background -as explained in the previous chapter- might be interpreted as a sign of the stance of the government in support of the expansion of the reach of epistemic communities.

Another example of Turkey's participation in the promotion of PPP in healthcare is the government's close collaboration with the EBRD in its efforts to proliferate the model around neighboring countries. As explained by Kılıç, Deputy Country Director of EBRD, in the 6th PPP Forum that I participated, Turkish case of city hospitals is used by the EBRD as a successful example to trigger 'transnational demonstration effect', which Kılıç defined as replication of the successful model to the EBRD's other Countries of Operation. She noted that the Turkish model had attracted a high level of attention, and EBRD's Turkish hospital PPP experience had been showcased with several governments, including Kazakhstan, Morocco, Georgia, Uzbekistan, Romania and Croatia. She also mentioned that she planned to visit Saudi Arabia to present the Turkish model together with the Head of PPP Department of the former Ministry of Development Sedef Yavuz Noyan.

This active role of international actors was, as mentioned, a continuation of the practice in the HTP. However, the case of city hospitals is distinct from the first phase of the HTP in the sense that it also involves private actors directly as contractors, sub-contractors, consultants and the like. The contracts are subject to private law rather than administrative law, and thus details of these contracts as well as negotiations are kept as 'trade secrets', shifting the nature of the contracts from public-private contracts to private-private contracts.

New to healthcare provision, this form of relationing should be analyzed from the lens of comparative competencies of the involved actors. Involved private actors, which include management consulting, legal, construction, project management, facility management and medical technology companies, have the expertise of project management, planning and handling legal and management issues in such projects. On the other hand, the government and the bureaucracy lack such expertise, and even are uninformed about the details. This imbalance in the levels of expertise introduced information asymmetry to the city hospital projects at the expense of the public sector, making the public side generally follow the lead of involved private actors. A number of evidences displays this information asymmetry.

First, it should be noted that the role of consultancy, accountancy, legal and R&D firms does not only bring transaction costs as explained in the section on financing, but also renders the government passive in the projects. Most notably, Law No. 6428 leaves the decision of conducting the following activities or contracting them out to external actors to the MoH: i) preparing preliminary project, preliminary feasibility reports, feasibility reports, main standards document and tender document, ii) auditing of all activities of the contractor under the terms of the contract (Republic of Turkey, 2013). An example of contracting out as part of the first group, as publicized by Erbaş (2018), contains preparation of all the legal documents including draft tender documents and draft contracts for 2 million Turkish liras (p. 157). The second group of activities, i.e. the possibility of contracting out the audit function, was declared unconstitutional by the Constitutional Court (2015) on the grounds of the absence of mechanisms to detect possible cases of incompetency of the auditors or irregularities in auditing, as well as the sanctions to be applied in such cases (p. 84). In 2016, contracting-out of audit practice was re-introduced along

with the stated mechanisms and sanctions (Republic of Turkey, 2016, Article 74). This means the government is allowed to involve private actors in the practice of auditing the planning and execution phases, while it voluntarily abandons itself the opportunity of developing in-house auditing know-how on the PPP projects.

Second, management consulting firms have played a pivotal role in the establishment of the system. MoH Undersecretary Gümüş noted the following in 2017:

> the second phase of HTP in the consultancy of McKinsey & Company, aiming an enhanced collaboration between the private and the public. Knowing the interests of the each other, [we initiated] a new form of governance that [would] generate increased welfare and efficiency.[3]

A second evidence to the prominence of management consulting firms could be the report on the healthcare industry in Turkey, which was prepared with the cooperation the Investment Support and Promotion Agency of Turkey and Deloitte (2014). This report outlined the characteristics of the health system in Turkey and suggested policy implementations and investments proposals for the future. These suggestions in fact are comparable to the government's health policy, which reflect the market's 'best practices' as the outcome of the close relations with epistemic communities in policymaking and implementation, and the passive role the state has undertaken in the framing of policy as a result of the information asymmetry between the state and private actors and the ambiguity of process ownership within bureaucracy. These are also mentioned in the sectoral meetings I attended.

Another issue in this new form of relation is that the focus on development and growth has become more prominent in healthcare policymaking, in line with Turkey's engagement of epistemic communities. Organized since 2014, this annual

[3] During the symposium called "National Health Programs" that I attended in Acıbadem University, Health Policies Center in 31.03.2017.

summit brings together representatives of main stakeholders in the healthcare PPP ecosystem, namely governments, contractors, suppliers, financiers, consulting firms and academia, in order to share experiences gained from the successful PPP projects from North America, Europe and Asia. The Summit's 2019 edition that will be held in October 2019 is organized under the patronage of Investment Office of the Presidency of the Republic of Turkey, Istanbul Chamber of Commerce, Turkish Foreign Economic Relations Board, and Independent Industrialists' and Businessmen's Association and is organized by PPP Experts and Elmadağ Attorneys and Counselors (PPP Experts and Elmadağ Attorneys & Counselors, n.d.). Elmadağ Attorneys and Counselors is a law firm listed on Legal 500, a global ranking of reputable law firms, which actively takes part in PPP projects in Turkey, while PPP Experts is a London-based advisory and training firm, and Turkey's MoH as well as several Turkish PPP stakeholders are clients of this firm. The body of speakers in this event included representatives of the private sector, domestic NGOs representing private investors, and organizations working in the area of investment and trade. The patrons and organizers, as well as the body of speakers and the topics of discussion display an important point that is apparent in many of the forums and other forms of gathering: the case of city hospitals, and healthcare in general, is taken into consideration in terms of its financial and investment-related impacts rather than healthcare policy goals. While a wide variety of topics were discussed ranging from new technologies and innovation to legal aspects, their contribution to healthcare policy goals are left aside in these discussions. This investment-focused discourse is vital in the consideration of the city hospital program.

These evidences, however, should not be interpreted in a way that the government has done whatever the demands of private actors were. The dominance

of construction companies in city hospital projects created discontent among the private health circles that gained momentum in the first phase of the HTP (Yılmaz, 2017a, p. 204). Private hospital owners expressed their concerns about the city hospital program that these hospitals would be detrimental to their businesses, as they were planned to be providing high-quality service. This discontent was expressed by OHSAD's President Bahat in 2015, who called the opening of city hospitals 'a political decision', and expressed disapproval towards the opening of '10-12 of these hospitals' (Medimagazin, 2015). However, this concern has been met with the design of the model that included the aggregation of public healthcare provision in places that are distant to city centers. This means that centrally located private healthcare facilities would not be affected by the city hospitals, and in fact, might benefit from their distant location, as the difficulty of access might lead some patients to choose these private facilities, which already offer significant coverage by the GHI. This has been reflected to the approach of private healthcare providers, which can be seen in the declaration of OHSAD after their 'Shared Wisdom Meeting' that took place in 2017. In this declaration, while they pointed out certain problems of city hospitals, they noted the potential that their competition with city hospitals and their distant locations were likely to provide (Medikal News, 2017).

The other side of the network comprises the actors excluded from the policymaking process. Public health professionals and civil society were not informed about the preparation of PPP hospitals and government did not consult any stakeholder in the policymaking process including patients' rights organizations, Turkish Medical Association and other civil and medical professional organizations except the ones representing the private actors in healthcare sector. Furthermore, for the case of PPPs, clear description of the policy to the civil society is especially

necessary due to the very complex structures of the contracts and the society does not understand and estimate the consequences of the projects on their healthcare needs.

TMA was very active in its opposition to the city hospital model. In this respect, it filed claims to courts, organized conferences that brought together the actors that they believed that should be included in the decision-making processes, and even published a book that covered different aspects of the model and its implications, which in fact provided a significant input to this thesis (Pala, 2018). The issues that TMA pointed out were well summarized in the public letter by the TMA President directed to the Minister of Health in February 2019, noting the main problems in city hospitals. The main points mentioned in this letter were as follows:

- Lack of proper planning of facility and human resources
- Administrative crises that occur due to the presence of a double-headed organizational structure, involving the physician in chief and the manager from the contractor company, where the chief physician is not in charge of the medical support services that the contractor company provides
- Prevalence of a profit-oriented focus in administration, including procurement processes of critical medical supplies
- That the city hospitals are located out of cities and lack proper transportation
- Harsh working conditions, disturbance of employee satisfaction and issues of occupational health and safety
- Increased stress in both patients and health professionals (Adıyaman, 2019)

Adıyaman's letter, in sum, pointed out the consequences of the continuation of the TMA's longstanding exclusion from the reform process as one of the most prominent professional organizations in healthcare.

5.3 Conclusion

With the new quasi-market created in the first phase of the HTP with the inclusion of private actors in support services for public healthcare facilities, the extension of coverage of the GHI to include private healthcare facilities and the rising volume of private provision of healthcare, healthcare reinstated its position as a profitable sector for high profits and capital accumulation. This shift was path-dependent within the rise of globalization of services and increased activity of international actors in healthcare services. The second phase of the HTP was a step forward in this privatization process of healthcare delivery. In this phase, the MoH's 'steward' function was strengthened with the introduction of the PPP model in healthcare: by contracting out of construction of new mega health facilities, called 'city hospitals', and then of operating these facilities. With significant financial and legal concessions by the state, investment in city hospital projects was made attractive for construction companies and financiers.

The story of emergence of the city hospital model has its roots in the already established closed ties of the bureaucrats and policymakers with the international policy circles. Being already attached to the international policy circles and participating in various transnational health policy networks in the first phase of the HTP, bureaucrats in Turkey had already begun to increasingly look to other nations as an example to learn and transfer the suitable policies. This coincided with the activities seeking to promote the implementation of the PPP model in healthcare conducted by a number of actors, most notably the UK's Department of Health and Department for International Development, the World Bank (especially the IFC), and the EBRD. The activities of these actors included organization of forums and conferences with the participation of delegations from emerging economies -

including Turkey-, provision of loan packages and project financing, as well as offering of advisory services. In this regard, especially for the Turkish case, loan packages and project financing instruments were semi-coercive forms of policy transfer. On the other hand, forums and advisory services served as non-coercive mechanisms of dissemination of the ideational framework of PPP model in healthcare and of affecting the framing of health policies within the context of the ongoing transformation of healthcare policy.

A notable observation that I have made at the conferences I attended, as well as is present in many of the policy documents and discussion papers, is that discussions on the city hospital model generally revolve around the financial and commercial aspects, with reference to 'value for money', 'efficiency' and growth prospects of the sector, rather than healthcare outcomes and implications. The latter are mainly mentioned in public statements and addresses to opposition actors only by the government. Furthermore, in some conferences such as the 6th PPP Forum that I attended, and the annual PPP Healthcare Summit, the MoH was not among the participants; only the Ministry of Development sent a representative.

In conjunction with the foreign governments and international organizations, international consulting firms were engaged in the policy framing process as well. McKinsey & Company's provided consultancy service to the MoH in the formation of the city hospital program, and Deloitte's cooperation with the Investment Support and Promotion Agency of Turkey for the report on the Turkish healthcare industry are significant examples that have been made public. On the other hand, consulting firms have two additional fields of operation. For the MoH, the relevant legislation allows contracting out inherent functions ranging from conducting feasibility studies

to drafting contracts and auditing the contractor. On the other hand, contractors refer to consulting firms in tender, project management and operation phases.

In line with Stone's (2001) argument, this transfer network formed with the participation of a variety of 'policy transfer entrepreneurs' -as Dolowitz and Marsh (2000) put- has "construct[ed] the intellectual infrastructure for cross-national learning and create[d] justifications for transfer" (p. 21). The power of the international organizations and involved non-state actors was coupled with a passive role of the state, in a position following the lead of the international organizations and certain non-state actors, while excluding some others from the process. This passive role of the public sector is in line with Stone's (2004) analysis of emerging economies as receivers of the policy transfer network, which suggested that these countries were subject to direct imposition and one-size-fits-all approach from other exporter countries as well as international organizations since they lacked the necessary expertise and knowledge to comprehend the technical characteristics of policy and possible future implications of that policy for the country (p. 551). That international organizations and involved non-state actors do have the stated necessary expertise and knowledge has created an information asymmetry.

The information asymmetry between the Turkish public sector and international actors has allowed for an ease in policy transfer, as the state was supportive of a healthcare reform and an implementation of PPP in healthcare, but did not have the expertise. The consultancy services provided by McKinsey & Company and Deloitte, as well as the guidance of the IFC and the EBRD, and the ideas disseminated in international forums and visits have supplied this knowledge and expertise, and this rendered the state in a less powerful position vis-à-vis the others. In line with Stone's (2004) argument, this further resulted in the adaptation of

NPM policies and policies that make PPP projects appealing to investors (p. 557). This matches with my observations from the conferences I attended. In those conferences, the state representatives were not knowledgeable about the details of the issues under discussion, and generally followed the lead of the representatives of the private sector and international organizations.

Another example is the loss of autonomy of the state by allowing the resolution of disputes between the state and contractors to be handled by international arbitration will be applied to the merits of the case. After passing the relevant legislation, the parliament halted the requirement of arbitration hearings to happen in Turkey while preserving the requirement of application of Turkish law to the merits of the case, with the declared intention to make the projects more appealing to the financiers. Guarantee of demand and service use, a long list of exemptions from taxes and fees, fee-free use of the Treasury-owned lands, guarantees for loans in case of default, limitation on the liability of the stakeholders and making the contracts subject to administrative law have all been measures that provide assurances and incentives to the private actors involved in an effort to increase the projects' appeal, while shifting the risks towards the public sector. Making the PPP contracts subject to private law has had another implication, which has changed the nature of the contracts from public-private contracts to private-private ones, downgrading the position of the public sector. Therefore, the state mechanisms to oversee the maintenance of public interests were restricted.

While the role of the state in shaping the content of the PPP contracts was rather limited compared to commercial actors, this does not imply that the role of the state has been diminished in general. In fact, the government has persisted as an important actor as it makes and enforces the regulations and rules compatible with

the international corporate law and rapidly changing service delivery systems. In other words, the developments in the HTP and the city hospital program reshaped the state's role within an increasingly emerging pattern of 'state in network' with other political agents including non-state market actors and international institutions. In this regard, Evans and Davies' (1999) conception of 'policy transfer network' enables us to understand complex policymaking in inter-organizational setting through structural and interpersonal relationships, in which different layers of government gain certain essential skills and knowledge resources (p. 18).

On the other hand, the lack of expertise and knowledge has resulted in a lack of planning before the program started. The city hospital program has in fact been managed by what is called 'learning by doing' in the Preliminary Report of the PPP Special Expertise Committee for the Tenth Development Plan. First, frequent changes in the legal framework were made mainly following the requests of the international organizations, financiers and/or contractors. Second, long-term burden of rent and service fees on the public budget was not planned before the contracts were made. This should be considered together with the guarantees provided to the financiers for the loans of contractors, terms of which are not public due to the consideration of them as 'trade secrets'. Third, the tenders of 21 projects that cost around 12 billion US dollars were completed one after the other, and without planning a pilot phase to test their efficiency and outcomes. This is particularly important given that already established and running public hospitals at city centers are/will be closed down as part of the demand guarantee provided by the MoH to the contractors.

Moreover, public officials have claimed that the financing opportunities and the operational capabilities of the private sector will entail more qualified and

efficient services within the public service provision without involving spending from the public budget. Yet, there is no official statement from the government representatives concerning how much annual month will be paid to these billion-dollar-projects. Given that government payments to the contractors will exceed the investment budgets as argued in the media, the projects do not seem 'efficient use of resources' for the government budget, although it is suggested by government as the main reason of initiating such partnerships (Toker, 2018; Solaker, 2019; Kaya Eroğlu, 2019; Basa, 2018).

Additionally, it is likely that the contract management procedures between private and public and monitoring of these partnership arrangements may increase the transactional- administrative costs of these projects. Correspondingly, while the theoretical framework for the PPPs define it as a method that distributes risks, profits and accountability in a balanced way between the public sector and the private contractors, we see that it is easily falsified in the context of Turkish city hospitals. This is because the government incurs all the risk that the contractor is exposed to through Treasury guarantees for probable debts of SPVs taken from international and national banks. Given the level of this risk and the direct impacts of healthcare policy outcomes on public welfare, rigorous cost-benefit analyses should be conducted by the state.

Then comes the non-state actors that have been excluded from the reform process. As was the case for the HTP, the public stakeholders, such as unions of health professionals, patients' associations, the medical association and opposition parties were excluded from the policy network. Moreover, the consideration of 'trade secrets' has made it impossible for the mentioned actors -as well as the media- to reach the details of the contract, excluding limited cases where access to certain

details was granted by courts. These actors have also not been invited to the forums and conferences where policy transfer has taken place, and details of these events have generally been kept secret.

It is noteworthy that the Turkish government carried out the PPP in healthcare project at a time when similar projects failed in other country contexts. In fact, a number of empirical findings proved that the implementation of the PPP model in healthcare has been detrimental. The most prominent and recent example to this is that collapse of Carillion, a major PPP company in the UK, has been seen as the indicator of the PFI model to be defunct, inefficient and more costly to the public budget (Blaiklock, 2018).

Nevertheless, the combination of prioritization of electoral gains and lack of planning has driven the Turkish government to implement PPP projects in healthcare. The importance of domestic political factors in influencing policy transfers were also noted in the literature. As Stone (2004) suggested, "the changing dynamics of political interests and the socio-historical make up of a polity" were effective in the institution of the transferred policies (p. 547). The route to the city hospital model was in fact rooted in the first phase of the HTP. Inclusion of private healthcare facilities to the coverage of the GHI, and the proliferation of the practice of subcontracting support services in public healthcare facilities are the main two outcomes of the HTP that have extended the role private sector plays in the Turkish healthcare sector. On the other hand, economic development was an area of priority for the JDP government, which had been realized as infrastructural investment projects made with the Build-Operate-Transfer model of the PPP, such as roadways. Given the priority healthcare has in JDP's agenda, the prospect of possible electoral gains from a model that had proven effective was appealing.

The main benefit of PPP projects is keeping the burden of the cost of investment off-balance sheet, as such large investments would have detrimental impacts on the public balance sheet. Therefore, making these investments without directly reflecting their costs on the public balance sheet was seen as a win-win strategy. On the other hand, the global policy of fiscal relaxation coupled with low interest rates in foreign exchange borrowing had resulted in a major influx of foreign currency in emerging economies including Turkey. This encouraged many emerging economies, including Turkey, to rely on foreign debts without appropriate consideration of the future risks. However, this global economic outlook was misleading in the sense that its sustainability was not certain. In fact, it skyrocketed the vulnerability of these economies. Considering the reliance of the city hospital projects on foreign exchange borrowing, this risk was not expected.

Here, the recent declaration of the government in the 'New Economic Program' that called for suspension of projects that have not been tendered or started, and restructuring the business plans of ongoing projects with suitable financing conditions should be considered in line with the government's self-declared commitment to fiscal austerity. While this statement stands as a breakthrough in the sense that 11 projects with a total bed capacity of 13,600 will be suspended, the plan of restructuring business plans of ongoing projects bears ambiguity by not having specified the conditions for the 'suitability' of financing conditions. On the other hand, this might entail that some projects do not have sound financing conditions, which seems to confirm the arguments on insufficient planning of the projects with regard to their burden on the public budget and the risks they pose.

Making health policies with the consultations of the business firms is a relatively new form of public management. It seems that Jessop's (1999) arguments

are valid in this new era of Turkey. Just as he claimed, in this new type of knowledge-based and technology-driven economy, states are in an increasing need of the know-how and operational capacity of the private sector. Commercializing the social services but persisting as a regulatory agent, Turkish state lacks the market experience and the ability to rule contractual regulations, so it creates new partnership arrangements to be able to efficiently 'govern' recently commercialized public services.

The 'new form of governance' that is emphasized by nearly all the private and public actors, as an organizational necessity of these health campuses, bears a vital importance for my discussion of these PPP practices. The bureaucratic, centrally organized healthcare delivery system has been transformed into the contract-based partnership administration. Through the increased involvement of private sector into the policymaking and public service provision, managerial quasi-market has been incorporated into the hospital administration with the city hospital model.

All in all, coupled with the populist discourse, the yields of the ongoing neoliberalization process on the comprehension of the roles of the public and the private actors shaped the formation and implementation of the city hospital model. It is also safe to argue that achieving certain healthcare policy outcomes is a secondary component of the new decision-making process, and that economic development goals have subordinated healthcare goals. Whether the projects brought, or are likely to bring, economic development is also an important point to question. The recent increase in foreign exchange rates has showcased two burdens on the public budget: i) the cost of debt has risen as the loans outstanding are mainly in foreign currency, thus increasing the risk of default of contractor companies, which will put the MoH

and/or Treasury guarantees in effect, and ii) the rent and service fee payments to be made by the MoH have risen due to them being indexed to foreign currencies.

CHAPTER 6

CONCLUSION

This thesis scrutinizes the context within which PPP has been added on the agenda of Turkish health policymakers and through what political processes it is transferred and implemented into the Turkish political context. The thesis traces the roots of the emerging links between the private and public sector in the healthcare provision in order to lay the basis for the implementation of 'the PPP city hospital project' that has arrived in the Turkish scene very recently with much fanfare. In this regard, this thesis draws upon two research questions: 1) Through what kind of policy networks and with what motivations have the actors been involved in this network of transfer of the PPP paradigm to Turkish health care provision? 2) What are the political dynamics behind the introduction of public-private partnerships in health care provision in Turkey, and how do different actors perceive, contribute or resist the introduction of public-private partnerships in health care provision?

This thesis draws mainly on Evans and Davies' (1999) comprehensive research framework of 'policy transfer network' along with Stone's (2004) threefold actor analysis within these networks that includes states, international institutions and non-state actors. Combination of these two frameworks has allowed this thesis to examine the case of city hospitals in Turkey.

The political context for city hospitals was prepared by Turkey's journey with neoliberalization and reforming healthcare. Turkey has attempted to establish and then reform its healthcare system in every decade, especially since the 1960s. Post-1980s neoliberal economic transformation fundamentally shaped the healthcare policy trajectory in the following years. The loan agreements with international

financial institutions and related economic shifts towards marketization and liberalization directly affected the country's approach to healthcare. The Turkish healthcare system arrived the new millennium with problems including compensation of health professionals, multi-pillar framework of the social security system, unsatisfactory levels of social security coverage, mismatches in regional distribution of healthcare facilities and the like. The financial crisis in 2001 and its impact on the poor contributed to the elevation of the JDP to government and aggravated access problems in the healthcare system. In this regard, first, sharp devaluation of Turkish lira dramatically slumped the purchasing power of the population, which increased the burden of out-of-pocket payments of uninsured segments of the population. Second, the austerity policy adopted in an effort to overturn the adverse trend in the economy included severe cuts in public expenditures in social services, thus directly affecting the poorer segments.

Emerging out of this context, during the HTP, the healthcare sector underwent a major wave of transformation with commercialization and increased private activity. However, this did not take place in the form of direct privatization of healthcare, i.e. transfer of ownership of public healthcare facilities. Instead, a complex form of relation was formed between the public and the private actors, which served as the basis for the healthcare transformation in the last decade. In this regard, the HTP introduced the inclusion of private healthcare facilities to the coverage of the GHI, and the process of the practice of subcontracting support services in public healthcare facilities having become mainstream as the main two outcomes that have extended the role private sector plays in the Turkish healthcare sector, thus paving the way for the city hospitals.

Starting from this political and economic context, the motivations of the government, private actors and international/external actors become relevant in understanding how the city hospital model emerged out of a process of policy transfer.

The city hospital model had a number of promises that made the government embrace the model. Firstly, the prioritization of economic development by JDP in line with the ongoing neoliberalization process that was strengthened by the JDP, as well as the success of infrastructure PPP projects in gaining public approval, made this model appealing to the government. Secondly, the premise of this model to invest in public services without creating an immediate burden on the public balance sheet was seen as a win-win strategy, given the potential of entailing more qualified and efficient services within the public service provision with the financing opportunities and the operational capabilities of the private sector. The global policy of fiscal relaxation coupled with low interest rates in foreign exchange borrowing had resulted in a major influx of foreign currency in emerging economies including Turkey. This encouraged many emerging economies, including Turkey, to rely on foreign debts without appropriate consideration of the future risks. Here, it should be noted that motivations of Turkey's embracing this model were mainly related to its promise to contribute to economic growth in line with the ongoing neoliberalization process and to popular support for the government. In addition, the possibility of keeping these investments off the public balance sheet was another appeal of this model. Bearing in mind the role the populist rhetoric of economic development played in the JDP's elevation to government and its strong popular support, these promises stand as highly relevant for the JDP's embracing the PPP model. Therefore, the city hospitals program was not driven merely by healthcare policy concerns.

More importantly, it was a strategy that emerged out of the combination of economic growth, neoliberalization and populism, or 'neoliberal populism' as used by Akçay (2018) in an effort to discuss the greater framework that has shaped JDP's policy agenda. Here, other 'mega projects' including the Istanbul Airport, major bridges, highways and other construction projects have all emerged out of the same discourse, and have all followed similar strategies. The city hospital model has a special place among all these 'mega projects' due to the role healthcare provision occupies in the JDP agenda.

In this regard, the ties of bureaucrats with the international policy circles strengthened in the process of implementation of the HTP were effective. These ties rendered bureaucrats knowledgeable about how to form partnership relations with private actors. In addition, PPP projects in other areas such as infrastructure, public practices of contracting-out and government's support to the development of construction sector created large construction firms that possessed expertise of and financial means necessary for undertaking large projects. Given these phenomena and the bureaucracy's lack of expertise in PPP model in healthcare and their existent ties to the already established epistemic communities, Turkish bureaucrats sought opportunities for learning about suitable policies with an aim to transfer them to Turkish context. Meanwhile, a number of external actors, including UK's Department of Health and DFID, the World Bank and the EBRD, were actively promoting the transfer of the PPP model in healthcare to developing nations. The strive of these institutions was to export 'best practices' that were documented in guides for implementation to emerging economies. This network has been formed in line with Appuhami et al.'s (2011) description of the dominance international organizations create by means of "fiscal force, financial or moral authority, trade

practices, economic sanctions and monopolization of information or expertise" (p. 433). This interaction between representatives of international and foreign organizations and government representatives occurred in several media including forums, conferences, offering loans and advisory services, and foreign site visits.

The inferiority of healthcare policy concerns discussed above was reflected in these means of policy transfer. Two examples are: i) the contents of discussions in the sectoral meetings generally revolved around the financial and commercial aspects, with reference to 'value for money', 'efficiency' and growth prospects of the sector, rather than healthcare outcomes and implications, and ii) the government was represented by bureaucrats from Ministry of Development instead of Ministry of Health in some of these meetings. In addition, consulting firms have taken extensive part in all phases of the program, from policy framing to the tenders and operating city hospitals.

As part of the city hospital model, contractors and financiers are given significant financial and legal concessions by the state in an effort to make investing in city hospital projects attractive for them. These included Treasury guarantees to the debts of contractors, demand guarantees by closing the existing public hospitals, collaboration with international organizations such as the IFC and the EBRD in an effort to secure low-interest loans, exemption from significant taxes and fees. These steps have proven to be effective in attracting foreign investors and private contractors by limiting their risks and providing novel opportunities for high returns.

The nonequivalence of levels of expertise and knowledge between the public and private actors, in fact, created power and information asymmetries. These asymmetries have allowed for an ease in policy transfer, as the state was supportive of a healthcare reform and an implementation of PPP in healthcare, but did not have

the expertise, thus was open to the support and contributions of external actors, especially consulting firms such as McKinsey & Company and Deloitte. This asymmetry has also resulted in a lack of planning, as indicated by the PPP Special Expertise Committee for the Tenth Development Plan by referring to the main method as 'learning by doing'. Without a concrete plan, the future burden of these long-term contracts and financial and legal concessions granted to contractors and financiers have not been taken into consideration. As showcased by overseas examples such as the PFI hospitals in the UK and argued in the national media, these hospitals might have cost more than comparable investments conducted by the public sector, and being kept off-balance sheet hides this burden from the public. With the exchange rate risk and the guarantees provided by the public, high levels of burden on the public budget are very probable. In addition, legislative changes following the requests of involved private and international actors, making the contracts subject to private law, allowing the resolution of disputes between the state and contractors to be handled by international arbitration have restricted the ability of the state mechanisms to oversee the maintenance of public interests.

Correspondingly, the premise that risks, profits and accountability will be distributed equally between the business and the state seems to be easily falsified, as the government undertakes all the risks from the private sector by being guarantor of probable debts of SPVs to the international and national banks. This again necessitates a rigorous cost-benefit analysis of these projects, the results of which should have been available to the public, which are vulnerable to the financial risk incurred by the state through the burden on the public budget.

While the government has shared a number of significant duties with private partners, it should be noted that it is still an important actor with its regulatory role.

On the other hand, the contribution of the expected outcomes of the city hospital model to the popular support for the JDP has been a pivotal point in the formation of this policy, in line with the populist appeal of the JDP especially in relation to the promises and actions on healthcare provision. In addition, the developments in the HTP and the city hospital program reshaped the state's role within an increasingly emerging pattern of 'state in network' with other political agents including non-state market actors and international institutions.

All in all, the government, international actors and private stakeholders were, and still are, involved in the program due to significant benefits that conform with their priorities. However, this does not mean that each and every stakeholder of healthcare policy has received such significant benefits. Here, we should note the excluded portion of the non-state actors, which are highly relevant to the reform context, but have deliberately been excluded from the process. As was the case for the HTP, the public stakeholders, such as unions of health professionals, patients' associations, the medical association and opposition parties were excluded from the policy network. Moreover, the consideration of 'trade secrets' has made it impossible for the mentioned actors -as well as the media- to reach the details of the contract, excluding limited cases where access to certain details was granted by courts. These actors have also not been invited to the forums and conferences where policy transfer has taken place, and details of these events have generally been kept secret. This instance of exclusion is politically significant, and is indicative of the top-down, undemocratic manner shown during the reform process. In the case of UK, Aldred (2008) mentioned the similar problem by suggesting that the UK PPP hospitals were structured by top-down elite decision making without any collaboration from the staff, service users, patients and physician in chief. The author very well explained

that the policymaking process dominated by the private sector representatives and bureaucrats thoroughly excluded the role of physicians and patient representatives and thus did not take into account the public benefit and equity concerns in the health policymaking, which helps explain the Turkish context.

This thesis has a number of limitations. First, the consideration of details of city hospital project as 'trade secrets' limits the availability of official facts and figures. While I could reach basic information for each project; however, there was no single database that I could make use of, and my ability of making comparison and verification was strictly limited.

Second, the implementation of city hospital model is still an ongoing process. Given the frequency of changes in the legislative framework since its very first inception, it is safe to argue that there will be further changes when deemed necessary. While the changing framework and policy network supplemented the argumentation of this thesis, it also created a challenge of working in an environment that is under continuous change. The recent government declaration on suspension of pre-tender and unstarted projects and restructuring of ongoing projects with suitable financing conditions raises suspicion about the future of the program in general.

Third, bureaucratic structure and economic context has also been subject to changes and fluctuations during the course of this study. These changes include July 15 coup attempt, transition to presidential system, restructuring of MoH bureaucracy, closing up of Ministry of Development, and the ambiguity in transfer of duties and responsibilities of the High Planning Council and Ministry of Development to different government agencies.

Lastly, this thesis is based on a documentary analysis and participant observation. Given the fast-changing public officials in this period and the closed

nature of the projects, conducting interviews would not be possible. In addition, my intention was to explore the general framework that the city hospitals model was introduced into the Turkish context rather than examining the subjective interpretations of various actors about the model. Therefore, the comprehensive review of documents and my participation to sectoral events provided both sufficient and valuable inputs.

This thesis contributes to the literature on PPP and its implementation in healthcare particularly in Turkey by applying the policy network approach to the case under consideration. A vast majority of related studies focuses on the first phase of the HTP in Turkey, while the implementation of the PPP model in healthcare is left generally untouched. Studies on this area, on the other hand, approach the issue from a point of view limited to the traditional boundaries of particular social science disciplines. However, the city hospital framework is situated within an immense habitat with commercial interests, financial relations, struggles around political power, and the changing role of the state and social policy environment. The complexity of this habitat has made it imperative to touch upon financial, economic, political and social aspects of the policy transfer framework.

Thus, in this thesis, I employed a multidisciplinary approach that covers the interests and motivations of the multiplicity of actors, the interactions between these actors and their resultant transformation of each other. Based on these, I discussed the process of blurring of the boundaries between the public and the private with the PPP model and the impacts of the New Public Management paradigm. The case of the city hospital model is also potent of showcasing the new type of public-private relations that have emerged out of the PPP model, bearing in mind that it touches upon one of the public policy areas that can tolerate very low levels of risks such as

the default of the contractor. Therefore, the government's approach to the issue from the lens of the prevalent development discourse and its subordination of health policy goals, together with the role of international organizations and private actors involved, are capable of shedding light on the processes of public policymaking in general, making use of an extreme example.

With this start, this recently emerging area of the city hospital model has an enormous potential for further scholarly attention as time passes by and the program's outcomes become visible. As a recent phenomenon that includes closing of multiple public hospitals and establishing large healthcare complexes, there are various aspects of city hospitals on which further research could be carried on. First, a comprehensive fieldwork covering all involved and related stakeholders could be carried out. Second, the city hospital model could be approached as a form of public policy and its implications on public health, patient experience, the employee rights of health professionals, public health expenditures, private providers of healthcare services with the competition it creates, and medical tourism could be studies. Third, the management and financing structure of city hospitals, their revenue model, their profitability and sustainability as enterprises, and their probabilities of default could be discussed. Fourth, the future effects of the risks incurred on public budget, legal implications of such long-term contracts protected by the right of referring to international arbitration, and implications of binding the state with such long-term contracts could be studied. This list is not comprehensive, as the city hospital model is a complex one with the inclusion of public and private actors, as well as domestic and international financiers and consultants, for the provision of a critical type of public service.

APPENDIX

CITY HOSPITAL PROJECTS

AND CLOSE-DOWN OF EXISTING HOSPITALS

Project Name	Hospitals to be closed/moved
1. Completed	
Adana City Hospital	Not disclosed
Mersin City Hospital	Not disclosed
Isparta City Hospital	Not disclosed
Yozgat City Hospital	Not disclosed
Kayseri City Hospital	Not disclosed
Manisa City Hospital	Manisa State Hospital Merkez Efendi State Hospital (Pediatry, Gynecology and Obstetrics, Cardiovascular Surgery and Angiography Units)
Elazığ City Hospital	Not disclosed
Ankara Bilkent City Hospital	Ankara Numune TRH Atatürk TRH Graduate TRH Zekai Tahir Burak TRH Pediatrics TRH Ankara Physical Therapy TRH
Eskişehir City Hospital	Eskişehir State Hospital (except for Zübeyde Hanım Campus with a capacity of 178 beds) Yunus Emre State Hospital (Medical Oncology, Nuclear Medicine, Radiation Oncology, Burn and Cardiovascular Surgery Units)
2. Contract signed/under construction	
Ankara Etlik City Hospital	Dışkapı Yıldırım Beyazıt TRH Dr. Sami Ulus Gynecology, Obstetrics and Pediatrics TRH Etlik Zübeyde Hanım Gynecology and Obstetrics TRH Dr. Abdurrahman Yurtaslan Oncology TRH Ulucanlar Ophthalmics TRH
Bursa City Hospital	Bursa Prof. Dr. Türkan Akyol Pulmonology Hospital Bursa Ali Osman Sönmez Oncology Hospital Bursa State Hospital (partially)
Physical Therapy and Rehabilitation, Psychiatric, and High-Security Forensic Psychiatric Hospitals	Not applicable
Konya Karatay City Hospital	Konya TRH
Gaziantep City Hospital	Dr. Ersin Arslan TRH
Tekirdağ Health Campus	Tekirdağ State Hospital
Kütahya City Hospital	Kütahya Evliya Çelebi TRH
Kocaeli City Hospital	İzmit Alikahya Hospital (capacity of 200 beds) Kocaeli State Hospital (capacity of 320 beds, partially) İzmit Seka State Hospital (capacity of 320 beds, partially) Derince TRH (capacity of 469 beds, partially)
İzmir Bayraklı City Hospital	Alsancak Nevvar Salih İşgören State Hospital Tepecik TRH (partially) Dr. Suat Seren Thoracic Diseases and Surgery TRH (partially)
İstanbul İkitelli City Hospital	Not planned
Şanlıurfa City Hospital	Not disclosed

Source: Ministry of Health, 2019

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