THE IMPACT OF PUBLIC PRIVATE PARTNERSHIP MODEL ON HEALTHCARE SERVICE PROVISION: THE CASE OF ANKARA CITY HOSPITAL

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ABSTRACT

THE IMPACT OF PUBLIC PRIVATE PARTNERSHIP MODEL ON HEALTHCARE SERVICE PROVISION: THE CASE OF ANKARA CITY HOSPITAL

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The way of providing public services by the state has been transformed throughout history. Historically, the mechanisms like concession, public procurement etc., were used in line with the political and economic context of the time. The rise of neoliberalism introduced new mechanisms for infrastructural projects, including Public Private Partnerships (PPPs). This study analyses the emergence and development of PPPs worldwide and in Turkey. As one of the leading countries that use the PPP model in infrastructure projects, PPPs finally became a part of the health system with the Health Transformation Programme. The study aims to understand how health PPPs, so-called city hospitals, have transformed health care service delivery. In this regard, a comprehensive document-based analysis was conducted regarding the health PPPs. The findings were tested with a field study conducted in the Ankara City Hospital and with Turkish Medical Association (TMA) members. The social and economic consequences of the reform, such as eligibility for healthcare services, were contested. Based on findings of field study

and document-based analysis, the study concluded that city hospitals project was not planned in a way to respond to the needs of the healthcare sector; instead, their impact on state-capital relations was more prioritised.

Keywords: Public Private Partnerships, Public Service, Health System, City Hospitals, Health Care Delivery

ÖZ

KAMU ÖZEL İŞBİRLİĞİ MODELİNİN SAĞLIK SİSTEMİNE ETKİLERİ:
ANKARA ŞEHİR HASTANESİ ÖRNEĞİ

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Neoliberal dönemde kamu hizmetlerinin sunumunda Kamu Özel İşbirliği (KÖİ) gibi yeni mekanizmalar ortaya çıkmıştır. Bu çalışma, KÖİ modelinin dünyada ve Türkiye'deki gelişimini mercek altına almaktadır. Türkiye'de diğer sektörlerde başlayan KÖİ uygulamaları Sağlıkta Dönüşüm Programı kapsamında sağlık sisteminde de kullanılmaya başlanmıştır. Çalışmanın amacı KÖİ modeliyle inşa edilen şehir hastanelerinin Türkiye'de sağlık sistemini nasıl etkilediğini anlamaktır. Bu amaçla, kapsamlı bir literatür araştırması yapılmış ve bu çalışmanın çıktıları bir saha çalışması ile test edilmiştir. Bu vesileyle, sağlıkta KÖİ kullanımının sağlık hizmetlerine erişilebilirlik gibi sosyal ve ekonomik sonuçları analiz edilmeye çalışılmıştır. Çalışma, şehir hastanelerinin sağlık sisteminin ihtiyaçlarından ziyade sermayenin çıkarlarına hizmet ettiği sonucuna ulaşmıştır.

Anahtar Kelimeler: Kamu Özel İşbirliği, Kamu Hizmeti, Sağlık Sistemi, Şehir Hastaneleri, Sağlık Hizmeti Sunumu

To my beloved late aunt, Zahide Küçükkahraman, who is the most ingenuous person

I met in this world and sadly lost her struggle against cancer…

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TABLE OF CONTENTS

PLAGIARISM iii
ABSTRACT iv
ÖZ vi
DEDICATION vii
ACKNOWLEDGEMENTS viii
TABLE OF CONTENTS ix
LIST OF TABLES xii
LIST OF FIGURES xiii
LIST OF ABBREVIATIONS xiv
CHAPTERS
1. INTRODUCTION 1
 1.1. Methodology. 5
 1.2. Limitations and Mitigations 6
2. UNDERSTANDING PUBLIC PRIVATE PARTNERSHIPS 8
 2.1. Historical Development of PPPs 8
  2.1.1. Ideological Background 10
  2.1.2. Modern PPP Practices in the World 13
 2.2. The Conceptual Framework 16
  2.2.1. Definition of PPPs 16
  2.2.2. Types of PPPs 21
 2.3. Advantages and Disadvantages of PPPs 23
  2.3.1. Advantages of PPPs 23
   2.3.1.1. Financial Benefits of PPPs 23

2.3.1.2. Value for Money 25
2.3.1.3. Risk Transfer 27
2.3.2. Disadvantages of PPPs 31
2.3.2.1. Contrary Arguments to PPPs 31
2.3.2.2. Disadvantages Related to Nature of PPPs 37
2.4. Organisation of Partnership 42
2.4.1. Bidding Procedure 42
2.4.2. Establishment of Partnership 45
2.5. PPPs and Healthcare 54
2.5.1. The use of PPPs in the Healthcare Sector 54
2.5.2. World Practices in Health PPPs 56
3. PUBLIC PRIVATE PARTNERSHIPS IN THE TURKISH CONTEXT 60
3.1. Political Economy of Turkey 60
3.2. Historical Background of PPPs in Turkey 62
3.2.1. Legal developments on PPPs until JDP Era 63
3.2.2. JDP policies on PPPs 66
3.3. The Construction Procedure of City Hospitals 78
3.3.1. The Latest Health Reform in Turkey 78
3.3.2. Organisation of Health PPPs in Turkey 80
3.4. Advantages and Disadvantages of Health PPPs in Turkey 89
3.4.1. Advantages of PPPs 89
3.4.2. Disadvantages of PPPs 91
3.4.2.1. Finance 91
3.4.2.2. Complexity of Contracts 95
3.4.2.3. The Role of MoH 97
3.4.2.4. Impact on Urban Structure 100

3.4.2.5. Conditions within City Hospitals 103
3.4.2.6. Democratic Deficit 105
3.5. The Findings of the Court of Accounts 106
4. REFLECTIONS OF HEALTH PPPs IN THE FIELD................................ 115
4.1. Methodology of the Field Research.. 115
4.2. The Findings of the Field Research 120
5. EVALUATION AS CONCLUSION 137
REFERENCES 144
APPENDICES
Appendix A: Human Subjects Ethics Committee Approval 155
Appendix B: Approval of Provincial Directorate of Health of Ankara 156
Appendix C: Turkish Summary / Türkçe Özet 157
Appendix D: Thesis Permission Form / Tez İzin Formu 169

LIST OF TABLES

Table 1. Main Types of PPPs 21
Table 2. Categorised Catalogue of PPP/PFI Project Risk Factors 28
Table 3. Critical Success Factors and Success Sub-factors for PPP Projects 52
Table 4. Legislation on Different PPP Models..... 71
Table 5. The List of Hospitals to Be Closed in Ankara 85
Table 6. The Volume of City Hospitals 93
Table 7. The Project Companies in City Hospitals 98

LIST OF FIGURES

Figure 1. Number of Different Types of PPPs 71
Figure 2. Total Value of Privatisations. 74
Figure 3. Total Value of PPP Investments in Turkey.. 74
Figure 4. Total Value of PPP Invetsments per sector 75
Figure 5. Companies Receiving the Most Public Tenders 77
Figure 6. Relations Between Actors in Health PPPs... 82
Figure 7. Provinces Where City Hospitals Will Be Constructed 88

LIST OF ABBREVIATIONS

BBO	Buy-Build-Operate
BLT	Build-Lease-Transfer
BO	Build-Operate
BOO	Build-Own-Operate
BOT	Build-Operate-Transfer
CPI	Consumer price index
DBFO	Design-Build-Finance-Operate
DBO	Design-Build-Operate
DBOF	Design-Build-Operate-Finance
DP	Democratic Party
EIB	European Investment Bank
EPC	Engineering, Procurement and Construction
EPEC	European PPP Expertise Centre
EU	European Union
GHI	General Health Insurance
GDP	Gross Domestic Product
HSEC	Human Subjects Ethics Committee
HTP	Health Transformation Programme
ICD-10	International Classification of Diseases
IFC	International Finance Corporation
IMF	International Monetary Fund
IVF	In-vitro Fertilisation
JDP	Justice and Development Party
MIGA	Multilateral Investment Guarantee Agency
MoH	Ministry of Health
MR	Magnetic Resonance
NAO	National Audit Office
NGO	Non-governmental Organisation

NHS	National Health Service
NPM	New Public Management
NPV	Net Present Value
OECD	Organisation of Economic Cooperation and Development
OM	Operation-Maintenance
PBSP	Performance Based Supplementary Payment
PC	Project Company
PFI	Private Finance Initiative
PPI	Producer Price Index
PPP	Public Private Partnership
PPPs	Public Private Partnerships
PSC	Public Sector Comparator
SEE	State Economic Enterprise
SSI	Social Security Institution
SPV	Special Purpose Vehicle
TL	Turkish Lira
TOR	Transfer of Operation Rights
UK	United Kingdom
UN	United Nations
UNECE	United Nations Economic Commission for Europe
USA	United States of America
USD	United States Dollar
VAT	Value Added Tax
VfM	Value for Money
WB	World Bank
WHO	World Health Organisation

CHAPTER 1

INTRODUCTION

Capitalism has a remarkable capacity in adapting itself to changing conditions. It has shown its different faces at different times in terms of relations between state and society as well as state and the capitalist class. By only analysing the capitalist system in the 20th century, it is possible to see this transformation. It started in a harsh manner; the classical era of capitalism disregarded any humane concern and saw the human as merely a cog in the wheel. However, when the system hit the wall in 1929, it had to show a friendlier face and embraced a new style that considered humane concerns. After World War II, the capitalist world turned into full-fledged welfare states providing basic amenities like sanitation, public health, facilities for education and housing, and even social and economic security against unemployment and illness in old age. The need to finance them forced states to raise taxes, start new industries or take over the existing ones and commercial undertakings such as railways and airlines and convert them into public executions.

The petroleum crisis crashed the system in 1973, and capitalism, one more time, discovered a new way of securing itself. This time, mainly a backlash to the classical period with few reforms and several new mechanisms that would prevent a crisis like the Great Depression, was experienced with the introduction of neoliberalism. Although three phases pretend to present different socio-economic structures, they are essentially based on an omnipotent principle: to promote capital owners and protect their privileges. To this end, the system generated various mechanisms to integrate capital owners into public service delivery. This study focuses on one of these mechanisms: Public-Private Partnerships (PPPs).

Not any change in the political and economic system happens suddenly and occasionally. As mentioned, the system has introduced PPPs as appropriate means to achieve the targets in the new form of state-capital relations. Hence, understanding PPPs is vital to grasp the systemic change in capitalism after the 1980s. Therefore, this study elaborates on the development of PPPs in a systematic manner. The main focus point is the PPP practices in healthcare provision. Since PPP practices in the health system came into account during the Justice and Development Party (JDP) rule, the focus point will be on that period.

After the sensational victory by polishing off the old parties in 2002, the JDP government attempted to transform many parts of the administrative system. One of the most radical transformations came into the health sector's agenda with the Health Transformation Programme (HTP) in 2003. As a part of the programme, the JDP government aimed to integrate PPPs into healthcare delivery with a mega project: city hospitals.

Within the framework of the city hospitals project, the government stipulated to provide healthcare in new buildings with the latest technology and in a cost-effective way by using private capital. As a result, private capital started to shape the health policy, besides the rising number of private hospitals. Despite intense propaganda by the government and support from capital owners as well as the public at the beginning, there have also been significant criticisms of the project regarding its long-run consequences.

Since the repercussions of using PPPs have extended to many spheres, it is necessary to select and focus on one of them; otherwise, it will be complicated to compare various outcomes of PPPs in different fields. The study's focal point will be the health system to overcome this difficulty. The reason why the health system is selected has two-fold. The first one is related to healthcare's significant and essential character in human life. It is for the maintenance of life, which is the primary purpose for everyone. The second reason is conjunctional. The Covid-19

pandemic spread from China to the overall world in December 2019 has proved that universal healthcare is vital for public health. The significance of access to free and qualified health services has been understood in this process. Therefore, the transformation of the health system seems to be more contested than PPP applications in other sectors.

In its attempt to indicate PPPs' impacts on healthcare, the study suggests that health PPPs are only a tiny part of the macro-level transformation. The city hospitals projects in Turkey are not well-planned because their impact on state-capital relations is more prioritised than the needs of the health system. And, the scale of new city hospitals is a significant indicator of that. While trying to understand the reasons of the implementation of PPPs in healthcare service delivery, the focus of the study is on neoliberal socio-economic transformation that led to the capitalisation of public services. Then, the study also analyses the outcomes of the PPP model in healthcare delivery.

The literature in this realm touches upon different dimensions of the issue. Authors like Emek and Kucukkocaoglu (2019) focus on the financial aspects of the PPP model in a comparative manner with public procurement; Sonmez and Pala (2018) indicate the role of PPPs in the commodification of health services. In addition, the legal dimension of health PPPs is another topic extensively covered in the literature as done by Erbas (2021) and Karasu (2011). On the other hand, some authors focus on the consequences of transformation in the healthcare service delivery introduced by city hospitals. In this vein, some studies, as Basdegirmen and Cal (2021), evaluate the organisational capacity of city hospitals, and some try to analyse service satisfaction from city hospitals for both service providers and service users by underlining positive and negative aspects, as Ozzeybek (2018) and Turkish Medical Association[1] (TMA) did.

[1] Please see the website of Turkish Medical Association, Observation Committee for City Hospitals at https://www.ttb.org.tr/kollar/_sehirhastaneleri/

The study will contribute to the literature with its comprehensive character. It does not only give one dimension of the issue, such as the development of city hospitals project, legal and financial dimensions or operational processes of the new hospitals. Instead, it covers all these dimensions, and beyond that, the study tries to associate city hospitals project with the political economy structure in Turkey. In other words, the study aims to answer why PPPs have become a tool in healthcare delivery and how health PPPs have affected service provision at the same time. Therefore, the study reveals a broader perspective on health PPPs by combining theoretical approaches with reality on the ground.

After the brief introduction, the study goes on with a review of current literature on PPPs in Chapter 2. This part will introduce the historical and ideological background of PPPs. After understanding the rationale lying behind the emergence of PPPs, it will cover the leading world practices. In addition to the general framework on PPPs, this part covers the specific characteristics of health PPPs.

PPPs in Turkey follow world practices in Chapter 3. This section focuses on the PPP experience in Turkey. The same order in Chapter 2 is valid here, and after the presentation of general information about PPP practices in Turkey, the health PPPs are in front. In that respect, this section elaborates on city hospitals in Turkey. The literature is covered in a critical manner. In the last part of the chapter, the findings of the official report by the Court of Accounts are shared by referring to its significance in presenting some official facts which are not available in any other resource.

Chapter 4 will present the methodology and outcomes of the field research conducted with various stakeholders in city hospitals projects. This chapter will reflect the views of the health officials in the Ankara City Hospital and TMA members regarding the consequences of city hospitals projects on provision of healthcare services. The information in the literature tried to be contested through the findings obtained via semi-structured interviews. This section gives the chance

to test the reliability of the study's claim based on various actors' views who are part of the city hospital projects. It also reflects how multiple actors in the field approach partnership as well as common points and contradictions in their views.

Finally, the fifth chapter presents concluding remarks and a broad vision of the study's contributions and challenges. It also evaluates outcomes of literature review and field research in line with the principles of good governance on PPPs.

1.1. Methodology

There is extensive literature regarding the impacts of PPPs in different sectors. The findings from these studies are vital; however, it is also of paramount importance to observe the repercussions of PPPs in the field. Therefore, the methodology of this study involves both an extensive document-based analysis and qualitative research based on interviews with the health officers in the Ankara City Hospital and TMA.

The document-based analysis covers the academic books, articles and reports of international organisations, including the International Monetary Fund (IMF), World Bank (WB) and Organisation of Economic Cooperation and Development (OECD) and relevant authorities in Turkey. The purpose of this part is to perceive the transformative impact of PPPs in healthcare delivery. To this end, a comparative analysis is given for PPP practices in healthcare in Turkey and the world. While analysing the literature in Turkey, the relationship between the organisation of PPPs and the structure of the political economy in Turkey is particularly focused.

The document-based analysis provides valuable insight for identifying key policy actors, their roles, and the policy-making process regarding the health PPPs. Relying on this analysis, interviews with the members of Ankara City Hospital, Turkish Medical Association, Ankara Chamber of Medical Association (ACMA),

and several political parties from the government and opposition were planned. Nonetheless, due to pandemic conditions and reluctance of some contacts, the scope of field study remained at the level of the Ankara City Hospital and TMA.

Since this is a field study, necessary permissions from the Human Subjects Ethics Committee (HSEC) were granted on July 26, 2021. After that, in line with the directive of TUBITAK on research, including interaction with public institutions and officers, I applied for the Provincial Directorate of Health of Ankara to get the necessary permission to conduct interviews in the Ankara City Hospital. Upon consent granted by the Hospital's Ethics Committee and delivered through the Provincial Directorate of Health on September 27, 2021, I could start to conduct field research.

1.2. Limitations and mitigations

There were significant limitations encountered throughout this study. The main limitation was the Covid-19 pandemic that started in March 2020 during the initial stages of this study. Since Ankara City Hospital was entitled as pandemic hospital, it could not become possible to conduct face to face interviews and observatory visits for a long time. As vaccination accelerated and the pandemic seemed to be under control, field visits could be achieved despite the risks. In some of the interviews, online tools were used as mitigation.

Another significant barrier was difficulty in obtaining official permission for field study in the hospital. Furthermore, the concerns of health officers in participating into the study made initiating the field research further difficult. The scope of the topic which is not restricted to healthcare provision but also handles its relation with political economy, made health officers hesitant for contributing to the study. Although it is guaranteed to keep secret their identities, many officers who were connected rejected to contribute to the study.

Lastly, the political party members I got in touch with did not show any interest in participating in the study. Most of them did not respond to the request to conduct an interview, and those who replied, rejected. Therefore, the analysis of policy making process by the JDP members and why the members of the opposition object to the city hospitals project became deficient. In order to eliminate this problem, an extensive analysis of open resources which give place to opinions of government and opposition members on city hospitals was conducted.

CHAPTER 2

UNDERSTANDING PUBLIC PRIVATE PARTNERSHIPS

2.1. Historical development of PPPs

The boundaries of public service cannot be thought of separately from the concept of sovereignty. When nation-states had emerged as sovereign entities over a precise territory, they inevitably needed to reach and consolidate their control in each part of their land. The concern for sovereignty made the construction of infrastructure facilities such as transport and postal services inevitable. Nevertheless, states lacked the necessary financial resources for such costly affairs. At that point, the idea of benefitting private finance in the provision of public services came into appearance beginning from the earlier periods of modern nation-states.

The first model based on the partnership of public and private actors emerged in France in the mid-1800s with the introduction of the concession model. The French government granted privileges to different companies to construct roads, railways and water supply systems. The concession mechanism's essential feature is that public authorities retain ownership of a facility or service but grant concessions or leases under which private contractors carry the cost of operation and maintenance, collect the resulting revenues and have the surpluses as profit (Hodge & Greve, 2005).

Another claim is that the common act by public and private actors go back to the 16th century (Wettenhall, 2003). According to this view, the formation of Britain's navy to terminate Spanish sovereignty on seas and colonise overseas land was the initial exemplar of the partnership. Most of the vessels in the British fleet were

privately owned. The powerful merchants and aristocratic landowners provided not only ships but also soldiers. They financed it in return for a license that mostly took the form of 'letters of reprisal', which authorised the holders to set forth armed vessels to capture Spanish goods at sea. In return, they could get the financial benefits of those seized items on the condition that one-tenth of the value had to be surrendered to the Crown. Next, the Crown authorised them to govern lands acquired in its name, form companies like the East India Company on the condition to deliver a share of their profits to the centre. In other words, the formation of overseas empires by Britain and also Spain and the Dutch was a product of a joint attempt of public and private actors. However, it was not directly related to the provision of public service; therefore, it cannot be defined as a partnership in terms of the content of the study; instead, it may be called as mix of public and private attempts. Thus, the idea of partnership under defined rules that bring responsibilities and benefits to both parties had come into the agenda with granting concessions for substantial infrastructure projects, firstly in France and followed by other European countries (Wettenhall, 2003).

As the state's role in the market had evolved, the position of public and private actors shifted. In this way, it can be claimed that services have always been provided by public and private actors together as a natural consequence of the capitalist accumulation regime, but the scale of their involvement has changed according to the shifting priorities of the state and capital owners. As the interests of private actors are completely predominant, private participation in the delivery of services has risen. When the concerns like the welfare of citizens are more prior, the public sector's role is enhanced. In other words, the role of public and private in service delivery resembles a tide. There is a centre-periphery relation, in a sense, between them in terms of distribution of surplus. The interests of capital have always been at the centre, but the position of public interest in the periphery has changed. The more it approaches the centre, the more roles the public has. When the system locates citizens' welfare in the periphery's outer part, people are left to the fairness of capital. The second part of the 20th century witnessed such a shift.

Initially, during the post-war era, the state undertook the responsibility to deliver a wide range of services by not increasing taxes extensively. Thus, the state had to bear a significant financial burden. Industrial production ensured the necessary resource based on cheap oil, and there was no trouble in this respect. However, when the oil crisis hit the world in 1973, leading to a ten times increase in oil prices, the rise in the cost of production prevented surplus. As a result, states were deprived of adequate financial resources to maintain services (Sundaresan, 2012).

Furthermore, the crisis of the welfare state is also associated with bureaucracy. The increased volume of bureaucracy required to deliver a wide range of services during the welfare state was blamed for inefficiency and ineffectiveness and held responsible for the crisis. Then, a new era that downgraded the public's role in service delivery and gave the floor to private actors began in the 1980s. This period paved the way for the emergence of PPPs in a modern sense.

2.1.1. Ideological Background

It is highly expected that the UK pioneered in PPPs as the ideological background of neoliberal transformation was prescribed and firstly incorporated into the policy agenda there. The analysis of the crisis by Milton and Rose Friedman precipitated steps towards marketisation in public services. They enunciated that the welfare state's interventionist measures prevented people from making their own decisions and caused the concentration of economic and political power in the same hands. The welfare state policies did not only restrict freedoms but also caused a waste of time and resources with its large and slowpoke bureaucracy. The inefficiency of the Keynesian state emanated from the decision-making process, which bypassed the market mechanism. Governments allocated resources wastefully to provide cheap or free services (Friedman & Friedman, 1980). Thus, Friedmans advocated returning to the market's secured hands to relieve the damage led by the welfare state's maladies. The theory of public management that promoted the idea of managing the state like a firm has spurred the sphere. On the other hand,

devolving all affairs to the market could lead to catastrophic consequences, as the classical phase of capitalism proved. Therefore, to prevent the concentration of all power in the hands of market forces, the state has been attributed a regulatory role as a new item to Public Management and prepared the ground for the theory of New Public Management (NPM), that generated an ideological base for PPPs as a model for service delivery.

How Friedmans defined the government's role as “doing what markets cannot do and enforcing the game's rules” was conceptualised by Osborne and Gabler (1992) as steering but not rowing. At base, NPM merges neoclassical economic theory and private management studies elements, including an emphasis on value for money, efficiency, competition, choice and market mechanisms, making NPM a leading form of managerial practice in the public sector (Whiteside, 2019).

In this vein, NPM encourages decentralisation of government, stressing results rather than procedures or public interest ideals, disaggregating bureaucracy and letting the managers manage, separating responsibility for the purchase of public services from that of their provision as opposed to direct provision of them (Yescombe, 2007).

PPPs are a product of NPM, which proposes either privatisation or contracting out public services to the private sector. During the early stages of NPM, the wave of privatisation was dominant. Next, PPPs came into the agenda due to the public's negative response against privatisation and the reality that not all services are open to privatisation (Whiteside, 2013).

Apart from NPM, another ideological base of PPPs is governance. The term is related to how power is exercised in the management of a country's economic and social resources for development. According to Bovaird and Löffler (2003), governance refers to the set of formal and informal rules, structures, and processes that define how individuals and organisations can exercise power over the

decisions (by other stakeholders), which affect their welfare and quality of life. They assume that governance involves six groups of stakeholders: Citizens, the voluntary sector, business groups, media, higher levels of government, including the international level and local authorities. The concern for governance has arisen in the Western world for various reasons. This has been fuelled by concerns about corruption, environmental degradation, abuse of monopoly power, and the salaries paid to executives and board members in the private sector. In the public domain, it has partly arisen because of the exposure of corruption and unethical practices in the public sector and partly through the realisation of governments that they were in danger of losing their residual legitimacy, as citizens were widely seen to be losing trust in government in general, as well as in their government in particular (Pierre & Peters, 2000).

The World Bank (1994) epitomises governance as predictable, open and enlightened policymaking; a bureaucracy imbued with a professional ethos; an executive arm of government accountable for its actions; a robust civil society participating in public affairs; and all behaving under the rule of law. As Kaufmann (Kaufmann, Kraay, & Mastruzzi, 1994) assert, governance also refers to how public officials and institutions acquire and exercise the authority to shape public policy and provide public goods and services. It proposes integrating different stakeholders into the decision-making process during the formation of the public policy agenda and action stage. In that respect, it is clear that PPPs are appropriate alternatives to service provision in line with governance. It also serves for the sound development targets extending the capacity of public sector management.

The World Bank proposes that the PPPs carry core principles of governance: equality and non-discrimination, accountability and participation. It also underlines that PPPs can be successful if only the implemented context has particular features. These are:

- To make a clear separation between what is public and what is private, hence a tendency to divert public resources for private gain
- To establish a predictable framework of law and government behaviour conducive to development, or to eliminate arbitrariness in the application of rules and laws
- To eliminate rules, regulations, licensing requirements, and so forth, which impede the functioning of markets and encourage rent-seeking
- Not to give priorities inconsistent with development, resulting in a misallocation of resources.
- Not to allow excessively narrowly based or nontransparent decision making (WorldBank, 1992).

The accomplishment of good governance principles is evaluated as a factor that prepares the ground for promoting PPPs as an effective way of public service provision. In short, NPM advocating efficiency of private management, separation of service providers and producers and making the private as the sole producer has come together with governance that prioritised active participation of various actors to service provision, the delegation of authority and improving information and transparency to prevent the abuse of power, thereby bringing PPPs into the forefront.

2.1.2. Modern PPP practices in the world

The first concrete steps in the field of PPPs came in the UK. The British government announced the Private Finance Initiative (PFI) in 1992 to stimulate service development through private investment while controlling short-term public borrowing or tax increases. Early PFI schemes typically involved private financing, design and construction of new buildings and facilities and leased back to the public sector in long-term agreements of up to 30 years (Bishop & Waring, 2016). During the late 1990s and 2000s, these schemes became a central part of both the expansion and modernisation of public services. They used to fund

transport, health, education, and prison developments (Edwards & Shaoul, 2003a). The early propaganda of the UK government regarding the projects' successful outcomes made PPPs attractive for many countries. International institutions like the IMF and the WB have also contributed to the spread of PPPs practice. They appreciated the model's pertinence with NPM reforms and public governance recommendations.

As a result, PPPs were initially embraced by developed countries such as Canada and Australia for the renewal of infrastructure. To illustrate, Australia started to implement large-scale PPP projects beginning in 1987 and increased steadily until 1997, when Asian financial crisis hit the market. After a short break due to the impact of the crisis, PPP procurement gained momentum again from the early 2000s till 2008 when it reached a peak with the procurement of projects whose value came to $12 billion. A declining trend after 2009 crisis followed it. Currently, the volume of PPPs in Australia has exceeded $60 billion (Zou & Yang, 2015).

European countries have been late-comers to the PPP move. Although introduced initially to Europe in the late 1980s through the Channel Tunnel project, procurement through PPPs did not increase significantly in the European Union (EU) member states until a decade later (Liebe & Howarth, 2020). PPPs started to gain momentum in Spain, Ireland, and Portugal in the 1990s, while it was the mid-2000s when France, Germany, Italy and a number of other member states introduced legal frameworks and institutional arrangements allowing private finance in infrastructure (Button, 2006). According to the European Investment Bank (EIB) statistics, the volume of PPPs increased until 2010 – the peak year by value for new PPP projects in the EU. Between 1990 and 2010, more than 1400 PPP projects were signed corresponding to an estimated capital value of almost €260 billion.[2] To respond to the rising demand, the European Commission referred

[2] See the website of the European Investment Bank: https://data.eib.org/epec

PPPs, for the first time, in Internal Market Strategy document in 2003. The document underlines the need for legal regulations in the field of PPPs. In this line, a Green Paper was published in 2004 that generated a policy framework on PPPs at the EU level.

The global economic crisis adversely affected the PPP market in Europe, thereby reducing demand for PPPs after 2010. The EIB data indicates that during the last decade, the volume of PPP investment was nearly €100 billion with almost 400 new projects, meaning that at the end of 2020 total volume of PPP investments in Europe reached nearly €368 billion.

In 2020, Germany was the largest PPP market in Europe in terms of value, with a total of €2.8 billion while France was the largest in terms of the number of projects with 12 deals closed and second in terms of value. The transport sector was prior with an investment value of €4.9 billion, which is more than half of the total PPP investment, €7.9 billion (EIB, 2021).

Next, PPPs were offered to developing countries that need basic infrastructural themes but lack the necessary financial resources. In that way, PPPs reached an absolute scale in the mid-2000s in countries like Turkey, Brazil, and China. After a decline in the effects of the global economic crisis, the developing world embraced PPPs extensively. In developing countries, the total volume of PPP investments reached nearly €170 billion in 2012. Despite a downward trend after this peak year, the developing world has still a primary role in the PPP market. In 2020, the top five countries with investment commitments were all developing countries, namely Brazil, China, India, Mexico and Bangladesh (WorldBank, 2021).

According to Bayliss and Wayenberge (2018), three main reasons played significant roles in the widespread espouse of PPPs. First, unlike the privatisation of the 1990s, PPP policy is now driven far more by global finance availability than

by the previously perceived potential for efficiency gains through privatisation. Second, this has led to the institutional restructuring and reconfiguration of infrastructure intending to facilitate financial investors' entry. Third, this shift has been supported by a policy framework that is strongly oriented towards private sector involvement rather than alternatives based on public sector provision.

The shining era of PPPs started to come to an end with the global financial crisis in 2007. The availability of extensive credit facilities came to an end. Moreover, market failure discredited neoliberalism, and some NPM ideas, mainly that the private sector is inherently efficient and effective (Whiteside, 2018). Hence, as one of the products of those ideals, PPPs began to be questioned. PPPs advocacy has been given up, especially in the developed countries.

It is mainly related to governments' attempts to reorient PPPs' financing model to capture the possibilities offered through the search by institutional financial investors for long-term and stable returns rather than supporting a return to public finance. This reorientation corresponds to financial investors' search for investment opportunities that offer stable, long-term yields, particularly after having suffered substantial losses through exposure to the global financial crisis (Bayliss & Waeyenberge, 2018). In other words, PPPs have turned into a rewarding tool for major financers which provide stable and guaranteed profits. Nonetheless, this tool's public side implications are open to debate and tackled in the following parts. Before that, the definition of PPPs has to be clarified.

2.2. The conceptual framework

2.2.1. Definition of PPPs

One of the most problematic parts of PPPs is the multiplicity in the definition of the term. As countries handle PPPs with varying purposes and perspectives, there naturally emerge different definitions and interpretations concerning the content

of PPPs. It is possible to categorise those various approaches into two groups in a broader sense: those who think of PPPs as a governance tool and those who evaluate them as a language game (Hodge & Greve, 2005). The former consists of the proponents of PPPs in line with the principles of NPM, while the latter embodies the critical approach.

The UK, as the pioneering actor in the field of PPPs, introduced the concept as a means of harnessing the private sector's efficient management and commercial expertise to bring greater discipline to the procurement of public infrastructure, thanks to engagement of the private sector to design, build, finance and operate infrastructure facilities through a long-term contractual arrangement (HMTreasury, 2012). Unlike classical procurement, the private sector is responsible not just for asset delivery but also for overall project management and implementation and successful operation for several years thereafter in the PPP model (PricewaterhouseCoopers, 2005). The institutions that support PPPs have also defined the term by focusing on different aspects of the model. To illustrate, the OECD (2008) defines PPPs as an agreement between the government and one or more private partners according to which the private partners deliver the service in such a manner that the service delivery objectives of the government are aligned with the profit objectives of the private partners and where the effectiveness of the alignment depends on a sufficient transfer of risk to the private partner.

At that point, the long-term service provision based on a lease-based contract and properly sharing risks are put forward. The IMF focuses on the role of PPPs in the improvement of infrastructure. The IMF evaluates PPPs as arrangements where the private sector supplies infrastructure assets and services traditionally provided by the government (IMF, 2004). The WB shares the same vision and refers to the contribution of PPPs in improving infrastructure by vesting control rights with the private sector, bundling into one contract the design, construction, operation, and maintenance of the facility, and by transferring the risk of cost and time overruns to the private partner (WorldBank, 2017).

Although the EU does not have an official PPP definition at the Community level, it defines PPPs on the Green Paper as forms of cooperation between the public and private sectors for the funding, construction, renovation, management or maintenance of an infrastructure or the provision of a service (EC, 2004). The EU prioritised the cooperation between public and private actors as the 2004 enlargement encapsulates countries having experienced a socialist economic model. The mechanisms like PPPs would serve for the transition of these countries towards a free market and rejuvenation of the private sector. The USA National Council defines PPPs as a contractual agreement between a public agency – federal, state or local- and a private sector entity through which each sector's skills and assets are shared in delivering a service or facility for the use of the general public (Ke, Wang, & Chan, 2010).

The literature in this realm has also covered many definitions which support different aspects of official explanations. For instance, authors like Steane and Carroll (2000) and Bovaird (2004) underline PPPs' long-term character based on a mutual commitment between public and private actors. On the other hand, a significant segment of authors put emphasis not on sharing common purposes or skills but on risks. For instance, Carr (1998) suggests that a PPPs are a cooperative venture between public and private sectors, built on the expertise of each partner that best meets clearly defined public needs through appropriate allocation of resources, risks and rewards. Standard and Poor's supports this view by indicating that PPPs are any medium to a long-term relationship between the public and private sectors, involving sharing risks and rewards of multisector skills, expertise, and finance to deliver desired policy outcomes (PricewaterhouseCoopers, 2005).

A broader definition of the term, which brings different aspects together, was introduced by the Netherlands that evaluates PPPs as a form of cooperation between government and business (in many cases also involving non-governmental organisations (NGOs), trade unions and/or knowledge institutions) in which they agree to work together to reach a common goal or carry out a specific

task, jointly assuming the risks and responsibility and sharing their resources and competencies (IOB, 2013). In this context, the ones who evaluate PPP as a governance tool have been divided in terms of definitions, with each focusing on different characteristics. However, when various definitions are thought together, it can be reached to common points which are helpful to clarify PPPs as a term. These are;

1. A kind of cooperation between the public and private sector to reach a common purpose.
2. A well-defined contract between the public and private actors regarding the project's purposes and content.
3. A joint funding mechanism for the project by the public and private sector.
4. An explicit agreement about how to share the resources and tasks between involved parties.
5. The allocation of the risks between public and private actors sufficiently.

On the other hand, the critical approach tackles PPPs simply as a language game designed to mask its primary purpose. In this context, PPPs are not different from privatisation or contracting out. For this view, in order not to attract criticism from the public by using these concepts, the term PPPs was produced. In the last instance, it is another version of privatisation to promote private actors for the provision of public services at the expense of public organisations. Davidson (2004) argues that PPP policies have nothing to do with economics and everything to do with powerful vested interests that are happy to hide behind this issue's complexity to enrich themselves.

Nonetheless, many authors reject the view which induces PPPs to privatisation. They claim that there are significant differences between privatisation and PPPs. Yescombe (2007) outlines four main arguments which reject equalising PPPs and privatisation.

1. The Public Authority remains directly politically accountable for a PPP-provided service, but not for a privatised service. The citizen will usually

not be especially conscious that a PPP-based service is being provided by a private-sector company rather than the public sector, whereas this is obvious for privatised services.

2. In a PPPs, ownership of physical assets normally remains with (or reverts to) the public sector, whereas in privatisation, they become permanently private-sector owned.
3. PPPs usually involve the provision of a monopoly service, whereas privatisation usually means the introduction of competition to provide the service.
4. In a PPPs, the scope and cost of services are fixed by a specific contract between the private and public sectors. In contrast, in privatisation, they are controlled, if at all, by some form of licensing or regulation which allows for regular cost changes or are simply left to the forces of market competition.

This study attempts to indicate the legitimacy of critics against mainstream definitions of PPPs. It is clear that PPPs have carried significant differences from privatisation and can be seen as a continuum between public procurement and privatisation (Roehrich et al., 2014). Yet, at the end, the primary outcome of both privatisation and the PPP model is the commodification of the public services. If the purpose is not to mask the real intent, it is to produce an alternative way for the commodification in line with the protection of vested interests of the capital owners. Haether Whiteside (2011) reaches a similar outcome in his analysis of reform in the Canadian public healthcare system via the adoption of PPPs. He refers to what David Harvey (2003) calls accumulation by dispossession, a term which denotes a particular form of market expansion, namely when it is achieved by incorporating into the realm of private accumulation that has come to exist 'outside' of these circuits of capital. In that respect, PPP is not merely an economic or a profit-seeking mechanism.

Still, it is a model which necessarily involves a transfer of rights and controls away from the public sphere by vesting greater authority, decision-making, and power over important social concerns in the hands of private, unaccountable market actors (Whiteside, 2011).

While the critical approach has gained leverage with some PPP projects' failure, the inability to break down the hegemony of NPM ideals prevents them from blocking PPPs' spread in different visions.

2.2.2 Types of PPPs

The modern forms of PPPs are differentiated in many realms from their historic pioneer, which is the concession mechanism that grants the private entity the right to operate, maintain and collect user fees for an existing publicly owned asset in exchange for an up-front fee and sometimes a share of revenues (Little, 2011). The differences in PPPs' theory and practices by various actors caused the emergence of many types of PPPs. There are mostly slight differences among them. In the literature, the categorisation of PPPs is mainly held in accordance with the degree of private involvement in projects. By taking the density of their worldwide use, five main types of PPPs are defined.

Table 1. Main Types of PPP

Operation – Maintenance (OM)	•The private sector is responsible for all aspects of operation and maintenance. • Although the private sector may not take the responsibility of financing, it may manage a capital investment fund and determine how the fund should be used together with the public sector.

Table 1. (continued)

Design-Build-Operate (DBO)	• The private sector is responsible for the design, construction, operation, and maintenance of a project for a specified period prior to handling it over to the public sector.
Design-Build-Finance-Operate (DBFO)	•The private sector is responsible for the finance, design, construction, operation, and maintenance of a project. • In nearly all cases, the public sector retains full ownership over the project.
Build-Operate-Transfer (BOT)	•The private sector is responsible for the finance, design, construction, operation, and maintenance of a project for a concession period. •The asset is transferred back to the government at the end of concession period, often at no cost.
Build-Own-Operate (BOO)	•Similar to a BOT project, but the private sector retains the ownerships of the asset in perpetuity. • The government only agrees to purchase the services produced for a fixed length of time.

Source: Kwak, Chih, and Ibbs, 2009.

In addition to PPP models given in the table above, two additional types of PPPs started to be used in common in last years. The first model, Buy-Build-Operate (BBO), refers to transfer of a public asset to a private or quasi-public entity usually under contract that the assets are to be upgraded and operated for a specified period of time (Little, 2011). The second one is Build-Lease-Transfer (BLT) in which a private contractor builds and finances a project on behalf of the public partner and

then leases the project back to the client for a predetermined period. The BLT will be analysed in detail in Chapter 3, while the city hospitals project in Turkey is elaborated.

2.3. Advantages and Disadvantages of PPPs

2.3.1 Advantages of PPPs

The key literature covers many sources touching upon the advantages of PPPs mainly in three realms: efficiency and effectiveness of privately held projects ensuring financial benefits, value for money and risk sharing.

2.3.1.1. Financial benefits of PPPs

The vision glorifying the private sector's involvement in public service delivery, based on the idea that it is more efficient and effective compared to the public sector, emanates from the superiority of neoliberalism and NPM rather than concrete evidence to the most extent.

In this context, the first argument is that private actors have an incentive to induce optimal investment in infrastructure and quality at a relatively lower cost or risk than the public sector (Trebilcock & Rosenstock, 2015). In other words, private investors' competitive and profit-based characteristics force them to embrace the best way to ensure cost-saving. As a result, both construction and operation phases can be conducted less costly. Moreover, it is claimed that the construction phase in PPPs is completed more quickly than traditional procurement since the investors have to start to operate as early as possible to raise their profits. In this line, not only the cost but also timing would be saved, which is another concern of efficiency. There is no incentive to lower the costs and increase the profit in the public sector because of the absence of competition and having different matters like social benefits.

Another concern is about the impact of PPPs on the allocation of public resources. PPPs seem to be attractive for many governments since the financial cost is paid through long term payments, while benefits arise in the short run. The government shoulder the cost during the operational phase but not in the construction stage. Thus, a costly project becomes affordable without an initial payment from the budget or an increase in borrowing.

In this regard, Hodge and Greve (2005) liken PPPs to a mega credit card for governments. According to Bayliss and Wayenberge (2018), having such a credit card has the potential to close the infrastructure gap by leveraging scarce public funding and introducing public sector technology and innovation to provide better quality public services through improved operational efficiency. In that way, the short term fiscal constraints do not prevent huge infrastructural investments. Besides, PPPs also serve governments to achieve budgetary targets as keeping budget deficits within 3% of GDP as compatible with the Maastricht Treaty for the EU member states.

The advantage of PPPs is that not the overall liability but only the annual payment made to the project company is accounted for in the budget. This character of PPPs, called off-balance sheet treatment, is attractive because it helps in prioritising the short term benefits instead of long-term obligations. In addition to financing mega infrastructure projects through private sector funds, PPPs provide free resources for governments to be used in funding their public investment program in the short run. Hence, governments could stay popular in the eyes of the public for the next electoral period.

Finally, it is stipulated that the focus of PPPs on outputs creates more qualified services. Since the output specifications are fixed for lengthy periods, it becomes critical that the service levels are set correctly at the outset, which leads to even greater focus on defining service levels at the beginning of a project than has historically been the case (PricewaterhouseCoopers, 2005). As the project

company is under the obligation to maintain service standards throughout the operation phase and handle the project to the public sector in a functional situation, the same quality in the service level has to be secured during the project.

2.3.1.2 Value for money

The second dimension regarding the advantages of PPPs is related to the concept of Value for Money (VfM). The analysis of PPPs on the basis of the VfM had started with the release of Value for Money Assessment Guidance by the UK Treasury in 2006. The report defines the term as the optimum combination of whole-of-life costs and quality (or fitness for purpose) of the good or service to meet the user's requirement. It is not simply to prefer services based on the lowest cost bid; instead, it provides maximum benefit with current resources. The report also claims that many characteristics of the PPPs form part of the evidence for PPPs are the best way to provide the VfM. These are;

1. A major capital investment programme requiring effective management of risks associated with construction and delivery;
2. The structure of the service is appropriate, allowing the public sector to define its needs as service outputs that can be adequately contracted for in a way that ensures effective, equitable, and accountable delivery of public services into the long-term, and where risk allocation between public and private sectors can be clearly made and enforced;
3. The nature of the assets and services identified as part of the PFI scheme, as well as the associated risks, are capable of being costed on a whole-of-life, long-term basis;
4. The value of the project is sufficiently large to ensure that procurement costs are not disproportionate;
5. The technology and other aspects of the sector are stable, and not susceptible to fast-paced change;

6. Planning horizons are long-term with confidence that the assets and services provided are intended to be used over long periods into the future; and
7. The private sector has the expertise to deliver, there is good reason to think it will offer VfM, and robust performance incentives can be put in place (HMTreasury, Value for Money Assessment Guidance, 2006).

The rationale behind the promotion of PPPs on the basis of achieving the VfM is related to the risks that the private party undertakes. In order to eradicate the question marks regarding whether PPPs are of better value than traditional procurement, the most commonly used method is to apply for the Public Sector Comparator (PSC). In this way, two service delivery alternatives can be compared in terms of their financial and non-financial but quantifiable benefits. As a result, governments choose the lowest net present cost option. There are two main factors regarding the calculation of the VfM via the PSC. First, an amount -known as risk adjustment- in exchange for the transferred risk is added to the cost of the traditional service delivery model to estimate the exact cost of the project if delivered through traditional procurement. Second, a discount rate is applied to compare the two forms of cash -money spent today versus payments which are spread over many decades- based on the private sector principle that money spent today costs more since it had the potential to earn interest if spent gradually (Whiteside, 2013).

As a result, net present costs can be calculated for both the PPPs and PSC and the lowest cost is taken to represent best VfM. The UK Treasury carried out a study in order to indicate that PPPs represent VfM best. The results of the study claim that PPPs had saved 17% on the cost of conventionally procured projects (Shaoul, 2005). The strict relation between VfM and PPPs is advocated due to the chance to transfer some risks to private actors in the PPP model.

2.3.1.3. Risk transfer

Risk transfer is the most widely focused issue in the literature concerning the advantages of PPPs. The main dynamic of partnership is the allocation of risks to the party best able to manage each particular risk. Hence, the public sector can share the burden of mega projects and get rid of some parts of their excessive burden. For instance, under PPPs, the private sector takes the life cycle costs (construction, operation and maintenance) of the project, which requires long and complicated bureaucratic procedures within the conventional way. However, there are various risks for any project in different stages. Therefore, the determination of all possible risks and proper allocation between parties should be precisely defined with a correct contractual framework. In this vein, the identification of risks is crucial in the contractual process.

The risks differ based upon many parameters. They might emanate from structural problems in the country such as fragile economic situation; sector-specific problems in which the project will be held as emergencies like Covid-19 pandemic in the healthcare; issues pertaining to the contract management and stakeholders. In this vein, there is a widely accepted categorisation of risks in the literature. Based on research in PPP practices in the UK, three levels of risk factors in PPP projects are defined: macro, meso and micro.

The macro-level risks refer to the ones which are external to the project. They are mainly related to political, legal conditions, economic situation, social and natural developments. The meso-level risks are endogenous to the projects, such as the project's design, location and necessary technology for operation. The final group of risks, micro-level ones, are associated with stakeholder relationships. They are also within the scope of the project like meso-level risks, but the difference is that the source of micro-level risks covers party-related issues instead of project-related ones (Bing, Akintoye, Edwards, & Hardcastle, 2005).

Table 2. Categorised Catalogue of PPP/PFI project risk factors

Risk meta level	**Risk Factor Category Group**	**Risk Factor**
Macro level risks	Political and government policy	Unstable government
		Expropriation or nationalisation of assets
		Poor public decision making process
		Strong political opposition
	Macroeconomic	Poor financial market
		Inflation rate volatility
		Interest rate volatility
		Influetial economic events
	Legal	Legislation change
		Change in tax regulation
	Social	Lack of tradition of private provision of public services
		Level of public opposition to the project
	Natural	Force majeure
		Geotechnical conditions
		Weather
		Environment
Meso level risks	Project selection	Land acquisition (site availability)
	Project finance	Availability of finance

Table 2. (continued)

		Financial attraction of project to investors
		High finance cost
	Residual risk	Residual risks
	Design	Delay in project approvals and permits
		Design deficiency
		Unproven engineering techniques
	Construction	Construction cost overrun
		Construction time delay
		Material/labour availability
		Late design changes
		Poor quality workmanship
		Excessive contract variation
		Insolvency/default of subcontractors or suppliers
	Operation	Operation cost overrun
		Operational revenues below expectation
		Low operating productivity
		Maintenance costs higher than expected
		Maintenance more frequent than expected

Table 2. (continued)

Micro Level Risks	Relationship	Organisation and co-ordination risk
		Inadequate experience in PPP
		Inadequate distribution of responsibilities and risks
		Inadequate distribution of authority in partnership
		Differences in working method and know-how between partners
		Lack of commitment from either partner
	Third Party	Third Party Tort Liability
		Staff Crises

Source: Bing, Akintoye, Edwards, and Hardcastle. 2005.

Grouping and classifying project risks facilitates a strategic approach to risk management for public and private sector stakeholders. It may also indicate situations where common approaches to risk analysis and treatment, subsequent risk monitoring and control can be adopted in the risk management process. It differs in how stakeholders share the risks according to the context. For instance, it is highly expected that macro-level political and economic risks should be retained by the public sector while the remaining are either allocated to the private party totally or shared between the public and private with the condition that the latter shoulder the risk more than the former (Bing, Akintoye, Edwards, & Hardcastle, 2005).

However, there is no ideal way of sharing risks. In countries like the UK, where there is an experienced private sector with a consolidated free market, it is expected that the private party holds more risks. On the other hand, in a market dominated by the state and not having a well-developed private sector, the public sector cannot transfer most of the risks to the other party in PPP projects. Therefore, it is of utmost importance not to ignore that the content of risks and how to share them between parties are contextual in terms of the market structure, the sector in which the project is held, and the experience of stakeholders.

2.3.2 Disadvantages of PPPs

The opposite views on PPPs can be categorised into two main realms. The first part comprises views against the abovementioned pro-PPP arguments, while the second group consists of additional critical points focusing on the problems embedded in the PPP model. The contrary arguments on PPPs will be handled in detail since it serves one of the study's purposes, which is to indicate the maladies of PPPs.

2.3.2.1 Contrary arguments to PPPs

To begin with, the propaganda stipulating PPPs as a way of a more efficient and effective way of conducting infrastructure services with lower cost and risk does not reflect the reality, rather a neoliberal utopia (Coghill & Woodward, 2005). In fact, there are no fully informed actors, fair and competitive markets, achieving full efficiency and effectiveness. Otherwise, there have not existed monopolistic and oligopolistic market structures in various sectors, and neoliberalism would not need to distinguish itself from classical liberalism by taking many regulatory steps. Hence, labelling the public sector as inefficient based on some negative experiences in the welfare state era is unjust. There could be many examples of functionally performing public institutions and corrupt and inefficient private actors. It does not allow glorifying either a statist or liberal approach. In a similar

way, if the neoliberal agenda is the best alternative as claimed, it is a big question mark to explain the latest global crisis. If neoliberal transformation is inevitable and private service delivery as a part of this transition is the most effective way, then why countries like Turkey that embraced neoliberal agenda of the IMF and WB and privatised most of the State Economic Enterprises (SEEs) cannot get rid of repetitive economic crises and why they still endure many problems in service delivery and need to initiate new reforms? Even though there is no convincing answer to these questions, neoliberalism and NPM still secure their seats because of the hegemonic character of the ideology. As Coghill and Woodward (2005) assert, the lack of an alternative ideology in the public or political domain leaves opponents of PPPs with little for manoeuvre, limits the credibility of critical assessment of PPPs, and as a consequence, reduces public awareness of potential failings of PPPs.

Apart from efficiency concerns, the allegations on the cost-saving character of PPPs should be contested. The finance mechanism of PPP projects is based chiefly on borrowing from financial institutions. In financial markets, the cost of borrowing for private actors is higher than for governments. The lower credit risk of governments makes them eligible to get cheap credits. Therefore, the project's total cost will increase for the project company. In addition to the cost of borrowing, one more factor increases the project's cost, which is the profit concern of the private sector. The project company will take into consideration the cost while pricing the project, which makes the total cost of PPPs for the state more than conventional procurement. Similarly, even in the case of private sector cost superiority, savings are not likely to be passed on to the public but rather absorbed by the private partner in the form of higher profit (Whiteside, 2013).

The proponents of the cost-saving character of PPPs neglect that the cost cannot solely be perceived from a financial perspective since there are social costs of PPPs, too. The private sector may employ less personnel with low wages and stricter working conditions to raise profit. Thus, the eligibility of services and their

quality may lessen. Even worse, if there has not been a regular inspection mechanism for private companies conducting PPP projects, some parts of services may not be operationalised due to high cost, leading to fatal accidents (Whiteside, 2011). To illustrate, a project company that undertakes the construction of a railway may avoid setting a functional signalling system as it is expensive and open the gate to catastrophic accidents. It is hazardous for countries where bribery and patronage network are common since the private party may try to cover up its faults behind closed doors. As a result, not the private party but society generally endure negative consequences. Thus, PPPs can be defined as a tool to privatise profits but socialise losses.

According to Loxley (2012), the alleged positive impact of PPPs on budgetary indicators also does not reflect reality. How the payment of minimum due of a credit card does not mean extinguishing the total debt, the annual payments to the project company cannot cover the life-long cost of PPP projects. Though the total debt does not take place in the annual budget, the government is under a long-term payment commitment. In that respect, PPPs are used as a budgetary trick to lessen the short-term financial pressure on governments and create an illusion regarding the budgetary indicators in people's eyes. In addition, PPPs help the EU members and candidate countries fulfil the budgetary criteria determined by the Maastricht Treaty. In order to overcome the illusionary impact of PPPs on the annual budget, Loxley (2012) suggests that future payments to the private sector can be discounted back to give a present value, and the amount achieved should be treated as the current debt. Hence, it is easy to perceive how PPPs impair future budgets.

Another pro-PPP argument regarding budgetary affairs refers to governments' opportunity to use financial resources for more urgent needs while conducting infrastructural services simultaneously, which also encapsulates problematic aspects. First of all, PPPs are common mainly in developing and developed countries. It is understandable for developing ones since they need to set infrastructural services for the growth of the industry. However, if the purpose is

to close the infrastructure gap, then it is expected that underdeveloped countries must also share PPPs. Nonetheless, since these countries do not present potential for huge profits, the private sector is reluctant to participate in PPP projects despite governments' eagerness. These countries cannot find credit from international institutions to guarantee private stakeholders since their creditworthiness is not high in global financial markets. It paves the way for the acceleration of the development gap between developed and underdeveloped countries (Bishop & Waring, 2018).

That's why PPPs do not seem to be closing the infrastructure gap for the ones that are really in need; rather, they close the profit gap of the private sector in a sense and consolidate global inequalities. Similarly, the infrastructure gap between sectors is not closed as well. The mega projects require substantial financial resources, making private actors depend on financial credits. Since the creditors focus on the rate of return, they will finance the investments in profitable sectors that doom the degradation of the profitless ones. As a result, sectors producing public interest will have a secondary role since they do not address profit concerns.

Furthermore, PPPs are not helpful, as it is claimed, for efficient allocation of resources by allowing governments to use resources for urgent needs. This assumption presumes that all governments prioritise social needs while forming and conducting public policy. Therefore, the allocation of resources for those whose urgent needs should be clarified. Similarly, it is critical not to neglect the debased character of some governments. The partnership decision between public and private actors is taken behind closed doors. It is open to manipulation for the sake of any stakeholders but not the society since it is not at the table. Lastly, setting all service criteria at the beginning would be helpful for the standardisation of quality; however, such a precise specification also prevents flexibility in policy making (Whiteside, 2011). For services like healthcare, in which rapid developments have been experienced, the strictness of regulations can decline the quality in the medium and long run. Since the project company burdens the

responsibility to install and secure initial requirements but is not under obligation to renovate the service provision techniques following the upcoming developments, the service standards initially clarified will inevitably lag behind.

The promotion of PPPs as the service delivery model that worth money best needs to be discussed. The calculation of VfM is based on the postulated discount rate. As the rate changes, the VfM does not give the same results. The higher discount rate makes PPPs more attractive in terms of cost. As Shaoul (2005) asserts, the highly technical VfM appraisal methodology is not neutral but is itself biased in favour of the private sector option. The UK Treasury, for instance, had used a discount rate higher than the interest rate on government bonds in the calculation of VfM in its first report on PFI. Then, its analysis is based on a sample of 29 projects out of nearly 400, whose selection procedure is not explained (Edwards & Shaoul, 2003b). It is clear that VfM is another trick that underpins the private sector's superiority in public service provision.

The most concrete element appears to be the risk transfer in pro-PPP arguments. At this point, it is of utmost importance to have a balanced policy in allocating risks. For a healthy partnership, each party should undertake the risks and responsibilities that they can bear best. Otherwise, adverse outcomes may emerge for different parts of the projects in case of an imbalance in distribution. For instance, if the public sector assumes most of the responsibilities, it contradicts the main idea behind PPPs and only contributes to the increase in the profit of the private party. On the contrary, if the private sector is expected to undertake most of the responsibilities, it would be difficult for a partner since no party wants to be under such a burden. Moreover, this will be against competition because very few private actors would have the ability to handle multiple risks, which automatically eliminates many potential "partners" from the PPP procedure. Finally, though the discussion on a balanced allocation of risks sounds great initially, it seems to be an artificial argument to the most extent.

In each PPP project, some stages fulfilled by the public sector in traditional procurement are undertaken by the private sector, such as risks regarding the construction. Nevertheless, this does not mean that the risks inherent in those stages do not affect the public sector. Based on the concern of profit maximisation, the private sector will price the risks it assumes and add them to the total cost. In other words, the risks claimed to be transferred come back to the fold, and the public sector has to pay for it (Whitfield, 2001). In other words, the total cost of PPP projects for the public side is highly parallel to the volume of risks transferred to the private sector. The more the risks are transferred, the higher the total cost of PPP projects will be.

The inability to transfer risks in the long run also emanates from the differences between the nature of the public and private sectors. When any investment does not meet investors' expectations, they can prefer changing their decisions, giving up the project, and taking place in any other one. However, the public sector does not have the same chance due to the social character of public service. It cannot give up providing services that are not profitable.

Therefore, PPPs contain a significant danger in the operation process whose risks are mostly claimed to be transferred to the private party. If the private party cannot make a profit as it expects, or extraordinary developments emerge related to the operational procedure and internal dynamics of the project company, such as bankruptcy, then the public sector has to undertake service provision. Corner (2005) indicates that if a PPP project fails in the delivery of an essential public service, the public sector may have no option but to take back responsibility for delivering the service. Under these circumstances, it would be misleading for the contract to be drawn up based on the risk of failure has been wholly transferred to the private sector supplier. In that sense, the cost of operation will be added to the payment made until the private party recedes. Thus, it is evident that the abovementioned advantages of the risk transfer issue evolve differently in theory and practice.

2.3.2.2 Disadvantages related to the nature of PPPs

Apart from criticisms of pro-PPP arguments, there have also been important contrary views regarding PPPs' internal dynamics. The first and most significant issue is related to PPPs' structure, which paves the way for a shift in the balance between capital and state in public service delivery. The commodification of service provision through PPPs results in social needs becoming subordinate to financial flows, stemming from usage or activity levels, user charges and income generation (Whitfield, 2001). The bankable character of services comes before social needs, which erodes the publicness of services and serves to financialise them.

The de-politicisation in public service provision presents a contradictory character with the governance approach. Although governance proposes a participatory decision-making process with multiple stakeholders having –ideally- equal say over policy, PPPs allow for the domination of private actors who own the financial power. The public actors lose their control over policy making regarding public service provision. As the governments and parliaments cannot take essential decisions on social needs, the private actors capture the power to impose their wishes on those issues on behalf of capital owners' interests.

Skelcher (2012) states that such a process raises significant problems regarding democratic governance due to the state's changing nature and warns of a democratic deficit because of a shortfall in accountability management. This warning is based on the fact that when public tasks and responsibilities are shared with private partners, the government loses direct control; thus, parliaments and the public lose oversight and influence over the conduct of a service financed by taxes. It opens a gate of debate for the democratic character of PPPs. To begin with, PPPs erode one of the basic principles of democracy: accountability. The representatives are not responsible for people in the provision of public services since they transfer their operations to private actors. Neither citizens nor

representatives have any mechanisms to scrutinise the operational process. The nature of relations between principal and agent in terms of the latter's responsibility in response to delegated power by the former is broken down. In case of trouble in service delivery, people find a private actor who does not have any accountability towards society (Williems & Dooren, 2014).

Democracy is an open and transparent regime in which people can call elected representatives to account for their activities. On the other hand, as opposed to public demand for openness and transparency, private actors work within the principle of commercial confidentiality. The irreconcilability between these principles is solved to the advantage of the private sector in PPPs. Political actors make the decision to deliver any PPP projects, and it may or may not be open to discussion. Still, after the decision is taken, the process of procurement, the content of tender specifications, estimated total cost etc., are out of the control of the political body and not mostly released because of the commercial confidentiality. The decisions affecting citizens' daily lives extensively, from health to transportation and financed by their taxes, are taken behind closed doors, and their details are not declared (Williems & Dooren, 2016).

Democracy also requires the presence of different alternatives, in any case, the best of which to be chosen. Unfortunately, not many options are offered to governments as parallel to the domination of NPM ideas. The belief in private sector practices' superiority forces the public sector to embrace either privatisation or PPPs. During the early stages of neoliberal transformation, since the traditional bureaucracy is not familiar with the new realities, governments turn their faces to private advisors so as to overcome problems regarding the management of the transition process as well as the implementation of new models of public service provision. Hence, a consultant class that promotes the notion of managing a state like a company began to impose their ideals on governments. The consultants not only convince governments of the superiority of the new models but also affect the negotiations in the tendering process between public and private parties. The

complex and highly technical character of PPP contracts and the lack of experienced cadres in bureaucracy to handle this process have forced governments to rely on consultants. As a result, a real consultocracy that drives the global spread of the PPP business emerged (Hodge & Bowman, 2006).

The public and private actors' mutual interests also help PPPs get leverage. The vast infrastructure investments with the PPP model mean transferring a significant amount of finance to the private sector. Suppose the private actors believe that protecting their financial interests depends upon the maintenance of the government. In that case, they do not oppose it directly and may even support its activities through different mechanisms like donations. This commitment sourced from PPPs might affect other private actors, too. Coghill and Woodward (2005) assert that other businesses, mindful of possible future partnerships, would also have an incentive to seek harmonious relations with the government. The business community, in general, is liable to be well disposed towards a government that strives to be friendly towards business. Thus, most of the groups having the financial capacity abstain from opposing government policies. As a result, democracy loses its character as a system in which parties lose elections.

On the other hand, as the private actors are overfed by the government and raise their power, the government has also become dependent on their support to finance their policies to stay in power. Hence, private actors increase their capacity to impose on governments' policy making through their lobbying power. This mutual dependency creates an oligarchic bond between political and financial groups, which causes corruption in the use of public resources by governments for the sake of privileged groups serving for the consolidation of power. In this context, public-private partnerships turn into, in a sense, public-private dependency in an oligarchic political and financial system.

Another realm of trouble that PPPs cause is related with the fact that in case of a change in government, the long-term and inflexible character of contracts hamper

activities of the new governments. When the current political authority signs a PPP contract, it firstly limits its predecessors' budget autonomy. The newcomers should perpetuate annual payment, that is, transfer of finance to the same groups. In addition, PPPs also stifle the policy preferences of future governments. To illustrate, if there are 20-30 year PPP contracts in healthcare provision, it will not be easy to change even if an anti-neoliberal socialist party comes to power. Willems and Dooren (2014) assert that when future policymakers want to change public policy and adjust PPP contracts, they will face costly renegotiations. The private sector imposes articles guaranteeing their long term interests in contracts, which makes it difficult to cancel the contracts. Thus, though it is involuntarily, the future governments oblige to endure PPPs' negative consequences throughout contracts.

The rumour PPPs provide cost-effectiveness is groundless due not only to explicit but also implicit costs. Initially, PPPs have complex bidding and negotiation process. After selecting the winner bidder, there has been a long and technical process of negotiations. It requires public bodies to develop comprehensive project appraisal and evaluation methodologies and the ability to monitor large performance contracts to ensure contract payments are performance-related and that risk is fairly attributed between client and contractor (Whitfield, 2001). The time lost and money spent on consultancy mechanisms during the negotiation period raise the project's cost. According to Flyvbjerg (2017), mega-projects are inherently risky due to the long planning horizons and complex interfaces, but when the internal dynamics of PPPs are added like decision making, planning and management with multiple actors having conflicting interests and planners without deep experience who keep changing throughout the lengthy project cycles, the cost of managing such risks accelerate, though it is hidden.

A more critical hidden cost of PPPs is their impact on undermining social and moral values, especially for bureaucrats. The more bureaucrats embrace private sector practices and NPM ideas, the more they prioritise economic rationality and

neglect their responsibility to society. The loss of publicness of public services occurs not only through the operation of services by the private sector but also through the loss of moral purpose to present a public service by bureaucrats. The entrance of private-sector logic into public service provision transforms service providers in line with the values that prioritise self-promotion and self-interest. An act for the sake of society turns into an action serving individual purposes.

Several case studies, as conducted by Smith (2012), suggest that the growth of PPP contracts has led to a reduction in the capacity of public servants to work in the public interest, limiting the scope for individual discretion and professional autonomy in the face of strict contractual and performance criteria. The social cost of such a transformation can vary according to the sector in which PPPs are implemented. To illustrate, in the health care sector, the notion of minimising the cost and maximising the benefit might incline the project company -providing non-clinical support services- to cut wages, provide inadequate support services like hygiene, etc. The same motto may also lead doctors to incorrect operations to increase their premiums.

Moreover, in case of the absence of functional integration between clinical and non-clinical services conducted, in order, by public and private actors, some steps of the project company might jeopardise the effective delivery of clinical services. In other words, the internal bifurcation of authority hampers the administration of healthcare provision. According to Whiteside (2013), this feature of PPP hospitals is produced when authority and oversight over hospital services are no longer held exclusively by public health authorities but shared with private partners. Finally, all those concerns are sourced from the plethora of institutional differences between the public and private sectors that cannot be reconciled. NPM puts forward PPPs as a way to overcome these differences; however, the fundamental values and principles of the two parties are so distinctive that the attempt to reconcile them only contributes to erosion, especially for the public side.

2.4. Organisation of Partnership

2.4.1. Bidding Procedure

Ideally, the decision for infrastructure investment is given following the needs and demands of society. In line with their responsibility as elected bodies, central and local governments generate an investment plan in proportion to their budget. Next, they have to decide on the method to conduct investments. They can establish and operate the service themselves, deliver the establishment to the private sector with traditional procurement and operate themselves, or transfer both to the private sector through any type of PPPs.

Then, they should analyse the costs of construction and operation for those alternative procurement methods and choose the best way for the public interest. According to the OECD (2012), projects that can give a 'yes' answer to the following questions are the most appropriate ones for applying the PPP model.

- Can the project's risks be clearly defined, identified and measured?
- Can the suitable types of risk be transferred to the private partner to ensure value for money?
- Does the project involve any transfer of risks onto other stakeholders, including workers and local communities?
- Is the risk appetite of potential private-sector partners sufficiently robust to explore a PPP?
- Do potential private-sector partners have a track record of good service delivery, responsible business conduct and PPP experience?
- What is the potential level of competition in the market? If competition is lacking, is the market contestable?
- Is there sufficient market interest in the project to generate a robust competition to ensure a value for money outcome?
- How large does the whole of life benefit from combining the construction and operating phases of a project in one contract?

• What are the risks of project failure associated with similar PPPs? What are the costs to the public authority associated with such failures?
• What contingent liabilities are associated with the project?
• Can the risks, cost and quality trade-offs be quantified and managed by the public sector?
• Can the desired project output be specified clearly ex-ante? Is the planned project operating in a rapidly changing policy or demand environment? Are the underlying assets to be used to deliver the output in an area subject to rapid technological change?
• Is the potential PPP project of a size sufficiently large to justify the transaction costs?
• Who will make the contractual payments to the private-sector partner? Can some or all of the payments come from end-user charges?
• If end-user charges are levied, will demand be sufficient over the project's lifetime to ensure that the private partner generates the revenue required for it to maximise its profit? Might the potential private-sector partners accept demand risk in addition to availability risk?

As a result of the analysis, if PPPs are evaluated as the most reliable procurement way for the project, the government declares a project charter. The content of the project is announced in general terms in this stage. The interested private parties convey their credentials which encompass their financial and technical competency regarding the project. The related authority analyses them, and the most capable firms are invited to the tender. The tender process is generally two-stage. First, the participants are allowed to revise their bidding which would decline the cost for the public. As a result, the most competent party is awarded. However, the evaluation of competency, which represents the best value, is pretty complicated. In the literature, Zhang's categorisation based on the assessment of competitive tenders in Build-Operate-Transfer is widely accepted for all types of PPPs. In that respect, he defines the following types of bid evaluation (Zhang, 2005):

1. Simple Scoring Method: Evaluation criteria and maximum possible scores are determined, with each criterion assumed to have equal importance. Each bidder is rated according to these criteria, and the bidder with the highest total score is awarded.
2. Net Present Value (NPV) method: The bidder offering the lowest NPV for the concession period (i.e. the lowest cost to the public) is selected. Using this method, only the financial and economic aspects of each tender are considered.
3. Multi-attribute analysis: criteria are decided in the same way as for the simple scoring method, but each factor is divided into sub-categories with relative importance weights assigned. After multiplying each bidder's weights and assigned scores, the bidder with the highest maximum score is selected.
4. Kepner-Tregoe Decision Analysis Technique: This technique evaluates proposals based on criteria identified as 'musts' and 'wants'. The 'musts' are the mandatory needs for the project and are expressed in the form of 'yes/no' questions. Bidders satisfying the 'musts' are then evaluated using a simple or multi-attribute scoring method based on the 'wants'.
5. Two Envelope Method: Bidders are expected to submit two different envelopes: the first provides technical information, and the second gives cost information. Initially, the technical offers are evaluated and then, for those approved, the financial envelope is opened. If the cost is within the client's acceptable range, that bidder is chosen.
6. NPV and Scoring Method: Two different evaluations are undertaken. NPV is used for financial assessment, and the scoring method is then used to review any unquantifiable information.
7. Binary and NPV Method: Bidders are first evaluated with 'musts' criteria, and those passing this step are then assessed according to their NPVs.

Recently, a new approach called 'best value' for bid evaluation has gained momentum. It proposes that not the cost but the bid's overall value should be considered. It is based on setting clients' needs and preferences and assessing each proposal's overall value accordingly (Dikmen, Birgonul, & Atasoy, 2009).

2.4.2. Establishment of partnership

Whatever method is chosen for evaluation; one private actor wins the bid. This actor is mostly a joint venture due to difficulty in fulfilling all project stages by a single party. Hence, companies from different sectors compatibly with the project's content – typically construction, engineering, procurement and maintenance firms, come together and form a project company (PC). It is also called a Special Purpose Vehicle (SPV) to emphasise its formation with a specific purpose, the construction and operation of a particular project. After that, a negotiation process starts between the related public actors and the PC. Both parties should have a clear agenda regarding the project before sitting at the table for negotiations. This process is not much problematic for the public side since it has a precise target and plan.

On the other hand, the private party has trouble in terms of unity since the PC comprises different actors with contradictory interests. In addition, the reality that partners of the PC, that is, equity holders; and investors of the project, i.e. debt holders, are different is another issue that makes the agenda of the private party more complicated. The investors are public and commercial banks, and public and private funds. Therefore, it is necessary to compromise the interests of debt and equity holders. They should eliminate their differences in critical issues and develop a unified and clear agenda regarding the construction and operation of the project. According to Yescombe (2007), the key issues that they have to cover are:

• The scope and structure of the project;

• Exclusivity and confidentiality commitments;

• Equity allocation;

• Project-management roles and responsibilities;

• An agreed programme for feasibility studies, the appointment of advisers, negotiations with subcontractors and other potential parties to the project contracts, and approaches to other prospective investors and lenders;

• Rules for decision making;

• Arrangements for funding of bidding and development costs, or the crediting of these costs against each sponsor's allocation of equity (taking account of both the amount of the costs and the timing of when they were incurred);

• Provisions for 'reserved roles' (if any)—*e.g.* if one of the sponsors is to be appointed as a subcontractor without being subject to third-party competition;

• Arrangements for withdrawal or transfer of a sponsor's interest.

When public and private parties come together with their precise agendas, they determine the basis of partnership. They try to agree upon the cost and duration of the project as well as the risks shared among them. As both parties sign the contract, the first step is to deliver the land or asset on which the project will be carried out to the private party. In this way, resource transfer from the public to the private party begins. Then, the PC deals with the engineering stage and handles the project proposal provided by the public party. When amendments, if necessary, are completed, it is presented to the public party for final approval. If the design is approved, then the construction stage takes place (Yescombe, 2007).

The private party is responsible for the facility's construction, yet the public party ensures necessary approvals and authorisations. The finance in this stage is secured through bank credits. With the completion of the construction, the service delivery starts. Again, the private sector is the main actor during the operation stage. However, in some cases like healthcare provision, the public party continues to provide core services while the private party only holds support services such as non-clinical services in hospitals. The PC may outsource some part of the service to different contractors. The private party gets payment from the public party for operation. In some cases, like toll roads, they charge citizens directly. When they are in need of finance, they mostly prefer bond transfer in the operation stage (HM Treasury, 2012). During the multi-decade contract, resource transfer goes on to the private party.

The public party has to monitor service quality. If the standards clarified in the contract are not met, then it should be compensated through the decline in the payment. If one of the parties does not meet its liabilities, the other party initiates a judicial process that might pave the way for the contract's cancellation. In addition, a provision stipulating a market test at regular intervals is held in contracts to protect parties against unexpected developments and secure their satisfaction with the project's conduct (Deloitte, 2006).

In that way, the project outcomes are put on the table, the applicability to the contract is checked, and if agreed, necessary amendments can be made. Parties even may decide on the termination of the contract. However, the demand of only one party is not enough. In this context, the other party resorts the case to the jurisdiction. In the contract, there are articles that protect parties against the other's arbitrariness and make the cancellation costly. If the unsatisfied party insists on the cancellation, it must assume a major compensation burden. Provided that both parties exercise due diligence, the PC's public service provision continues until the contract's termination. In the end, the infrastructure asset ownership is transferred to the public (Deloitte, 2006).

The shift in the public sector's role from service provider to service determiner and the private sector’s from asset provider to service provider forces them to change their traditional outlook. All contractual relationships of the concession company with other parties involved in the PPPs have to provide for the contract's extended life, establish measures to control and develop dispute resolution procedures. The private sector must also adjust its organisational cultures and structures to a long-term involvement instead of the traditional short-term and related temporary multi-organisations of the construction projects (Eaton & Akbiyikli, 2009).

The PPP model has to introduce several measures due to their permanent and irrevocable characteristics of public and private actors’ interests. The private party's expectation of securing its profit has forced the public side to incorporate guarantees into the contract. The type and amount of the guarantee vary from

country to country in accordance with the dynamics of the market. For instance, PPP projects need to encapsulate fewer guarantees in the competitive and stable markets with a sufficient number of experienced private companies. On the other hand, in state-based economies that lack a competitive private sector and are mainly dominated by a few leading companies, PPP projects include much more guarantees. Otherwise, it would be not easy to find a partner from the private sector. In that respect, governments have to provide some assurances to appease the concerns of the private party.

The UN (2011) presented a detailed study regarding the characteristics of various government guarantees and their repercussions. There are different types of guarantees, but according to the UN report, the most applied ones are as follows:

- **Revenue guarantee:** The government may consider providing revenue guarantees for high-risk projects. The government can guarantee a certain specified percentage of the projected revenues. Governments typically limit the maximum amount of revenues that the project developer can retain where these guarantees are provided. Any amount in excess of this defined maximum limit is taken by the government. The revenue guarantee, however, has a major drawback. When such a guarantee is available, debt can be structured around it and may practically mean transferring commercial risks to the government. In such a case, the private operator may lose interest in increasing its internal efficiency.

- **Foreign exchange risk***:* One of the serious concerns in investors' minds is foreign exchange risk. The revenues generated by most infrastructure projects are primarily in local currency. However, a large part of debt servicing and other payments are often made in a foreign currency. The government may undertake measures to limit the investor's risk from foreign exchange fluctuations. Where foreign exchange fluctuations exceed a certain defined limit, a part of losses due to such fluctuations may be offset by modifying tariff rates, government subsidies, adjustment of the concession period or other provisions.

- Tax incentives: PPP projects may qualify for various tax incentives offered by the government. These incentives may include:

- Exemption from registration tax on the acquisition of real estate;
- Exemption from or application of a lower rate of value-added tax (VAT) for infrastructure facilities or construction of those facilities;
- Reduction of or exemption from various appropriation charges;
- Recognition of a certain percentage of the investment as a reserve to be treated as an expense to compute corporate taxes;
- Allowing the project company to issue infrastructure bonds at a concessional tax rate on interest earned; and
- Exemption of capital equipment from import taxes and duties.

- Loan guarantee: A loan guarantee is an assurance to a lender providing credit to a project company. Such a guarantee provides security that, if a borrower defaults, the government will repay the amount guaranteed, subject to the terms and conditions of the agreement. As the guarantee reduces the lender's risk, the borrower should be able to obtain funds at a lower interest rate or negotiate a loan that might not otherwise be available.

However, it is essential to highlight that the government's full guarantee reduces the incentives for the private operator to manage the project risks. As loan guarantees do not involve immediate cash spending by the government, they can be a more attractive tool to the government than direct loans or grants, particularly in periods of fiscal restraint. However, they can generate sizable financial obligations for the government and may significantly affect its budgetary framework (ESCAP, 2011).

It is evident that the government guarantees are mainly for the private party's sake while they raise the government's financial burden and the risks it takes. As the guarantees, except tax reduction, do not have immediate and explicit outcomes, the government prefers them to make finding a partner for projects more straightforward. This strategy is applied more in –especially- non-competitive markets since the private sector is highly affiliated with the public and hesitates to participate in risky mega-projects without leverage. However, such guarantees put the government at significant risk and responsibility. It is not only deprived of tax incomes due to the tax exemptions but also takes charge of the actual financial cost in case the private party cannot fulfil its responsibilities.

The literature also indicates that such government-backed projects often deteriorate because the promoter tends to exaggerate the debt-carrying capacity of the project, whereas the lender may not examine the project rigorously. The lack of due diligence often results in financing with a high debt-to-equity ratio, enabling short term promoters to undertake extensive construction activities with small equity contributions (Tserng, Ho, Chou, & Lin, 2014).

Another novelty, introduced with the rise of PPPs, emanates from the public sector's characteristics: the procedure's institutionalisation. In this vein, governments can follow two paths. First, they can establish either PPP departments in each related institution like ministries, general directorates etc. or a central PPP unit. The ones who propose the former claim that there are different dynamics in implementing PPP for each sector. For instance, the PPP contracts in the health and transportation sectors differ significantly. Therefore, the related authorities evaluate their projects separately through their own PPP departments. The ones who favour the latter enunciate that a central PPPs unit would optimise resources and experienced cadres and organisational memory formation. Akintoye, Beck, and Hardcastle (2003) underline the importance of creating a dedicated PPP unit. First, a danger exists that departments do not fully appreciate PPPs' budgetary implications due to the off-budget nature of PPPs, which can be

eliminated by a central PPP unit that can judge and approve the ability of an individual department to afford the PPP agreement. Furthermore, a dedicated PPP unit might create a centre of knowledge and expertise that can provide individual departments with technical assistance during a PPP creation process and keep a watchful eye on departments through its regulatory approval mechanism. In this context, countries follow different policies. To illustrate, the UK has a central PPP unit that acts as the procurement manager and financial advisor for all procurement stages, including financial close. In contrast, each ministry in Turkey has its own PPP units to conduct projects in their own scope.

The level of centrality depends on the administrative traditions of countries. The success of the above-mentioned PPP procedures depends upon the two parties' commitment. The political authority should design PPP projects, declare a notice of tender and prepare the legal and regulative framework and create support mechanisms during the project. It should also consider the suitability of PPP projects in terms of different characteristics like size and cost and clarify the service requirements in the contract in a precise manner. Likewise, the private sector should follow a consistent policy to carry out responsibilities in the contract.

Apart from those, general conditions in the country, such as economic situation, and social support for PPPs, also affect PPPs' success. In the literature, various approaches focus on the public's role in preparing an appropriate investment atmosphere or the technical capacity of the private sector. In this regard, Zhang (2005) identifies various critical success factors for PPPs by reviewing the literature and classifying them into five main groups. The content of each group is defined by success sub-factors that determine PPP projects' viability in mentioned context.

Table 3. Critical Success Factors and Success Sub-factors for PPP Projects

Favourable investment environment	- Stable political system; - Favorable economic system; - Adequate local financial market; - Predictable currency exchange risk; -Predictable and reasonable legal framework; - Government support; -Supportive and understanding community; - The project is in the public interest; - Predictable risk scenarios; -The project is well suited for privatisation; - Promising economy
Economic viability	-Long-term demand for the products/services offered by the project; -Limited competition from other projects; -Sufficient profitability of the project to attract investors; -Long-term cash flow that is attractive to the lender; -Long-term availability of suppliers needed for the project
Reliable concessionaire consortium with strong technical strength	-Leading role by a key enterprise or entrepreneur; -Effective project organisation structure; -Strong and capable project team; -Good relationship with host government authorities; -Partnering skills; -Rich experience in international PPP project management; -Multidisciplinary participants; -Sound technical solution; -Innovative technical solution; -Cost-effective technical solution; -Low environmental impact; -Public safety and health considerations

Table 3. (continued)

Sound financial package	-Sound financial analysis; -Investment, payment, and drawdown schedules; -Sources and structure of main loans and standby facilities; -Stable currencies of debts and equity finance; -High equity/debt ratio; -Low financial charges; -Fixed and low interest rate financing; -Long-term debt financing that minimises refinancing risk; -Abilities to deal with fluctuations in interest/exchange rates;
Appropriate risk allocation via reliable contractual arrangements	-Concession agreement; -Shareholder agreement; -Design and construct contract; -Loan agreement; -Insurance agreement; -Supply agreement; -Operation agreement; -Offtake agreement; -Guarantees/support/comfort letters

Source: Zhang, 2005.

In Weberian sense, these factors reflect an ideal type for PPPs. Nonetheless, there could be no context in which all these criteria are reliable. Thus, an entirely successful PPP project seems impossible. Nevertheless, the degree of success of a project can be evaluated according to the closeness to the ideal type.

Another problem, at this point, is that there is no hierarchy among these factors; therefore, the lack of success even in one aspect can lead to failure in a project. Similarly, this generalisation neglects the differences between countries as well as sectors in which PPP projects are implemented. For instance, some parameters, like currency exchange rates in volatile developing markets, cannot be predictable.

Thus, enlisting critical success factors might be valuable as it presents the main parameters to be taken into account in the decision-making process. However, they cannot offer a guarantee for the success of PPPs.

2.5. PPPs and Healthcare

2.5.1. The use of PPPs in the health sector

Based on the abovementioned aspects of the PPPs, the health sector started to benefit from advantages of PPPs beginning in the early 1990s. That was a time when all countries needed reform in the health system. There are multiple reasons for the requirement, many of which are related to financial concerns. First of all, in addition to the rise in the population, life expectancy had increased significantly due to the developments in medicine. Especially developed countries began to have ageing populations due to which health expenditure for those older adults had increased. Second, the new lifestyle – based on fast consumption and pleasure-introduced by the new face of capitalist culture challenged people's health in many ways. The rise in environmental pollution as a result of mass production, change in food habits, etc., paved the way for chronic diseases worldwide. The struggle with them necessitated new mechanisms in the health system. Moreover, the adoption of new technologies in the health system increased the financial burden on governments. The last and most important aspect of the reform in the health system is the ideological transformation in the world. The replacement of the welfare state with neoliberalism had to reflect in the providence of services. It required the integration of private mechanisms into healthcare provision. In that way, the spread of huge private hospitals was followed by the PPP (Agartan, 2017).

On the other hand, PPP was also embraced by developing countries to establish health infrastructure in line with the purpose of addressing demands from their newly developing regions for health care services. In order to overcome the

challenge of those needs, governments started to use the PPP. According to the World Health Organization (WHO), the PPP model has three main characteristics which would be helpful for governments in these challenges in their health system:

- Using the expertise and skills of the private sector: In modern technology-intensive healthcare systems, PPPs allow governments to leverage the expertise and skills of the private sector and thereby improving the quality and accessibility of public healthcare systems. PPPs shift the capability burden of the public sector into the private sector, where – arguably – there is much greater capacity to deliver infrastructure. Simply put, the private sector has a wealth of experience in structuring, procuring and managing the delivery of massive projects and has access to a wide range of resources and skills.

-Value for money: Governments want PPPs to provide more Value for Money (VfM) than traditional procurement forms that do not transfer risks to the private sector. VfM is defined as the optimum combination of whole life cost and quality to meet the user's requirement. VfM depends on appropriate risk transfer between the public and private sectors. Financially, private financing is a way to provide infrastructure without increasing the public sector borrowing and reducing pressure on public finance constraints and is driven by forces for governments to decrease public spending to meet political, legislated or treaty-mandated fiscal targets.

- Increased funding on health: According to estimations, the BRIC nations (Brazil, Russia, India and China) are expected to experience even more robust growth in health spending, which as a per cent of GDP is expected to grow from 5.4% in 2010 to 6.2% in 2020. This amounts to a 117% increase in actual spending over the decade, where China is leading the way. In order to create the fund, governments prefer to use private sources via PPP (Hamilton & Kachkynbaeva, 2012).

When the reform needs in line with changing dynamics in the healthcare service delivery, such as new treatment methods with high technology and expected outcomes of PPPs were taken into consideration together, governments began to use it in their healthcare reform agenda.

2.5.2. World practices in health PPPs

The UK introduced the first PPP practice in the healthcare provision under the title of Private Finance Initiative (PFI) in 1992. The main purpose was to stimulate service development through private investment. The UK was in need of renovating the health infrastructure since most of the hospitals were built during the Victorian era in the late 1800s. Therefore, John Major's government conducted an overall renovation plan for the UK's deteriorating public capital infrastructure without creating a new public debt or tax increase. The plan was based on the design-build-operate-finance (DBOF) type of PFI scheme. The National Health Service (NHS) Trusts and local authorities became responsible for awarding and managing contracts. In this regard, the signers of contracts, mainly consortiums formed by construction companies, banks and creditors, and medical firms, enter into the obligation of designing, building, and operating the hospital buildings when the construction is completed (Belek, 2016).

At that point, the issue of operation has to be clarified. The private actors are responsible for conducting non-clinical services such as cleaning, catering etc., while the core clinical services continue to be held by the NHS. The NHS Trust has to make payments to the private company in return. The payment consists of an availability charge and service charge. The former refers to leases paid annually for physical infrastructure and provision of facilities management, whereas the latter is made for non-clinical services. The terms of contracts may change from 25 to 49 years. During the period, the NHS became a leaseholder, and at the end, it will become the owner of the hospital building. The Trust also has a regulatory mission in the sense that it operates a control mechanism by checking the services

provided in the hospitals. When the Trust determines that the services are low-quality according to the contracted performance measures, it can deduct from the service charge (Belek, 2016).

The PFI in healthcare had become a state policy instead of the neoliberal agenda of the Conservative Party. Although the Thatcher government had introduced it, the Labour Party maintained the PFI projects in an accelerated manner when it came to power in 1997. As a result, more than 130 projects in the health system could be conducted in the UK in 20 years. According to statistics, the PFI model was reported to have conveyed some evident achievements. First of all, it was reported in 2003 that the late-delivery statistics for the public projects had decreased significantly from 70% to 24%. Secondly, the number of projects that were reported as incurring over expenses during the construction process decreased from 73% to 22%. From 1997 to 2007, 85 out of 110 new hospital projects were executed under the PFI model, which accounted for approximately 8.5 billion pounds out of a total of 9.7 billion pounds of the investment disbursed in the hospital building scheme (Ozcan, 2015). However, this success story came to an end in the late 2000s. Especially after 2010, the PFI model started to be rebuked. With the impact of the 2009 global crisis, the financial efficiency of the PFI was questioned. Even the House of Commons Committee of Public Accounts concluded PFI was not a satisfactory option in financing hospitals in a report in 2011.

Many critiques came regarding the payment load on the shoulder of the NHS for long years. Since the interest paid by the private actors to get debt would be higher than public sector loans, the payments by the NHS for contractor firms would be automatically high. The bankruptcy of the Carillion company, which got several tenders of newly building hospitals, had raised the debates over the financial reasonability of the PPPs.

In a similar way, the NHS Trust has to get a significant amount of additional financial support from the Department of Health under the scheme of financial easing initiative in order to meet the increasing financial needs of PFI projects. Moreover, in larger operational PFI sites, it is found that bed numbers had been reduced, the patient had increased, and staff workloads had become heavier. In some sites, this was identified as a cause of increased staff sickness and lower morale. With fewer beds and trained medical personnel and with the NHS having to underwrite these extra costs, meaning that resources shift from providers who remain in public ownership to those privately owned undermine further the goal of greater equity in the NHS (Shaw, 2003). Another criticism is related to the invisibility of future changes in the market. When the public sector binds itself with long term contracts, it cannot adapt itself to the structural changes in the sector, such as fluctuating clinical needs and medical and technological advances. As a result of those negative aspects, the UK’s PFI policy had changed after 2011, and the number of PFI projects in the health system has diminished significantly.

The UK is known to be the pioneer of the use of PPP in health care delivery. It was followed by many other countries like India, South Africa et. However, one of the followers differentiated itself by developing a different type of PPP: Spain. In Spain, health services are operated by local governments. When it became more and more difficult to meet rising demands in healthcare services, the Valencian government decided to apply for PPPs. It agreed with a consortium named Riberia and signed a 10- year contract in 1997. The contract included not only the construction of a public hospital but also the management of non-clinical as well as clinical services.

The main difference between the Spanish and UK style of PPPs is the delivery of clinical services by the private company. In that way, the public sector becomes the only financer and controller of services during the contract. The payment mechanism also differs from the classical type of PPPs. The payment is based on a capitation system. The government pays the concessionaire company an annual

fixed and pre-established amount for each of the inhabitants ascribed to it. The hospital owner is still public, and these hospitals are open to all citizens free of charge. This system is called the Alzira model since the first contract was about the construction of a hospital in the town of Alzira. The hospital started to operate in 1999.

During three years, the hospital had made a loss. According to the contract, the government would pay a capitation fee of €204 per resident per annum for 230.000 residents in the region. This would be renewed every year according to the consumer price index (CPI). However, it was not enough to meet the construction, establishment of related facilities and operation costs. Thus, terms and conditions were worse than the tenured government scheme, with less job security, lower pay scales and longer working hours. Then, the contract between the company and the Valencian government was renewed in 2003. The capitation fee for 2003 increased from €234 under the old contract to €379 Euro for the new one, an increase of 62% considering the extra primary healthcare services coverage. Moreover, the annual increase was no longer linked to the consumer price index but to the much more generous percentage yearly increase in the Valencian health budget, which was much more beneficial for the company (Acerete, Stafford, & Stapleton, 2011). After that, the company started to make a profit, and the system began to function properly. Then, the Alzira model was inspired by other local governments and has enlarged to other regions in Spain like Madrid.

The implications of world practices regarding health PPPs have spread to different parts of the world since they are propagated as success stories in reforming the healthcare sector to adapt it to rapid technological changes and increasing costs. The rumours that integrating private actors into the healthcare delivery would make the system more efficient and cost-effective have been accepted in some parts of the world, one of which is Turkey. The following section will elaborate on how PPPs entered Turkey and extended toward healthcare delivery.

CHAPTER 3

PUBLIC PRIVATE PARTNERSHIPS IN THE TURKISH CONTEXT

3.1. Political Economy of Turkey

In his book, "The Mcdonaldisation of Society", George Ritzer (2008) associates the popularity of commercial environments like malls with the search for security. Since the streets are unsafe, people shop in malls. Since the playgrounds are limited and unsafe, children play in commercial fun centres. In this way, parents, in fact, society as a whole, have surrendered responsibility for providing safe environments to commercial interests. The state has also left many of its duties to private interests. In terms of transfer of responsibility, society's attitude is a natural outcome of the disaffiliation of the state in many realms of service provision. It was not a sudden but procedural phenomenon. The state carried out various tasks in the past and still going on in some respects while it has given up many realms on behalf of private actors with the same claim of citizens, that is, security. It is promoted that a more efficient and secured socio-economic environment will emerge as the state recedes from the market. But even in its dominant period, the state has already taken many steps to open up a safe environment for capital. Turkey has not been out of this procedure.

The early Republican period was shaped by nationalisation attempts. The necessity to create a national bourgeoisie paved the way for the state's intervention due to the lack of capital accumulation by the Turkish bourgeoisie. This procedure has shaped the characteristics of capitalism in Turkey: a combination of statism and crony capitalism. The coalition of political and economic elites in the centre and the local notables as their ally in delivering state authority to the local in exchange for maintaining their privileges was shaken by an attack of a coalition

by peripheral elites and peasants represented by the Democratic Party (DP) in 1950. The initial claims by the DP for a shift to the liberalisation of the economy and giving up domination of central elites came to an end in a short period. The capital accumulation strategy did not change, but the only shift in the figures located in the centre did happen (Cizre & Yeldan, 2000).

During the post-DP era, the import substitution development model was embraced between two military interventions in 1960 and 1980. As Ahmad (1998) asserts economy expanded so rapidly in the sixties that an industrial sector emerged and cleavage between big business and the rest of the business community, consisting of small and medium-sized firms, erupted. This cleavage led to a political fragmentation at the centre-right, due to which supporters of the smaller enterprises broke away and started to be represented by the conservative parties. This distinction had shaped most of the post-1980 period when the Turkish economy experienced a structural shift.

The nature of state-capital relations based on patronage during the pre-1980 period continued after 1980. In the historical context of a state-dominated economy, politics was understood and defined as a strategy to build and sustain power by distributing material benefits generated by the state through clientelistic channels of interest mediation, with political parties and corporatist unions being two prominent organisations. In other words, the traditional democratic discourse was centred on the public sector manipulation of an electoral rather than a democratic form of capitalism (Cizre & Yeldan, 2000).

The decisions taken on January 24, 1980, became a crossroads in Turkey. The introduction of a neoliberal programme contained essential elements for integrating the Turkish economy into the global order. The pro-neoliberal views proclaim that neoliberal policies will inevitably eliminate the rent created by clientelistic relations, thereby providing more efficient distribution of resources. However, in the case of Turkey, the neoliberal agenda could not eliminate the

maladies in state-capital relations. The form of benefitting and the names of beneficiaries have changed throughout time, but the nature of patronage relations did stay the same. As Cizre and Yeldan (2000) assert, the consistent feature of Turkish neoliberalism is the persistent inabilities of the economic system to improve the lot of the great majority while it continues to guarantee the accumulation of massive fortunes for a narrow, albeit changing, circle of winners.

In the neoliberal era, the mechanisms used to provide the shifts in the winners' circle have changed over time. In the early 1980s, the allocation of foreign exchange quotas, tax rebates and access to preferential credits were important discretionary mechanisms used by the government to favour certain entrepreneurs. Nonetheless, bankers' and bureaucrats' scandals of abusing the system through fictitious exports to support the politically privileged entrepreneurs caused a rise in criticism (Bugra & Savaskan, 2014). Thus, another way to transfer capital to the private actors came into the agenda: privatisation and its sibling Public-Private Partnerships (PPPs).

3.2. Historical Background of PPPs in Turkey

The rise of understanding of "steering but not the rowing" has a reasonable ground. Turkish society was tired of a long-lasting crisis. The backward shift in the economic growth in the second half of the 1970s, combined with the US embargo after the Cyprus intervention by Turkish forces, paved the way for the devastation of socio-economic conditions of lower and middle-income groups (Zurcher, 2004). Thus, the economic liberalisation programme became an excellent propaganda tool for hope mongers, especially after the military coup on September 12, 1980. They claimed that as the military intervention had spurred the political sphere and ended social chaos, the transition to a neoliberal economy will do the same in the economic realm and solve the long-lasting problems. They put the blame on giant state and claimed that the private sector's effectiveness must be integrated into public service delivery (Onis, 2010).

During the 1990s and early 2000s, the inefficiency of public institutions was a hot topic. As a result of the import substitution development model, the SEEs generated many economic activities. However, though they were profitable institutions initially, the patronage politics put them in trouble. In Turkey, political parties had used the municipalities and SEEs like employment offices for their voter base, which provided maintenance of their support and a sense of control over these institutions. In addition, the rapid changes in governments led to the recruitment of employees, excessing the capacity in SEEs. When it combined with the vast rise in the salaries in 1989-90 to prevent the decline of the rate of votes by the Ozal government, the loss of the SEEs had increased (Boratav, 2010).

Another factor that exacerbated SEEs' financial situation was the decision of the government to withdraw the Treasury's support from SEEs in line with the 24th January decision. As a result, in order to find the necessary financial resource for their growth and modernisation, SEEs had to get into debt from domestic and foreign financial markets. Therefore, the institutions, which could produce added value and were relatively successful in terms of labour efficiency, started to be labelled as breaches in the budget and became the target of the governments beginning from the early 1990s (Boratav, 2010). As a result, the discourse of privatisation for efficiency and effectiveness became dominant. However, as time passed, it became clear that privatisation's primary purpose turned to meet the budget deficits while maintaining patronage relations with the party-affiliated interest groups.

3.2.1. Legal developments on PPPs until JDP era

PPPs were step by step embedded into the system. Since they were new mechanisms in the Turkish context, it was initially needed to establish a legal base. To this end, the first step was taken with the enactment of law number 3096 in 1984, which regulates the generation, transmission and distribution of electricity by means of concession agreements under the Build-Operate-Transfer (BOT)

model. The Law allowed private entities to construct and operate facilities that produce electricity with the Ministry of Energy and Natural Resources' permission throughout the concession period that can be arranged for up to 99 years (Gurgun & Touran, 2014). In that way, Turkey took the lead in the world in integrating PPPs into the legal system.

Turkey integrated many types of PPPs under various laws passed at different times. After introducing the BOT model, the second step came in 1988, with the transfer of the operational rights (TOR) model. Law no.3465 allows private entities to construct, maintain, and operate highways using TOR or BOT models for up to 49 years. The range of PPPs implementation was strikingly widened in 1994 with Law no.3996, which gives private actors the chance to take place in projects that require advanced technology or high financial resources by using the BOT model. Thus, the private sector could become the main actor in conducting substantial infrastructure projects like the construction of the bridge, tunnel, dam, highway, communication, railway, border gate, port, airport, electricity generation, transmitting and distribution, and preventing environmental pollution.

Another significant development regarding the institutionalisation of privatisation affairs came into appearance in 1994 with the introduction of Law no.4046. The Law foresees the establishment of the Privatisation High Council and the Directorate of Privatisation Administration to carry out the privatisation affairs.[3] The objective of this Law is to regulate the principles of privatisation, which aims to improve productivity in the economy and to reduce public expenditures through various methods, such as sales (either transfer of public entity assets/services or shares), rent, transfer of operational rights, the establishment of real rights on the property, and a revenue-sharing model. Another PPP model, the Build-Operate (BO) was introduced in 1997 with Law no. 4283, allows private companies to construct, own, and operate thermal plants for energy production for up to 20 years

[3] See the website of Privatisation Administration: https://www.oib.gov.tr/turkiyede-ozellestirme

but excludes hydroelectric, geothermal, and nuclear energy production, which are the focus of BOT models (Gurgun & Touran, 2014). Thus, law making process on PPPs was not comprehensive and came gradually.

Despite all those attempts, privatisation and PPPs did not gain acceleration in practice in the 1990s. In addition to the absence of favourable legal and institutional infrastructure, several reasons limited the exercise of privatisation and PPPs. To begin with, the 1980s and 90s witnessed a serious legal struggle between pro and anti-privatisation coalitions on how the private sector should participate in the delivery of public services. The ruling political parties in the early 1990s initially attempted to treat PPPs in the domain of private law, which provides more flexible solutions than administrative law in the design and implementation of a PPP contract. However, legal initiatives to treat PPP contracts in the scope of private law were overturned by the Constitutional Court (Ercan& Onis, 2001). The tension between politics and the judiciary concerning the interpretation of privatisation and PPPs resulted in the cancellation of many contracts by the administrative courts, the Council of State or the Constitutional Court. This conflict was solved in 1999 with a constitutional amendment proposing that public investments and services may be performed by the private sector through private law contracts so long as this is determined by the law (Emek, 2015).

The political atmosphere generated another barrier for neoliberal reforms. A fragmented political system, characterised by a succession of weak coalition governments, had been instrumental in the delays and setbacks experienced by the privatisation programme throughout the 1990s. Within a fragmented polity, newly established agencies responsible for the implementation of neoliberal reforms, such as the Privatisation Administration, fail to achieve the degree of autonomy needed to facilitate the programme's rapid and effective implementation (Ercan & Onis, 2001).

Furthermore, governments did not want to lose direct control over some resources used to maintain their patronage links; therefore, they did not fully commit to the privatisation and PPPs programme. Another tension emerged between public agencies concerning the allocation of authority. As Emek (2015) asserts, line ministries were concerned about losing their influence on PPPs falling in their sectors and responsibilities. The reason why different PPP models were introduced at various times is related to the fact that the line ministries' wish to control PPP projects in their respective sectors. Thus, the BOT model is applied for energy and transportation, while the Build-Lease-Transfer (BLT) is preferred in health projects. The degree of domestic private capital's capacity to deal with massive infrastructure projects without remarkable support by the state and the lack of a robust foreign anchor also contributed to the slow-scale improvement of privatisation and PPPs. The breaking point in PPP affairs occurred with the new peripheral actors coming into the centre: Justice and Development Party (JDP).

3.2.2. JDP policies on PPPs

When the JDP came to power in 2002, different groups -both domestic and international- had prejudices against the party due to its ideological stance. Being aware of that fact, the government did understand well the significance of global capital support. Hence, the party's vision was to support a hard-core liberalisation and democratisation attempt by immensely committing to the WB, IMF, and the EU's reform agenda, as an ally of global capital with all its heart and soul (Onıs, 2007). As the emerging Turkish market is highly profitable for them, the external support for the JDP formed a shield behind which it found the chance to challenge the domestic opposition.

One of the biggest problems was the lack of powerful domestic capital groups on the government's side. In order to solve this problem, the JDP followed a two-track policy. First, it did not openly target the leading business groups in Turkey in its early period. It tried to convince them to feel guaranteed about the protection

of their interests. On the other hand, the government was aware that it was in deep need of sustaining support from the capital owners. Hence, it had to follow a redistribution policy among different business groups to enrich the affiliated groups. This policy is what has converged Turkey towards competitive authoritarianism (Esen & Gumuscu, 2016).

Competitive authoritarian regimes are competitive in that opposition parties use democratic institutions to contest seriously for power. Still, they are not democratic because the playing field is heavily skewed in favour of incumbents (Levitsky & Way, 2002). On the other hand, such regimes undermine the opposition's capacity to organise and compete in elections. The government appropriates state resources for partisan distribution and packs state institutions systematically with its loyalists. It also controls the media to limit the opposition's access to voters and weaken its political campaigns. Lastly, government critics are threatened, harassed and, occasionally, prosecuted (Esen & Gumuscu, 2016).

The absence of checks and balances on the executive authority, mainly the President, the personalised nature of the administration, recruitment of new elites and ensuring unity through a rent distribution mechanism are basic characteristics of competitive authoritarian regimes. The power of the executive authority provides a powerful incentive for elites to stay on board rather than risk challenging the leader. In this way, the regime would eliminate potential challenges, and the authoritarian rule would consolidate (Smyth, 2014).

The tutelary democracy regenerated after the 1980 coup in Turkey, gave the floor to the military bureaucracy with unprecedented legal and institutional power, and the judiciary with extensive veto power. The unstable and fragmented party system paved the way for an unconsolidated democracy. When it came to power as a single-party government, the pledges for reform by the JDP raised the expectations for a structural shift in Turkish democracy. However, the party's pro-EU stance and attempts to curtail the tutelary forces' power during its early period

reversed, especially after 2011, when the party got almost half of the votes and consolidated its power. After that, Turkey has experienced generating political tutelage and an extensive process of elite replacement in the economic area. As Esen and Gumuscu (2016) assert, the popularly elected JDP government took an authoritarian turn. It used its electoral strength to dominate political institutions and exploit state resources in a partisan manner to block the opposition's chances of winning an election. All these developments have transformed Turkey from tutelary democracy to competitive authoritarianism.

As an important aspect of competitive authoritarianism, the government needed resources to be used in the distribution policy.[4] Thus, significant infrastructural investment based on the construction-led economic growth model targeted the growing middle classes. Its' conservative-traditional outlook allowed the JDP to consolidate its power by gaining the support of a coalition of economic interest groups (White & Herzog, 2016). In this way, the government used PPPs and privatisation to empower the representatives of capital owners from the periphery -so-called Anatolian Tigers- against secular business circles centred in Istanbul.

According to Cizre and Yeldan (2000), this development can be said to achieve three basic objectives. Firstly, by fragmenting labour, the party further weakens the power of organised labour and strengthens the position of capital within the production process. Secondly, the shift from economies of scale to economies of flexibility makes business less controllable. The Anatolian Tigers thus accelerate the globalisation of production in Turkey and facilitate global capital mobility; in that sense, they collaborate with the international system. Thirdly, as Anatolian Tigers are linked with Islamic capital, they represent a haven for the electoral force of the JDP; that is, they are not only interested in a critique of the existing order

[4] It is interesting to note that there are significant similarities between Turkey and Russia in terms of competitive authoritarian character of the regimes. The Russian political system with weak democratic governance and abuse of power by authoritarian political elites has used rents from energy sector for distribution policy. In contrast to carbon-rich Russia, Turkey lacks any highly prized energy resources. Therefore, it has to create alternatives. The similarities between Turkey and Russia in this realm may be further extended but it is out of the purpose of this study.

but are willing to battle against the profound and destructive societal dislocations caused by the partial move from a regulated to a market economy. However, as they are integrated into the centre more, criticisms of the order and negative consequences of neoliberalism have been eradicated. The enrichment coming through the redistribution of public resources by the government's hands has made party-affiliated business groups dominant actors in public service delivery.

In line with the purpose of preparing an appropriate legal and institutional ground for its allies, the reforms aiming to simplify the legal procedure regarding PPPs have continued. To this end, Law no.5335 was enacted in 2005 that proposed total or partial transfer of operating rights for the airports and passenger terminals to the private sector. In the same year, the essential step within the scope of this study came into the agenda.

Law no.5396 introduced an additional article to the Fundamental Law on Health Services (no. 3359 dated 1987). It proposed building health facilities through the Build-Lease-Transfer (BLT) model. The next year, regulations elaborating on the Law were enacted to clarify how the public and private actors would set a partnership on health facilities. It included the details on construction, renovation, furnishing, supply, maintenance, and operation of health facilities other than medical services within the BLT model framework (Gurgun & Touran, 2014). Another striking novelty of the Law was introducing the first public institution directly related to the PPPs, the PPP Department, within the Ministry of Health. The duties of the department enlisted in the regulation are;

- the selection process of private entities for the construction of the projects via a detailed tender process for a certain period which has to be less than forty-nine years,
- predetermining the design and basic standards of a project,
- defining the duration and leasing fee for the Treasury owned land, of which projects are planned to be constructed,

- identifying the tender specifications, required credentials and the scope of the agreements,
- preparing feasibility reports for the intended projects and evaluating them according to the value for money generation mechanism (Ozcan, 2015).

The construction of the so-called ‘integrated health campuses’ with the BLT model was a part of the government's healthcare reform. Later, they were named ‘city hospitals’ and claimed to represent a radical transformation in healthcare service delivery. The tendering process began in 2009. However, the difficulties led by the disorganised aspect of the regulations forced the government to prepare a new law.

In fact, the government's purpose was to have a single PPP law applied to every PPP project. However, there emerged two important barriers to a unified PPP legislation. First, the criticisms of private actors in the sense that PPPs in different sectors have different requirements prevented the enactment of a PPP law. According to this view, the distinctive sectoral principles and procedures do not allow the application of the same rules to all PPP projects. In addition, the line ministries’ wish to control PPP projects in their respective sector was also a barrier to such a fundamental law. As a result, the dispersed character of legislation has remained, and new Law (no.6428) specific to the BLT model was accepted in 2013. This Law regulates all the procedures concerning the construction of city hospitals and education facilities.

In this context, legislation on PPPs remains fragmented. Different types of PPPs are implemented in different sectors and covered by different laws and regulations. This structure paved the way for advice by the OECD (2017) for a legislative reform in the field of PPPs in order to generate a sustainable and coherent single framework. The following table summarizes the current and dispersed legal structure.

Table 4. Legislation on Different PPP Models

Model	Sector	Law no.
BOT, TOR	Generate, transmit and trade electricity	3096
BOT, TOR	Construction, maintenance and operation of highways	3465
TOR	Operation of airports and passenger terminals	5335
BO	Construction and operation of electricity generation plants and regulation of energy sales	4283
BLT	Construction of health and education facilities and restoration of services and areas other than medical and educational service areas	6428
BOT	Commissioning of certain infrastructure investments and services	3996

Source: Gurgun and Touran. 2014.

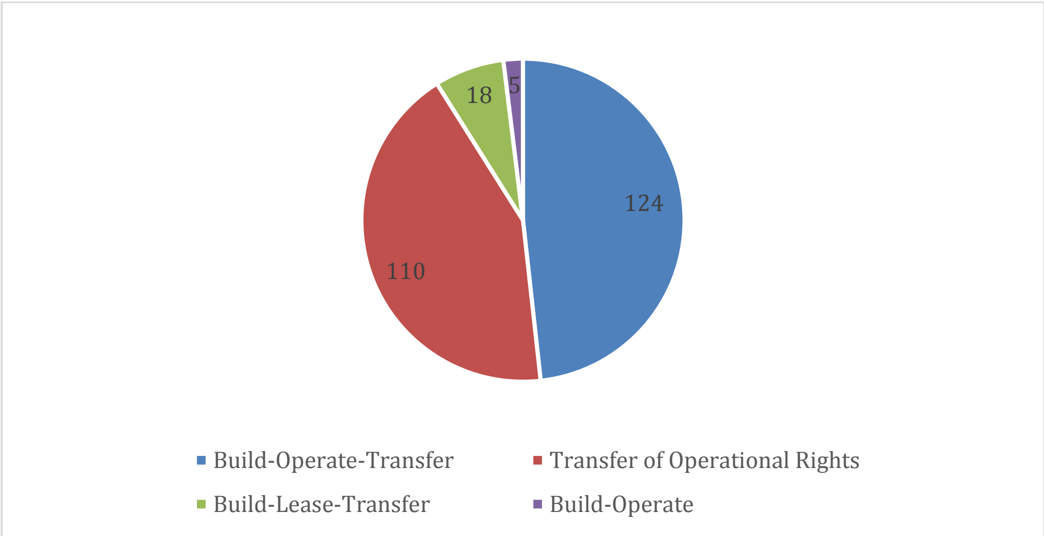

Figure 1. Number of Different Type of PPPs (1986-2021)

Source: Presidency of Strategy and Budget, 2022.

Although there were many significant developments regarding PPPs legal and operational infrastructure, the most striking change during the JDP era came with the Public Procurement Law (no.4734). The amendments in the Law served the purpose of the JDP's redistribution policy. The number of amendments in the Law has already exceeded 100. The trickiest ones have become the clauses regulating the exceptions among those changes. Simultaneously, alternative tendering procedures such as restricted and negotiated procedures that differed from the open tender method were defined previously confined to exceptional situations such as natural disasters and national defence. Moreover, the government widened the scope of direct procurement, allowing public authorities to carry out a tender without publication of notice and give tenders to specific contractors of their choice (Bugra & Savaskan, 2014).

In a similar way, the number of fields having an exemption clause that is totally out of the scope of the Public Procurement Law has increased. For instance, city hospitals' construction is not within the scope of the Public Procurement Law. Instead, the Law formulated a specific tendering procedure to regulate the BLT model. After 2003, the rate of the open tenders decreased from 71% to 53%, while alternative tendering procedures, as well as tenders within the scope of exemptions, rose from 29% to 47% (Gurakar, 2016).

The final step to increase the control of the political authority over tenders was to eliminate the power of the Public Procurement Agency. The Agency's discretionary power to investigate a questionable public tender following, for example, media coverage of the irregularities in a particular case, was reduced; now, it could investigate only if complaints were made by one of the firms participating in the tender (Bugra & Savaskan, 2014).

All these developments have brought question marks regarding the quality of the legal framework. The results of the World Bank's (2018) global assessment of effectiveness in regulatory frameworks regarding infrastructure PPPs highlight

that Turkey has poor or average scores: preparation 60/100, procurement 58/100, and contract management 65/100. It is an inevitable outcome of degradation in legislative structure on behalf of patronage relations.

The legal steps aiming to eliminate legal and institutional barriers, which limited the government's discretionary power over public procurements, allowed it to prepare the appropriate ground for a new class of business groups. Then, the reverberations of this policy have extended far beyond the estimations of the dominant economic groups, and the process of new elites' recruitment has accelerated. It is essential to highlight that not only the legal steps but also radical steps in their implementation changed the sphere on behalf of the "rich clubs of the JDP".

The dramatic rise in privatisation revenues in the JDP era is not surprising, mainly due to two reasons. First, privatising profitable institutions at an affordable price is a practical tool for resource transfer. Thus, block sales of enterprises have become the dominant type of privatisation. Second, powerful external anchors such as the EU, the IMF, and the World Bank fully support privatisation. In order to get the support of global actors against its domestic loneliness at its early stages, the JDP tried to benefit most from integration with the global markets. Hence, it has to meet international economic actors' expectations, as the sale of Tobacco Institution (TEKEL) to British Tobacco demonstrated. In this regard, it could be better understood to generate privatisation income for more than 17 years (1986-2003) of total revenue in just one year (2006).

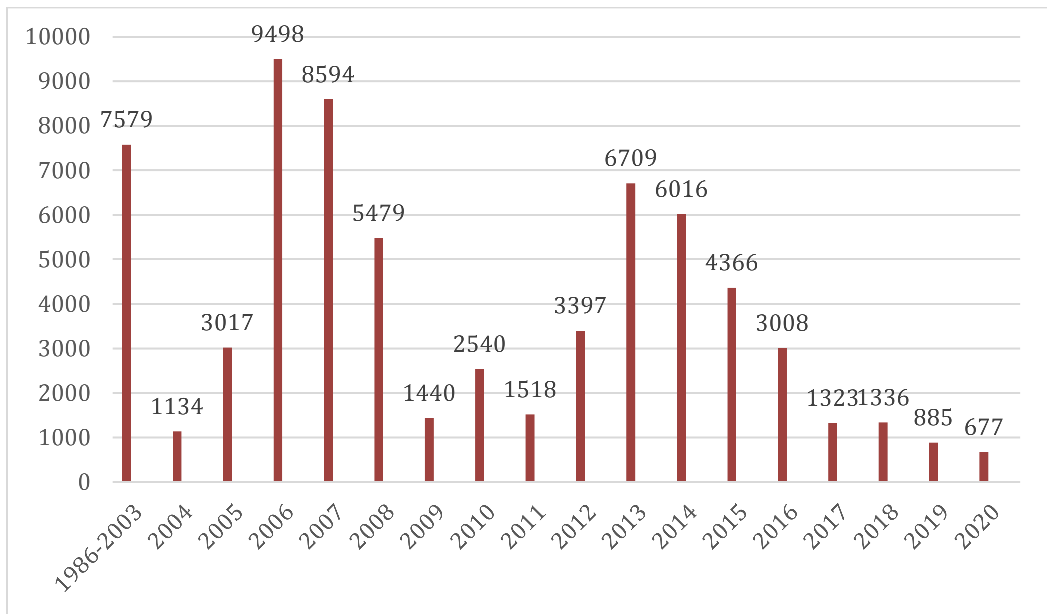

Figure 2. Total Value of Privatisations (Million USD)

Source*:* Privatisation Administration, 2021.

In addition to the privatisation, PPPs constitute another channel of the JDP's redistribution policy. From 1986 to 2021, 257 PPP projects with a total contract value of $170.2 billion have been launched.

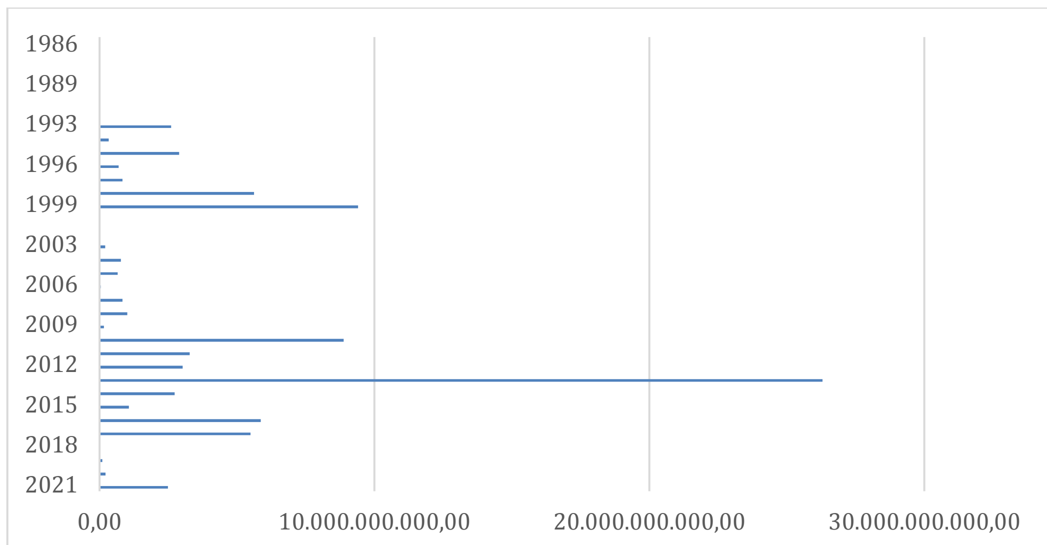

Figure 3. Total Value of PPP Investments in Turkey (USD)

Source: Presidency of Strategy and Budget, 2022.

Among 257 projects, the construction of energy power plants constitutes the leading field with 98 projects. It was followed by highways and service facilities (43 projects), ports (23 projects), health facilities (18 projects), airports (19 projects), border gates (23 projects), marines and tourism facilities (19 projects), mining (8 projects), industrial plants (2 projects), solid waste (2 projects), railways (1 project) and cultural facilities (1 project) (Presidency of Strategy and Budget, 2022).

Although the energy sector is at the forefront in terms of the number of projects, it is seen that the volume of PPP investments in the transportation sector is much higher when considered in terms of investment size.

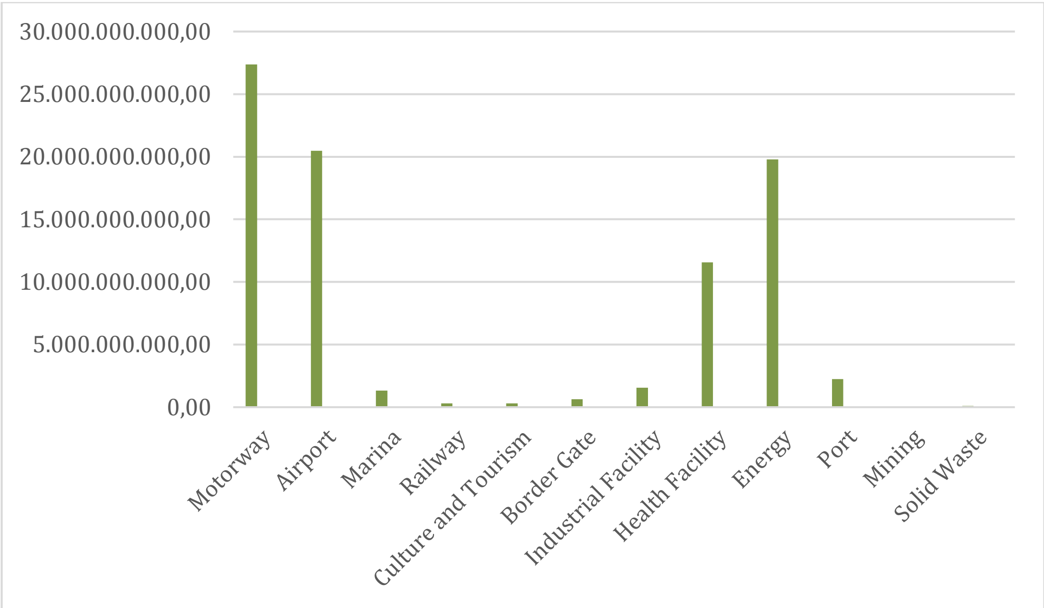

Figure 4. Total Value of PPP Investments per sector (USD)

Source: Presidency of Strategy and Budget, 2022.

The magnitude volume of PPP investments indicates that the distinctive character Turkish PPP market is the domination of megaprojects. Turkey launched five projects with EUR 5.1 billion aggregate value, while France had 15 projects with

EUR 4.2 billion worth in 2018 (EPEC, 2019). Turkey is also ranked 1st in all low and middle-income countries with an average of $547 million investment value per project in PPP inventory (Ayhan & Ustuner, 2022).

PPPs have become a much more useful tool for the party-affiliated business groups because they are not deep-rooted manufacturing companies, mostly established in the 1990s and early 2000s and operational in the construction and service sectors. As most PPP investments are in these fields, the new highways, airports, hospitals, dams, and power plants are left to a couple of firms. In fact, this was the exact opposite of Recep Tayyip Erdoğan's claims while he was defending the amendments in the Public Procurement Law.

"The Public Procurement Law, as it is, serves the interests of 50 or 60 firms. I will not leave the construction of a 15 000-kilometre long highway to 50 or 60 firms (Gurakar, 2016)."

It is evident that the government has restructured the dynamics of capital in the country. In accordance with the strength of their affiliation with the government, a helix-shaped capital structure emerged. The first part of the spiral comprises leading firms such as Cengiz, Limak, Kolin, Kalyon and Ronesans that have signed many large-scale infrastructure public contracts. The middle-scaled Anatolian Tigers took a slighter share than the "club of the rich" and generated the third layer as subcontractors of the projects or suppliers of necessary equipment. In between, there is Istanbul centred capital which has no direct affiliation but a discreet relation with the government based on protecting their existing privileges.

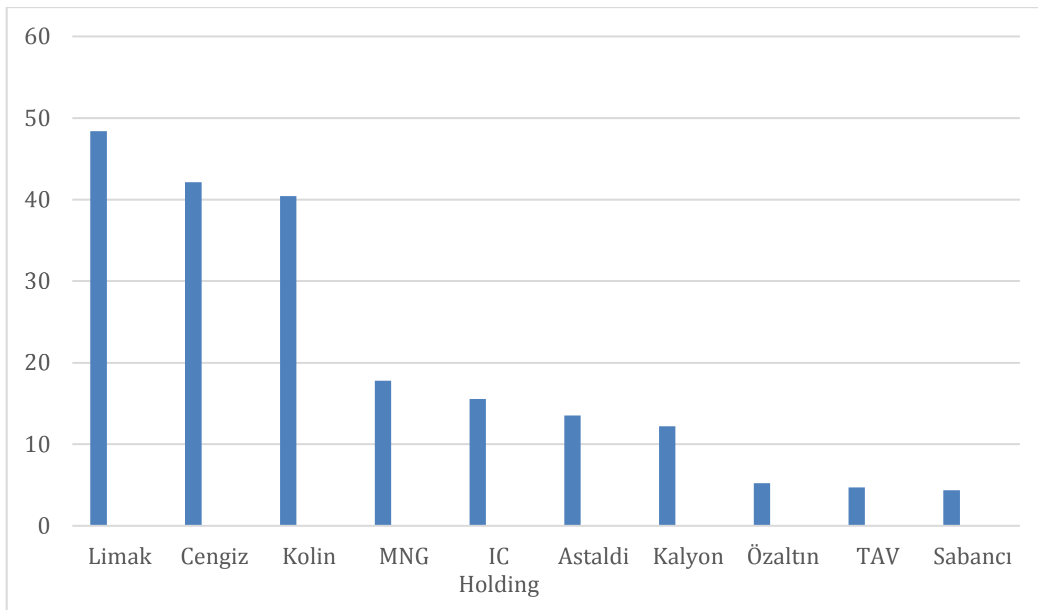

Figure 5. Companies Receiving the Most Public Tenders (billion USD)

Source: World Bank, 2020

There is another layer that represents not the business relations but the civil society side of the helix. The rent created by the vast infrastructure projects has been shared not only with the affiliated firms whose well-being depended on the survival of the government but also with civil society organizations, mostly religious-based, which take the responsibility to carry out the ideology of the government to the poor segments of the society through a charity mechanism. In this way, the government feeds these groups in return for their activities to consolidate the party's voter base. As a result, there arises interdependency between those firms & associations and the government since their survival depends on the maintenance of the rent mechanism.

According to Gurakar (2016), the creation of a renter mechanism by the JDP has three main characteristics. First, unlike the previous governments, the JDP creates rent not by benefitting from gaps in law but by directly enacting the law. Second, the rent is distributed to the groups having direct political affiliation or indirect private relations with the government in a to the point manner. Finally, the JDP

could form new resource allocation configurations for the voters. In order to ensure and protect voter satisfaction, directly affiliated companies take the responsibility to finance charity works by transferring a small amount of the share they get. At the same time, municipalities determine the target groups in need, and the religious associations take the stage to accompany them in the distribution of aid. Hence, the government, municipalities, firms in different layers and the associations and NGOs have turned into the cogs in the wheel and dedicated themselves to preserving the new rent creation and distribution mechanism on which their survival depends (Gurakar, 2016). As PPPs are one of the primary sources for harbouring it, this mechanism has reached such a point that it could shape even the most basic life areas, including healthcare. The construction of city hospitals with the BLT model not only serves to renovate health infrastructure for Turkish citizens but also accelerates the already ongoing process of neoliberal transformation of the health system and resource transfer to designated groups.

3.3. The Construction Procedure of City Hospitals

3.3.1. The Latest Health Reform in Turkey

The construction of city hospitals was projected as a part of the HTP. The JDP had promised an extensive public administration reform in all fields before gaining a landslide victory in the 2002 elections. In this line, it announced an “Urgent Action Plan” when it came to power. As the preparation of a legal basis for all the reform agenda will take much time, with the World Bank's support, the government declared its reform plan specific to the health system in 2003.

The following principles summarise the main lines of the HTP:

1. The Ministry of Health as planner and supervisor.
2. General Health Insurance gathering all people under a single umbrella.
3. Widespread, easily accessible and friendly health service system:

a) Strengthened primary healthcare services

b) Effective and graduated chain of referral

c) Administratively and financially autonomous health enterprises

4. Knowledge and skills-equipped and highly-motivated healthcare human resources.

5. System-supporting educational and scientific bodies

6. Quality and accreditation for qualified and effective health care services

7. Institutional structuring in rational drug use and material management

a) National Pharmaceuticals Agency

b) Medical Devices Agency

8. Access to effective information in decision making: Health Information System

Three new topics were added to the HTP after the establishment of the new government in 2007. These are:

1. Health promotion for a better future and healthy life programmes,

2.Multi-dimensional health responsibility for mobilizing parties and inter-sectoral collaboration,

3. Cross-border health services to increase the country's power in the international arena (Yasar, 2011).

In order to achieve these targets, the government took several steps. The most profound change came with introducing the General Health Insurance (GHI) and establishing a single institution "Social Security Institution (SSI)" by abrogating the Social Insurance Institution, Retirement Fund, and Bag-Kur in 2006. The second significant amendment was regarding the payment by the insurance funds to service providers. Previously, payment by health insurance funds was on a retrospective fee-for-service basis, and fee schedules and payment mechanisms across the different health insurance funds and types of the hospital (*i.e.* university, public and private) were not co-ordinated (Akdag, 2009). In 2007, the Health Budget Law was adopted. Based upon this law, the SSI developed a fixed price for outpatient and inpatient health services in line with the international classification of diseases (ICD-10).

The medical professionals came across important novelties in their work lives. To illustrate, the HTP introduced the institution of "family medicine". Like General Practitioners in the UK, family doctors as independent, capitated employees have become responsible for primary care. Another innovation regarding medical professionals was the introduction of contract basis employment. One of the rationales behind the HTP was to overcome the deficient number of health staff and their uneven distribution throughout Turkey. In order to solve this problem, new faculties of medicine were opened. Besides, health staff could be appointed to less developed areas with additional premiums to their salaries thanks to contractual basis employment.

Moreover, new doctors were banned from opening private clinics. The HTP stipulated a performance-based supplementary payment (PBSP) system to compensate for their financial loss. Finally, Turkey promoted a governance approach, similar to the UK, in coordinating health services. In this regard, decentralisation of decision making and implementation process was advocated. The HTP stipulated many articles concerning the devolution of authority to autonomous health enterprises. However, there emerged a massive gap between discourse and action. The reform attempts targeting decentralisation turned into a powerful centralisation, especially after 2017. In the Turkish context, governance does not serve to strengthen the local and autonomous structure but marketisation. Thus, the premise of governance, "a more participatory decision-making process" has been interpreted as a way of integrating private actors into service delivery in healthcare. The so-called partnership between public and private actors came under these dynamics.

3.3.2. Organisation of Health PPPs in Turkey

The healthcare PPPs is a long and complicated procedure. It starts with the related authorities' decisions regarding the necessity of a city hospital in a defined place. Previously, the High Planning Board, under the Ministry of Development, was

giving this decision comprising relevant ministers under the chair of the Prime Minister. However, with the transition to the Presidential system in 2017, the post of prime minister was abrogated. As a result, the Ministry of Development was transformed into an office directly affiliated to the Presidency. The High Planning Board was also abolished, and its authority was shared by the President and the Economic Policies Council, another new office under the Presidency. Thus, the decision making power in PPP projects is directly controlled by the President anymore.

When related authorities agree on the project's necessity and feasibility, developed by the Ministry of Health, a tender notification is declared. There are three options as to how health PPP projects can be awarded. These are the open bid procedure among bidders selected via a prequalification process, open bid procedure, and a negotiated procedure. The healthcare PPP regulations favour the open bid procedure among selected bidders (Rodrigues, Sahbaz, & İnal, 2013).

In the open bid procedure among selected bidders method, candidates should prepare a comprehensive tender documentation which shows their economic, financial and technical competencies. After the initial evaluation, those who fulfil the prequalification criteria are invited to submit their projected technical solutions with the estimated cost based on the preliminary project, which includes alternative solutions, and approximately identifies the facility's concept and basic design components to be tendered. Then, the MoH improves and standardises the base project according to the solutions submitted and puts it out to the third stage tender to collect price bids. At the very last step, after the submission of proposals in a sealed envelope, a descending price auction commences where bids for service fees are lowered until they reach an acceptable, from the government‘s perspective, level. The MoH prefers using service fee as an evaluation criterion in choosing the winning bid (Emek, 2017).

A winner is generally a group of companies in the construction, medical and finance sectors. They form a consortium, called special purpose vehicle (SPV), an autonomous legal unit based on an agreement between the shareholders. The agreement gives place to the basis of its establishment as well as clarifies details like its name, ownership structure, management control and corporate matters, authorised share capital and the extent of the liabilities of its members. The project company has to provide a bid bond of 3% of the total investment to undertake the project when the implementation agreement is signed. The contract's content and scope signed between the MoH and the SPV define both parties' rights and liabilities.

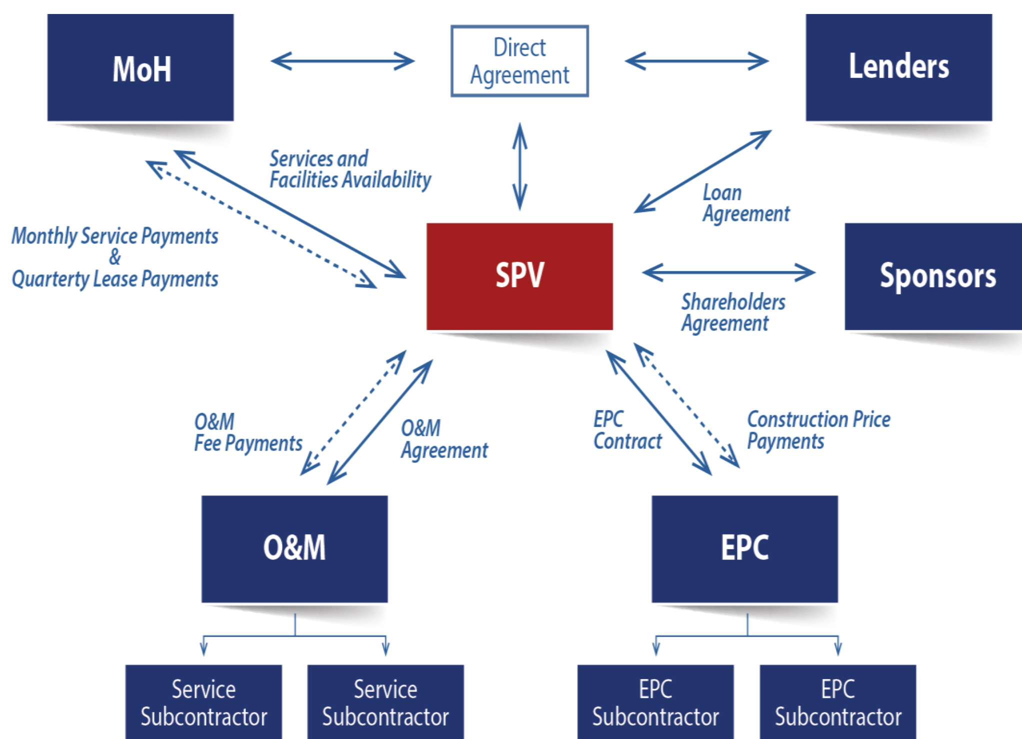

Figure 6. Relations between Actors in Health PPPs

Source: Adapted from Whiteside, 2020.

The project's term may be up to 49 years, but parties in the tender documentation determine it. This period starts from the handover of land on which the construction will be held to the project company. The land for projects is allocated free by the public from mostly Treasury-owned land. The project company does not gain ownership but servitude over the land during the project period. Alternatively, health PPP project facilities may be developed on the project company's land or on land belonging to other private parties, in which case the government would need to pay compensation to those affected if the land is not otherwise purchased. In either case, securing the land and obtaining the required permits is the Ministry of Health's responsibility (Rodrigues, Sahbaz, & İnal, 2013).

The large-scale and long-term infrastructure projects entail vast financial tools. The SPV provides a part of the finance as equity, and the remaining is borrowed from financial institutions or by placing debt securities in the capital market. In health PPPs in Turkey, the bidding companies generate at least 20% of the total project cost from their equity, while the remaining part is obtained through credits from domestic and international financial institutions. They could generate significant financial resources thanks to extensive debt guarantees by the government. The MoH has direct negotiations with creditors to ensure credit opportunities for the private companies.

Although the Law permits concessions up to 49 years, the term of contracts in health PPPs in Turkey is 28 years, 3 for construction and 25 years for the operational period, as a result of bureaucratic resistance. After completing the construction, the project company undertakes the duty to manage it. In this context, services in the city hospitals are divided into clinical and non-clinical services such as linen and laundry, and waste management. The former comprises two parts: core clinical services (all types of treatment) and clinical support services (laboratory, imaging, sterilization and disinfection, rehabilitation). The MoH only undertakes the core clinical services in the city hospitals, while the

clinical support services and non-clinical services are left to the project company. In this line, the MoH provides the clinical staff and responsible for their personnel affairs, whereas the services including imaging devices, laboratory facilities, cleaning, catering, maintenance, information management systems, security, car parking and waste management and the personnel conducting these affairs are under the duty of the company.

The separation of services in such a way is a contesting issue. In line with neoliberalisation, some services in hospitals, such as security and cleaning, have already been transferred to the private sector; however, it is not reliable for clinical services since they are integrated. To illustrate, in cancer treatment, defining radiology and imaging services not as the core but as support service seems to be highly problematic. In this vein, there emerges a contradiction of interests between two main parties; on the one hand, doctors conduct patient treatment to raise public interest, and on the other hand, the company workers run a significant part of treatment and have to prioritise the profitability. Moreover, a new division of labour, such as providence of MR services by the company swiftly and reporting services by the public more slowly, brings a synchronisation problem. It does not only damage the procedure of treatment in a healthy and integrated manner but also works peace inside hospitals. According to Pala (Pala, 2018), the lack of clarity in the definition of clinical support services went further upon an amendment in contracts made later. It was accepted that services requiring advanced technology and high funding might be handed over to companies, which means that all services with high rates of return may be transferred to companies upon their request.

In addition to non-clinical services, the running of city hospitals was left to the tender winning company. They could directly run or rent commercial areas like restaurants, clothing shops etc. and in return, pay rent to the MoH for these areas. Another privilege of project companies was about the buildings of the closed hospitals. In the beginning, it was planned to transfer the land of closed hospitals

to the project company. Here, it is necessary to elaborate on the status of existing public hospitals in provinces where city hospitals are constructed. The contracts include the condition that the existing hospitals will be closed in parallel to the new hospitals' capacity. In other words, in line with the purpose of renewal of healthcare infrastructure, the existing public hospitals move to the city hospitals after the completion of construction. For instance, in Ankara, the capital city of Turkey, there will be two city hospitals, Bilkent -already functional- and Etlik -still in construction-, and as a result, 13 public hospitals located in the central town will be closed. It will transform not only health services but all urban structure.

Table 5. The List of Hospitals to Be Closed in Ankara

1. Numune Training and Research Hospital
2. Yuksek İhtisas (High Specialisation) Training and Research Hospital
3. Zekai Tahir Burak Training and Research Hospital
4. Ataturk Training and Research Hospital
5. Dıskapı Training and Research Hospital
6. Abdurrahman Yurtarslan Oncology Training and Research Hospital
7. Sami Ulus Training and Research Hospital
8. Etlik Zübeyde Hanım Training and Research Hospital
9. Gazi Mustafa Kemal Public Hospital
10. Ulus Public Hospital
11. Ulucanlar Eye Hospital
12. Dıskapı Children’s Training and Research Hospital
13. Ankara (Altındağ) Physical Medicine and Rehabilitation Training and Research Hospital

When hospitals are closed, their buildings, mainly in city centres, remain empty. It was revealed upon lawsuits brought by the Turkish Medical Association that tender specifications prepared by the MoH also included the free transfer of land once occupied by closed public hospitals to tender winning companies for their business enterprises such as hotels, luxury housing or shopping malls though not envisaged either in Board decisions or legislative arrangements (Pala et al., 2018).

In response, the tenders, including this article, Ankara-Etlik, Ankara-Bilkent and Elazıg city hospitals, were suspended by the Council of State. As usual, the government preferred to bypass judicial processes, which could lead to cancellations or postponement of projects, and it introduced a legislative arrangement. The new regulation included that tender specifications envisaging hospital land transfer to companies are not to be complied with. In order not to encounter similar problems, a clause "decisions of annulment by the administrative jurisdiction are not enforced, but relevant revisions are made according to justifications given for annulment" was added. As a result, the project company cannot get the right to use the land of closed hospitals, but a more comprehensive limitation for the cancellation of various provisions of tenders by courts was introduced. The question of what will happen to the land of the closed hospitals is still a question mark.

The project company's privileges in contracts are not limited to the ones mentioned above but are much more extensive. The project company is granted tax prerogatives as well. For instance, the documents between the MoH and the project company are exempted from stamp duty during the investment period. More significantly, the project company's expenditure related directly to the investment in the same period is also exempted from value added tax. As Ozcan (2015) asserts, the contracts in Turkey, as in the UK, appear to be heavily stacked in favour of the interests, effectively shielding them from any real risk –whether from inflation, fluctuations in the value of the Turkish lira, or the potential financial collapse of the hospitals.

Having all these concessions, the project company operates the city hospitals for 25 years. Throughout the period, it is responsible for the effective functioning of the clinical support services and non-clinical services as well as keeping the construction and all facilities functional. The project company may only assign its rights or transfer its obligations under the implementation agreement with the Ministry of Health's consent. The MoH may transfer its rights and obligations

under the project agreement: however, in such case, the term of the agreement, lease price, scope of the services undertaken, and other similar provisions may not be changed without the consent of the project company (Ozcan, 2015). During the operation period, the company should cover any fault or damage. In case of a deficiency in service delivery, the MoH has the right to impose penalties such as cuts in service payment. Suppose the project company fails or a force majeure event occurs and cannot maintain the operation; in that case, the government has certain step-in rights, including taking over certain contractual arrangements that the project company has put in place.

For the disputes arising during the implementation of the contract, Turkish law is applied. However, not administrative but private law is applied for these contracts. The contracts under administrative law are more rigid and provide more superior power to the public party. In contrast, private law is based on equality between parties. Thus, the public party gives up its legal privileges in city hospital contracts. Moreover, before a lawsuit is brought to the relevant judicial court in projects including any foreign actor, parties may agree and decide to apply for international arbitration. As in almost all city hospitals projects, at least one of the creditors is foreign; thus, international arbitration becomes inevitable.

There is a further international guarantee for project companies through the Multilateral Investment Guarantee Agency (MIGA) within the World Bank. The MIGA provides political risk insurance to investors and lenders. It insures projects against losses related to currency inconvertibility and transfer restriction, expropriation, war and civil disturbance, including terrorism, breach of contract, and non-honouring of sovereign financial obligations. MIGA provides a deterrence mechanism against government actions that could disrupt insured investments. It is known that project companies of Adana, Elazıg, Yozgat and Bursa city hospitals applied for MIGA for political risk insurance (Erbas, 2021).

The city hospitals operate according to the aforementioned principles. At the end of the contract, the health facilities will have to be returned to the state in good working conditions and without any debt. If land belongs to the project company, then the parties hold negotiations to determine the price paid to the company. In that way, contracts terminate.

Figure 7. Provinces Where City Hospitals Will Be Constructed (the blue ones)

Source: Retrieved from the web-site of the Ministry of Health

The health system administration with PPPs has transformed both public and private actors' organisational culture. Public and private parties must adjust to the service sector's move and the commitment to a long-term relationship. The private sector's responsibility shifts from asset provider to service provider. The private sector must adjust its organisational cultures and structures to a long-term involvement instead of the traditional short-term and related temporary multi-organisations of the construction projects (Eaton & Akbiyikli, 2009).

The public sector, on the other hand, has to replace its service providing role to the most extent. It is still responsible for the provision of core clinical services, but it also has to deal with contracting, monitoring and supervising. In other words,

the public sector is not only a service provider anymore but also a service specifier. In this sense, health PPPs do not only transform contract procedures in construction but have long-term repercussions regarding service providence and actors' capacities.

3.4. Advantages and Disadvantages of Health PPPs in Turkey

The literature covers different dimensions of city hospitals projects. Some of them are related to policy making process that indicates the advantages and disadvantages of health PPPs in terms of finance, contract management etc. Another realm of analysis is on the organisational changes in healthcare delivery. In this vein, the consequences of the new operating system implemented in the city hospitals are handled, such as accession and changing role of parties in health governance. The following part categorises these themes in terms of positive and negative aspects as stipulated in the literature.

3.4.1. Advantages

The government members have always propagated the advantages of the city hospitals. By defining the project as his dream, the President focused on the project's importance even on pandemic days. He claimed that Turkey's "relative success" in dealing with the pandemic depends on the city hospitals. The advocates of the city hospitals have two main focus points: finance and renovation of infrastructure.

It is highly expected that the government has underlined the infrastructure issue because it is aware that the eligibility for such huge, modern and fully equipped health facilities free of charge receives receptive audiences from poor and middle-income groups of society. For those who have to maintain their lives in narrow houses and workplaces with little private space and got health services in old and small hospitals with crowded corridors, the nature of new city hospitals makes

sense. It might be a sign of welfare shared with them and an indicator of improvement in the periphery's status. The eligibility for health services at the same level as private hospitals' quality is mainly focused on during the opening ceremonies of new city hospitals.

The proponents of city hospitals aim to transfer the health PPPs to other countries as well. For this purpose, the International Health Services (USHAŞ) was established in 2019 as the relevant institution of the MoH. The USHAŞ promotes efforts to make Turkey one the world's leading value-added healthcare providers by combining the dynamism of the private sector with the power of the public sector. In this vein, USHAŞ supports transferring city hospitals model to enhance work areas of Turkish companies. Kazakhistan became the first country to sign a cooperation agreement regarding the transfer of city hospitals model. Since 2019, Turkish companies (YDA and Ronesans) have been active in health PPP projects in Kazakhistan.

The replacement of old establishments with city hospitals is a positive development increasing the quality of service delivery. In parallel to that, renovation speed is another aspect appreciated by the proponents of city hospitals projects. It is claimed that city hospital constructions are generally completed faster than public hospital construction in traditional procurement methods. In other words, the transformation of health infrastructure is experienced in a pretty short period.

The advantageous side of city hospitals in terms of finance reflects a short-term perspective. During the construction period, the private party burdens all the costs. Therefore, already indebted countries like Turkey prefer PPPs, lacking the necessary resources for substantial infrastructure projects. Since the total cost is not paid at once and payment is dispersed over the years, it becomes possible to conduct such mega projects. The government always states that it is a success story

to complete huge health facilities without paying even one Turkish lira. Although it is valid for the construction period, it will not reflect the whole reality, as explained in the following part. Ozcan (2015) asserts that advocators underline the characteristics of city hospitals that they are constructed in a relatively short time; the quality of clinical services is improved tremendously while ensuring effective delivery of both social and financial benefit to the public.

3.4.2. Disadvantages

The Covid-19 pandemic proved the significance of the quality and capacity of health facilities as well as their eligibility. Though the mainstream media covers city hospitals' issue as a positive step affecting the Turkish health system in this direction and the openings of new projects during this period as building blocks of the struggle, the reality seems different. A good starting point would be to mention why city hospitals' so-called positive aspects are not so.

3.4.2.1.Finance

First of all, focusing on the construction of city hospitals at no cost might reflect the attempt to hide the enormous financial burden in the long run. The lease and service payments for 25 years, adjusted yearly according to the inflation and change in the exchange rate, create an enormous debt burden to be paid for generations. In line with the commercial confidentiality principle, the government does not declare the exact amount of payments. However, there are calculations made following the annual budget of the MoH.

Emek (2019) conducted a study based on average payment per bed in city hospitals. In 2018, 8 new city hospitals became operational. The amount separated into availability and service payments in the ministry budget in 2019 was 6.2 billion TL, which means that the average payment per bed would be 735.000 TL according to January 2019 prices. Suppose this calculation is extended for 18 city

hospitals, with a bed capacity of 27.215, whose financial closure is completed. In that case, the total amount of yearly payment for 2019 reaches 20 billion TL, which is approximately %40 of the total budget allocated to the MoH.

The investment programme of the MoH states that the number of city hospitals planned to be constructed is 31. Fortunately, the MoH gave up the PPP model for the construction of hospitals whose financial closure was not completed. Thus, the number of health PPPs will stay at 18 if an opposite decision is not taken. However, the cost led by the existing hospitals is already excessive. For example, Kayseri City Hospital, built on the PPP model, started to operate in 2018 with a 1607 bed capacity. The total investment value was 427 million TL, and the annual lease payment was 137 million in 2019. To compare with the public procurement, Erzurum Hospital, with 1200 bed capacity, was built in 2011 with only 193 million TL. It indicates that a 1200-bed hospital could be built with only a 1.5-year lease value of a city hospital (Ayhan & Ustuner, 2022).

When the periodical increase in these amounts according to inflation and exchange rate and the volatility in the value of TL are also taken into account, it is better understood that the burden of city hospitals will create a deep black hole in the budget. The concentration of money for city hospitals will sweep away two-fifth of the MoH's total budget and create deadlocks for other public hospitals. The investments, goods and service procurement as well as payments for salaries of health officials for remaining public hospitals, will be in trouble. It is obvious that city hospitals reshape the health system in the long run. It will curb down the ‘social’ character of healthcare service delivery through canalising finance more to the private actors. As a result, it will imply the health system's financialisation and a deep crisis for remaining public mechanisms for healthcare. In this line, the JDP’s purpose of resource transfer to the affiliated groups dominates the health system's restructuration.

Table 6. The Volume of City Hospitals

Hospital	**Bed capacity**
Adana City Hospital (operational)	1550
Mersin City Hospital (operational)	1294
Isparta City Hospital (operational)	755
Yozgat City Hospital (operational)	475
Kayseri City Hospital (operational)	1607
Manisa City Hospital (operational)	558
Elazığ City Hospital (operational)	1038
Ankara (Bilkent) City Hospital (operational)	3810
Eskişehir City Hospital (operational)	1081
Bursa City Hospital (operational)	1355
İstanbul Başakşehir City Hospital (operational)	2682
Konya Karatay City Hospital (operational)	1250
Tekirdağ City Hospital (operational)	480
Kocaeli City Hospital (in construction)	1210
Kütahya City Hospital (in construction)	610
Ankara (Etlik) City Hospital (in construction)	3624
Gaziantep City Hospital (in construction)	1875
İzmir Bayraklı City Hospital (in construction)	2060

Source: Retrieved from the https://www.kamuajans.com/turkiyede-acilan-ve-acilacak-olan-sehir-hastanelerinin-isimleri

In Chapter 2, while enlisting the critical success factors for PPP projects, the risk-sharing issue was already focused. The risks should be allocated in a balanced way based on the principle that the party that best performs should own the risk. The

health PPPs in Turkey do not reflect this character. As just asserted, the public side assumes most of the financial burden. In addition to huge payments for availability and services, the private party is also secured against potential changes in financial markets. The service payments are paid quarterly (in January, April, July and October). The average of CPI and producer price index (PPI) in the last month before the payment period is calculated in each period. This number is compared with the average CPI and PPI in the last month before the tender. The rate of increase between this two determines the increase in the payment.

However, before the final rate of increase is concluded, an additional calculation called as adjustment coefficient is taken into account. A further increase is probable in the service payments in accordance with the change in the exchange rate in the currency that the credit is obtained. In each payment period, the three-month average of the related currency exchange rate before the tender is compared with its value three months before the payment period. If the increase in the exchange rate exceeds the rise in inflation, then this difference is added to the increase in service payment (Emek, 2017). In that way, the private party is secured against the instability of financial markets.

The company also receives availability payments from the MoH annually for the rent of buildings and facilities repair. Availability payments are increased annually by the arithmetic average of the PPI and CPI in Turkey for the preceding year. This annual increase may be further adjusted to take into account the increase in the Central Bank's currency basket if such an increase is higher than the average of the PPI and CPI (Emek, 2017).

The government provides a demand guarantee for volume-based services to assure a minimum income for the project company. It comprises 70% occupancy in operation and 80% for high-security forensic psychiatry hospital. When demand for services is less than the determined rate, the Ministry is under the burden of additional payment to the company for the amount lower than the guaranteed.

The private company undertakes the cost during the construction process, but even this was allocated to the public since the Treasury guarantees payment to the creditors. This guarantee is also reliable for the process of operation. If the project company fails to operate, the contract is cancelled before the termination date, and the health complex is transferred to the Ministry. In such a situation, the external credits used until that time will be under the Treasury guarantee. A further step is taken with eradicating the principle of legality of tax affairs. The project company is excluded from the VAT and Stamp Duty for transactions during the construction period through a by-pass of taxation law. In this context, all the risks are publicised in a sense while the profit remains in private actors' hands.

3.4.2.2. Complexity of Contracts

The Turkish health system had a social character in its foundation. To generalise qualified and free of charge health services was among the primary purposes of the new Republic. Though the number of private hospitals increased after the 1980s, the health system's social character has also been protected till recently. Thus, in general, the MoH and health bureaucracy have not experienced ruling privately-dominated mechanisms.

The PPPs are not confined to decide to the place of a new hospital and the project company to construct it; instead, they are multi-dimensional. Initially, it is needed for a deep-rooted feasibility study. Then, the PPP contract, consisting of various sub-contracts that cover different aspects of the project, must be written. The MoH should not neglect to specify all technical details and the responsible party throughout the project in these contracts. Such complex -in addition to long-term- characteristics of PPP contracts require a team of experienced professionals in their preparation, negotiation, management and supervision. This is the only way to overcome the possible problems for the public side, such as the distribution of risks mistakenly.

One side of the complexity is related to the multiplicity of the sub-contractors. The project company may subcontract with various companies for different parts of services. For instance, the imaginary and cleaning services may be held by sub-contractors. In this respect, disagreements between these companies and problems emanating from the lack of coordination between them are another realm of the problem the public party faces (Sozer, 2013). In order to deal with those troubles due to the complexity of PPP contracts, the MoH established a PPP department and transferred several professionals from the private sector.

Yet, it is not enough to close the gap between the public and private parties raised by the information and experience asymmetry on behalf of the latter. There are significant indicators that show the inexperience of the MoH. To illustrate, the MoH declared three different numbers about the bed capacity of Ankara City Hospital in 2017, just before its opening. It was 3660 on the MoH's web page, 3662 in the presentation by the Minister of Health in the Parliament and 3704 in a study "Value for Money: Case of Ankara City Hospital". After the hospital started to operate, it was finally concluded that its bed capacity is 3810.

Moreover, the study was distributed to the members of Parliament during the budget discussions to convince regarding the viability of city hospital projects with the claim that the construction of Ankara City Hospital is 1.3 billion TL more profitable than the public procurement, including several mistakes. For instance, as Emek (2017) asserts, while calculating the total construction cost per metre, the unit cost was taken at 1610 TL, and 2% was added for landscaping. The result was 1772 TL in the study, but all calculators give the result as 1642,2.

A more striking mistake is about the application of the Public Sector Comparator. The project's cost is calculated for both PPP and public procurement methods before the tender in this system. However, the Ministry takes the 2016 prices while calculating the cost of public procurement but the prices in the tender document signed in 2011 for the PPP method. The tender notification for Ankara City

Hospital was declared on 21.06.2010, which means that the comparison should have been made before this with the current prices. As a result, since the study disregards the increase in prices, such as the unit cost of construction and interest rate, it shows that public procurement is more costly. However, when the simple mistakes are corrected and the same period prices are taken into account in such a calculation, the result is that while Ankara City Hospital 's cost is 7,535 billion TL in the PPP model, it would be 4,671 billion TL in public procurement.

Not the cost but the legitimate concern that "does the team making such simple mistakes could conduct extensive feasibility studies and manage this complex procedure for 29 years" seems more thought-provoking.

3.4.2.3.The role of the MoH

The characteristics of PPPs have reshaped the role of the MoH in a complicated manner. The ministry was responsible for determining health policy and delivering healthcare services. The neoliberal transformation initially added the responsibility to manage private health services and regulate relations between Ministry/social security institutions and private hospitals. Then, the Ministry's mission has become a controversial issue with the introduction of PPPs in the health system. The MoH does not only provide healthcare services anymore, but it turned into an administrative unit that decides policy, provides service to some extent, concludes contracts, finances services held by private actors, regulates and supervises service delivery at the same time (Karasu, 2011). These additional roles create a dichotomy. While the Ministry assigns some of its responsibilities to private actors, on the one hand, it needs a more extensive bureaucracy on the other. This is against the main premises of New Public Management and neoliberal arguments. They propose a more diminutive and effective unit, independent of bureaucratic barriers and delegation of authority. In this context, the nature of city hospital projects contradicts these theories.

The replacement of boutique hospitals with huge health campuses paved the way for the enlargement of health facilities' scale dramatically, which has caused management problems but more significantly destroyed fair distribution of capital. Only a limited number of firms can place a bid on mega projects. The total cost of these giant projects and difficulty in finding credits is not the only limitation to deter many firms, but the rule that the contractor should finance at least 20% of the project with its equity is influential. Thus, a small number of companies, mostly by generating consortiums, having necessary equity and credibility in financial markets, could bid in tenders. It inevitably leads to capital concentration, as can be seen in city hospitals. To illustrate, Ronesans Holding and Astaldi-SPA-Turkerler were awarded 53.8% of all investments and 51.3 for total bed capacity. The outcome is clearly monopolization in healthcare service delivery.

Table 7. The Project Companies in City Hospitals

Hospital	Project Company
Adana City Hospital (operational)	Sıla Consultancy and Rönesans Holding (IFC under World Bank added later)
Mersin City Hospital (operational)	CCN Holding
Isparta City Hospital (operational)	Akfen Construction, Tourism, and Trade Inc.
Yozgat City Hospital (operational)	Sıla Consultancy and Rönesans Holding
Kayseri City Hospital (operational)	YDA Construction, Industry and Trade Inc.- Inso Sıstemı Per Le Infrastrutture Sociali S.P.A
Manisa City Hospital (operational)	YDA Construction, Industry and Trade Inc.- Inso Sıstemı Per Le Infrastrutture Sociali S.P.A
Elazığ City Hospital (operational)	Rönesans Holding and Sıla Consultancy
Ankara (Bilkent) City Hospital (operational)	CCN Holding
Eskişehir City Hospital (operational)	Akfen Construction, Tourism, and Trade Inc

Table 7. (continued)

Tekirdağ City Hospital (operational)	Akfen Construction, Tourism, and Trade Inc.
Bursa City Hospital (operational)	Rönesans Holding and Sıla Consultancy
İstanbul Başakşehir City Hospital (operational)	Rönesans Holding
Konya Karatay City Hospital (operational)	YDA Construction, Industry and Trade Inc.- Inso Sıstemı Per Le Infrastrutture Sociali S.P.A
Gaziantep City Hospital (in construction)	Samsung C&T Corporation - Kayı Construction, Industry and Trade Inc.
İzmir Bayraklı City Hospital (in construction)	Astaldi SPA-Türkerler
Kocaeli City Hospital (in construction)	Astaldi SPA-Türkerler
Kütahya City Hospital (in construction)	Guris Construction and Engineering Inc.
Ankara (Etlik) City Hospital (in construction)	Astaldi SPA-Türkerler

Source: Retrieved from the website of Turkish Medical Association

An additional ramification of PPPs is the rising dependency of the MoH on the project companies. As the government's target is to disperse financial burden throughout the years, it does not want the contract's collapse that burdens all the costs at once. Thus, it has to be flexible and adapt itself to the new realities on the ground on behalf of the private party. It may explain the logic behind the periodical changes in city hospital contracts. Thus, health PPPs display the failure of the main arguments of New Public Management and post-Fordist approaches. First, the existing system has not been replaced with a mobile, effective structure but the scale is extended far beyond the previous one and health bureaucracy accelerated. Second, health PPPs have not introduced competitiveness to the health market; rather, imperfect competition in tenders has encompassed an oligopolistic market structure. Last but not least, the entrance of private actors into service delivery had not brought a fair and efficient distribution of capital by ending state monopoly. In contrast, the capital is concentrated in the hands of a small group of private

actors. Hence, the market structure has not changed but state monopoly has been replaced by a monopoly or an oligopoly of private actors. It may seem a slight shift for some; however, it has significant repercussions if the topic is healthcare.

The danger may not be the shift in the actors providing healthcare services but the purposes and priorities. The necessity to consider public health to stay in power has given the floor to the need to maximize profit and minimise the cost to secure power. The difference between state and private sector monopoly in terms of "what to do so as to maintain power" has a transformative impact on the health system.

3.4.2.4. Impact on urban structure

Another realm that interpretations focus on is with regard to the physical aspects of city hospitals. Both inside and outside of them attract criticism. In terms of the latter, there are two main dimensions of critiques. First, the selection of the site where the health campuses are constructed is contested. According to Sozer (2013), city hospitals are intensely constructed in coastal cities where fewer new health investments are needed. As a result, both public and private investments in health sectors are concentrated in the same cities, raising the existing inequalities. Second, it shows that profit-based logic dominates public investments as well. The regions where investments seem to be risky in terms of profitability are not preferred mostly for health PPPs. Thus, the socio-economic disparity widens among different areas of the country. If these projects had been designed as a tool to turn underdeveloped regions into attraction centres, they would produce more meaningful outcomes. They might be a pull factor instead of a push.

Another point about site selection is the use of city hospitals to increase the attractiveness of some regions inside cities. On several occasions, projects are designed far from city centres. The concern to create new mechanisms of rent by raising sites' value seems to be determinant in these selections. Yet, it has

significant repercussions for users. The main indicators of the universality of healthcare services have two-fold: physical and financial eligibility. The latter refers to providing services free of charge or with payment proportional to the beneficiaries' income, while the former refers to various requirements such as the presence of enough health facilities, health officers so on. However, it is not limited to their existence but also eligibility. The health facilities must be constructed in places to be easily accessed by users. In this vein, the health facilities should be built around densely populated areas, and public transportation network is constituted to provide access from all residences in the vicinity.

However, several city hospitals are highly criticised, by particularly TMA members, as they generate problems in terms of physical access. The closed hospitals were mostly located in city centres, and the public transportation system was organised accordingly. The radical change in place of hospitals increased the cost for people to access health services. Here, I want to give an example from my own experience. My residence Sentepe -in the Yenimahalle district- is a densely populated area due to the recent urban transformation project. Before opening the Ankara City Hospital, different hospitals could be accessed easily by public transport in less than half an hour, such as Numune Hospital, Yuksek İhtisas Hospital, Gazi Mustafa Kemal Hospital and Ulus Public Hospital. There is also a bus route reaching Abdurrahman Yurtarslan Oncology Hospital. Now, Numune and Yuksek İhtisas Hospitals moved and Gazi Mustafa Kemal Hospital is waiting for the move to Ankara City Hospital. The Ulus Public Hospital moved to another district since the Ministry rented a new building for the hospital. Then, the only alternative for people became Oncology Hospital until Etlik City Hospital will be opened. There are two routes to Ankara City Hospital: either changing two minibuses or two buses plus underground. Both take almost 1.5 hours.

Furthermore, there are two university hospitals next to the old Numune Hospital, Hacettepe and İbni Sina Hospitals, which are still easy to arrive. Thus, people prefer to apply them instead of Ankara City Hospital. As the university hospitals

want to reply to demand, they have to focus more on policlinic services by pushing educational services into the background. The overburden in these hospitals also prolongs the waiting period to get an appointment for a medical examination. Furthermore, it forced a change in the public transport system. As routes of public vehicles are determined following significant health and education facilities, the transfer of old hospitals made some routes dysfunctional, creating a need for new ones to access the newly opened city hospitals. It brings an additional cost for municipalities.

The difficulty in access to the city hospitals is not only due to their remoteness or difficulty in finding public transport, but transportation infrastructure is lacking on several occasions. To illustrate, Ankara Metropolitan Municipality's ex-mayor declared that the cost of roads constructed for accession to the Ankara City Hospital is around 800 million TL.[5] It is possible to build a boutique hospital with this amount of money.

The users of the hospitals and municipalities are not the only victims of the site selection of city hospitals. The chemists, medical stuff sellers, and similar shops for health medical equipment in closed hospitals' vicinity lost their job mostly. The demand is mainly shaped by proximity to health facilities in these fields. As the new city hospitals are mostly far from the closed ones, these shops had to be closed if not able to be moved to the new hospitals' vicinity. Therefore, market loss in the medical stuff sector generated another unjust treatment. In a sense, it constitutes another form of concentration of capital. The closed hospitals were located in different parts of cities. Thus, the medical stuff market was shared between wider groups of investors in a more just manner. Now, a small and lucky group that can initiate an investment next to new city hospitals can benefit from the market. In other words, city hospitals have –directly or indirectly- changed the dynamics of the market towards oligopoly.

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[5] See the website of the Ankara Metropolitan Municipality: https://ankara.bel.tr/haberler/baskent-yeni-yol-ve-kavsaklari-tam-gaz.

The last remark on site selection is interested in the infrastructural characteristics of the selected site. It became a matter of dispute in several lawsuits brought by the TMA. In administrative actions they brought, the members of TMA requested the cancellation of some projects since the selected site was not a healthy choice. In Isparta province, the hospital was constructed in an area where the air pollution is at the highest level in the city. In Bursa, a valuable agricultural land that is highly open to the flood was assigned for the city hospital project. Similarly, Ankara City Hospital was built on a stream bed. Nevertheless, the warnings regarding the danger and negative environmental impact of construction on these lands could not conduce to a positive change in projects.

3.4.2.5. Conditions within city hospitals

After a gloomy analysis of the outside of city hospitals, it should be looked at from the inside, too. The large extent of hospitals creates extensive management and coordination problems. First of all, the outcomes of a systematic study by the World Health Organisation on hospitals' efficiency and optimal size show that hospitals with bed capacity under 200 and over 600 are inefficient in terms of management and finance (Hamilton & Kachkynbaeva, 2012). The number of beds in operational city hospitals varies in a wide range from 475 to 3711, whose average is nearly 1500. Thus, city hospitals do not encounter efficiency concerns of neoliberalism.

The magnitude of scale has other repercussions. The large volume of indoor space increases expenditure on heating, lighting, cleaning and repair. In city hospitals in Turkey, the average indoor space per bed is 287 m^2, and it can be as high as 350 m^2 in some hospitals. This space is generally around 150-200 m^2 in newly built hospitals in developed countries. In other words, indoor space per bed in city hospitals in Turkey is larger by about 40 per cent than what is recently preferred in modern hospitals. It causes an increase in maintenance costs which means more payment for services.

In terms of work relations, city hospitals have a dual character. There are two types of employers and employees: health officials under the MoH and workers of the company. The wide gap in personal rights between them might degrade work peace. To illustrate, while it was accepted to transfer sub-contracted workers in public hospitals to permanent employment status, those working in city hospitals and workers in public hospitals moved to city hospitals are excluded from this arrangement (Pala et al., 2018). In this way, a probable tension for the project company workers is created, which may reflect in their relations with the health officials. Though there is a clear division of labour, robust coordination is essential between public officials and company workers. For instance, the quality of imaginary services conducted by company workers is vital to diagnose an illness by the doctor. How to cope in case of any problem in the relations between public officials and private workers as well as the company and the MoH are prone to trouble.

The uncommon scale of city hospitals has also made some accounts more difficult. For instance, it is more difficult to reach patients for consultations. A worker in Mersin city hospital quotes her experiences in this way:

> In a turn of duty, I counted how many steps I have to take to have access to the closest and the farthest patient. The former was 29, and the latter was 53. In a 16-hour based duty, I visit each patient six times at least, which means that I have to take 354 steps per patient. If you multiply this number with the total number of patients –each service has 24 beds-, the physical tiredness of a health worker may be better understood. Moreover, the number of workers in support services decreases at the end of the official working hours. The inevitable result is more work, less personnel (Ugurhan, 2018).

The same difficulty is valid for patients and their companions. The hospitals try to take necessary precautions such as compact cars between services and wheelchairs inside buildings. However, hospitals' vast capacity requires extensive measures in these realms, significantly raising the cost. It forces them to keep the measures at a moderate level that aggrieve people.

3.4.2.6. Democratic deficit

The principles of good governance must be applicable for a successful PPP experience. There are several implications of good governance; the most significant one is transparency. Only an accountable system would present all aspects, negative or positive, of long-term PPP projects. In this realm, Turkey does not perform well. Turkey has a poor score 40/100 on Transparency Index 2020, making it 86th among 180 countries. It is known that corruption is a common practice. Nonetheless, the new executive system has exacerbated it by eliminating the control mechanisms over bureaucracy by the independent judiciary and institutions. The lack of responsibility makes institutions feel free in their acts. For instance, they do not publish their annual report on time. It has ramifications on city hospitals and also overall PPP projects as expected. In addition to the fragmented nature of PPPs in different sectors, the interpretation of the principle of commercial confidentiality in a broad manner and applying exceptional tendering procedures have turned health PPPs into a mystery. It may open the way for closed-door bargaining that benefits the private actors or makes them unsecured against the government's would-be interventions. To insist on foreign arbitration in legal disputes in city hospitals contracts show mistrust toward the bureaucracy, including the judiciary.

The transparency and accountability problems are side effects of deterioration in the quality of democracy; hence a structural transformation is needed to overcome them. Besides, specific to PPPs, establishing a centralised PPP unit responsible for preparing, initiating, and supervising all PPP projects that transparently conduct all affairs might make the system more accountable and democratic. Turkey can follow a similar path to the UK in this realm. The UK system enables a sustainable risk management process so as to eliminate uncertainty among the whole PPP portfolio. The National Audit Office (NAO) publishes reports on PPP projects and occasionally advises a risk management procedure for ongoing projects. Moreover, in 2012, HM Treasury reported that the UK government started

publishing the whole government accounts to increase PFI obligations' transparency and launched the ‘Operational PFI Savings Programme’ as an improved cost-saving mechanism to ensure transparency for the functioning projects (HMTreasury, 2012).

Another realm of concern regarding democracy is the democratic deficit that PPPs create. The health PPPs in Turkey are long term projects. They determine the characteristics of healthcare delivery in the next 25 years. When any party comes into power, it has to follow the JDP’s path for a while not to shoulder the cost of expropriation of city hospitals. In other words, even a left-wing government will have to embrace neoliberal policies due to financial concerns. It not only prevents a systematic change in health policy but also lays the financial burden on next generations. As can be seen, the negative aspects of health PPPs outnumber the positive ones. The following part will indicate how the Court of Accounts reports affirmed this study's thesis.

3.5. The Findings of the Court of Accounts

In line with the duty to perform audits, trials, and guidance to contribute to accountability and fiscal transparency in the public sector, the Court of Accounts publishes audit reports for public institutions annually, which put forward the inspection outcomes. In the last three reports on the Ministry of Health prepared according to 2018, 2019 and 2020 records and published in 2019, 2020 and 2021, in order, there are significant findings that indicate problems in the city hospitals. The reports reveal how commercial confidentiality is practised to a dangerous extent. It is stated that although the tender document of city hospitals and the contracts and annexes as to the investment and operation period, including consultancy services purchases, was requested from the Ministry verbally and in writing, they could not be obtained as expected. Therefore, the findings listed in the report are achieved, based on the documents and annexes as to the payment

acquired on-site, alongside the documents without a wet signature as to the management and operation of the health facility, including the contract and its annexes and other documents.

1. Problems regarding the financial accounts of city hospitals: In the examinations, it was observed that the commitment amounts of some city hospitals, whose contracts were signed and committed, were not accounted for and remained unrecorded. Besides, it is understood that the realisation of the commitment amounts on a quarterly basis is not monitored in the accounting system.

As a result of not making the accounting records regarding the assets and liabilities and inventory transactions of city hospitals in service following the legislation; 25 Tangible Fixed Assets and 30/40 Short/Long Term Domestic Financial Liabilities account groups and operating results accounts do not reflect the actual situation completely and accurately. Furthermore, it has been determined that the demand guarantees specified in Annex-18 titled "Payment Mechanism" in the annexes of the city hospital contracts and committed to the company in charge by the administration are not accounted for and are not shown in the balance sheet footnotes.

2. Unduly executed debt undertaking commitment by the administration and no accountings and reports about it: From the provisions included in the annexes of the city hospital contracts, it has been observed that the administration has undertaken commitments for the principal, interest and similar expenses that the companies in charge are obliged to pay to the finance providers for these projects, and this transaction was not reflected in the financial statements. In the Regulation on “Debt Undertaking to be Performed by the “Ministry of Treasury and Finance”, the procedures and principles regarding the debt undertaking process are regulated. According to that, the related authority has to present the draft version of the contract to the Ministry of Treasury and Finance before publishing the

tender specifications. Following the Ministry's approval, issues regarding the debt undertaking are presented to the Presidency upon the proposal of the Minister. With the approval of the Presidency, the administration initiates the tender, and the draft contract is sent to the Ministry again before it is signed. In the event that the Ministry evaluates the provisions regarding debt undertaking and gives a positive opinion, the matters regarding debt undertaking are presented to the Presidency again. If an affirmative decision is made, the agreement expressing the debt undertaking commitment is signed.

In Annex-23, titled "Compensation at Termination" of the city hospital contracts, it is stated that in cases of breach of contract provisions by the administration or unjust termination of the contract, breach of the contract provisions by the company or the company's unfair termination, the principal, interest, insurance, financing expenses (including all kinds of hedging and other affiliated agreements and break-up costs and expenses), including the bridge loan related to the financing of the project within the scope of the contract, is committed to be paid to financiers. On the other hand, Article 50 of the city hospitals contracts stipulated that following the implementation of the provisions of Annex-23, the facility built within the scope of the contract will be transferred to the administration. Considering the provisions of the contract and its annexes, since the transaction is actually a debt undertaking commitment process defined in Article 8/A titled "Debt Assumption" of the Law numbered 4749, the relevant authority can only be exercised by the President pursuant to the existing law.

It is understood from the aforementioned explanations that the process of debt undertaking commitment described in the Law No. 4749 was not followed, and commitment to undertake debt has been made in violation of the Law. Furthermore, it was determined that the debt undertaking commitment transaction should be recorded in the accounting records using the 934-Debt Assumption Commitments Account and 935-Debt Assumption Commitments Account. This transaction was not performed and was not reported.

For the reasons explained above, it is considered that, among the provisions included in the city hospital contracts, the administration has actually committed to undertake debt even though it is not authorised, and that the provisions regarding this commitment have been signed by non-authorized authorities. On the other hand, there are no accounting records for the mentioned commitment transactions.

3.Introducing burden of proof for administration in the city hospital contracts to apply for the responsibility of the company in charge: In Article 14 of the contract titled "Compensation and Liability", which regulates the parties' liability, it is understood that a finalised court decision is sought to go to the company's responsibility. However, such a condition is not required for the administration, and it is allowed to go directly to the responsibility of the administration.

In this line, while the city hospital contracts require a finalised court decision to go to the responsibility of the company in charge in accordance with the provisions regulating the parties' obligations, it is considered that it is against the fairness and public interest not to seek a finalised court decision for the responsibility of the administration.

The point mentioned in the findings precisely indicates that the interest of the creditors overrides the public interest. Despite the fact that the interests of the companies in charge are protected to the degree that requires a court decision, no such protection is provided for the public interest; even if one of the parties is assumed to be a public party, the contract does not protect the interests of both parties equally and fairly.

4. Copy Differences, Citation Errors and Provisions of Unknown Origin in Contracts of Operational City Hospitals: It was observed that the copies of contracts of Yozgat City Hospital were submitted to the audit team by the abolished Public Hospitals Authority of Turkey lack Articles 66 and 67. Still, they

are available in copies obtained on-site. In the copy of the contract obtained on-site, article 66 is related to "Cost and Expenditures", and Article 67 regulates "Applicable Law". The difference between the contract copy presented to the audit team and the one obtained on-site causes uncertainty about which contract is the basis for implementation.

It has been observed that there are references to the provisions not included in the provisions of Annex-22 titled "Amendment Procedure", which regulates the procedure of the amendments to be made in the contracts.

5. The presence of several provisions in city hospital contracts against the Law no.6428: While calculating the availability payment, it has been observed that in addition to the company's loans provided in foreign currency, the exchange rate is also updated for the amount of equity that the company has to provide as per the contract.

While calculating the availability payments for the eight-city hospitals in operation, it is understood that for the amount of equity that the company is obliged to provide, in addition to the updates made according to the domestic price indices, the exchange rate correction coefficient is also applied. The provision of this article allows the application of the exchange rate adjustment coefficient at the borrowing rate for the service payments to be calculated. The Law does not stipulate the payment of price difference for the amount of equity that the company has to provide.

It is understood that the provisions regarding the place of arbitration have not been brought into line with the Law in force at the time the contracts were signed and the current Regulation. In Annex-6, titled "Direct Agreement of the Providers" attached to the contracts, the place of arbitration of any dispute arising from or directly related to the Direct Agreement of the Funders is determined as Istanbul for Mersin City Hospital and London in the other seven city hospitals. The

eleventh paragraph of Article 4 of the Law No. 6428 on Building, Renewal and Service with PPP by the Ministry of Health and Amending Certain Laws and Legislative Decrees states that for legal disputes that may arise between the parties during the implementation of the contract, Turkish law is applied and the court of Republic of Turkey are authorised in settlement of disputes. However, parties may agree that the conflict can be resolved within the framework of the International Arbitration Law (dated 06.21.2001 and numbered 4686) on the condition that Turkish law is applied to the conflict and the case to be seen in Turkey. However, this article was changed, and the statement "the case to be seen in Turkey " was repealed by Law no.6639 on 27.03.2015.

The administration, in its response, stated that foreign creditors generally provide finance financing for city hospitals projects. The determination of Turkey as the arbitration place of legal disputes with the financiers is not accepted by foreign investors based on claims regarding various problems in the Turkish judiciary. Thus, it becomes obligatory to make amendments concerning the arbitration rules accordingly.

6. Failure to obtain assurance that the competent authorities duly make the amendments of contracts of city hospitals: As a result of the examination of the contracts and their annexes signed on various dates regarding the operating city hospitals and submitted to the audit team, it is understood that these contracts were amended as a whole on 26.08.2014 and changed on other dates after that as well. After the tenders were finalised and the contracts were signed, it was not determined, during the on-site inspections, whether the changes in the contract, the annexes of the contract and the elements that make up the contract cost were made by the competent authorities following the procedure. As a result, although the response given by the administration claimed that the amendments made in the contracts were carried out in accordance with the provisions of the legislation, no document was submitted to form a basis for this claim.

***7. In case of breach of contract provisions or unfair termination of the contract by the company, the equity rule becomes meaningless due to the fact that the administration will pay all kinds of penalties and expenses incurred by the early termination of the contract to the company as compensation**:* It was not understood why the administration had to pay the cost, such as penalties and expenses arising if the company violated the contract provisions or terminated the contract unjustly. In addition, undertaking the financing risk of the equity by the administration de facto alleviates the obligation of the incumbent company to bring 20% equity, arising from the legislation, and allows the said share to be provided as a loan with a government guarantee.

While contractors of the city hospitals are required to submit their financial statements to the administration quarterly and annually, they do not regularly present the financial statements as of the relevant periods and/or do not present all the financial statements they need to submit. Therefore, the rule that the incumbent company will provide 20% of the fixed investment amount is followed in a limited way. It is understood from the financial statements presented by the companies in charge at the end of the investment period in some city hospitals that the companies do not comply with the 20% equity rule.

8. Paying for ground and garden maintenance service for the areas that are actually in the construction: The administration cannot use some parts of the campuses where Adana, Manisa and Elazığ City Hospitals are located as they are construction sites during the inspection. There are workers' barracks and work machines in these areas. Thus, ground and garden maintenance services cannot be provided due to construction activities, but availability payment for these services was made in full.

9. Lack of Type and Number of Medical Devices and Equipment Specified in City Hospitals Contracts and Annexes: During the on-site inspections, it was determined that some of the medical devices and fixtures included in Annex-13

(especially in vitro fertilization and laser eye surgery devices) are not available in health facilities. To illustrate, despite the absence of in vitro fertilisation (IVF) unit at Elazig Fethi Sekin City Hospital, there is an item under the name of "IVF" in the invoice and related payment documents issued by the company within the scope of laboratory service payments and that the guarantee amount has been paid in full.

It is considered that this situation stems from the lack of a control system that will detect risks starting from the planning phase of city hospitals and during the contract period, as well as the lack of communication and coordination between the responsible units.

10. The Administration's undertaking the payment of Stamp Tax to be paid by the company regarding the "Availability Payments" and "Service Payments": The provisions of tax law should be applied, regardless of the contract's content, concerning the taxes to be added or deducted in the payments in city hospital contracts. Law No. 3359 and Law No. 6428 assert that exception provisions regarding stamp tax are limited to the investment period. For this reason, it is not possible to apply an exception, limited to the investment period, for the payments during the operating period with an arrangement in the contract.

In this respect, the Ministry’s assuming the stamp tax during the operating period should be abandoned. Stamp tax should be deducted from the payments to be made to the company according to Law No. 3359 or Law No. 6428, depending on relevance.

All in all, the findings of the Court of Account confirm the study’s main arguments. The reports sign structural maladies regarding the basic themes of PPPs. First, the contracts seem not well-prepared, as copy differences and citation errors indicate. Similarly, contracts include contradictory items like giving place to the 20% equity rule and providing guarantees for the equity at the same time.

Next, there is a fundamental problem of transparency. The contracts are hidden even from official inspectors of the state. Besides, they were amended several times, but the time and rationale behind these amendments are unknown. Also, the financial accounts of some projects do not reflect the whole components precisely, which prevents to access the entire amount of payments for these projects.

The reports assert that the mostly underlined principle of PPPs in the literature, that is, sufficient allocation of risks between public and private actors, is not valid in city hospitals projects. The public party shoulders a vast range of risks, including debt undertaking, accepting the burden of proof to apply responsibility of the company in charge and giving up legal privileges under the administrative law by accepting the application of private law. Moreover, the public party does not apply to the responsibility of the private actor even under the necessary conditions, such as making payments for the areas not operational.

Last but not least, the reports present legal deficiencies regarding these contracts. Many items within the contracts contradict the current legislation. In addition to procedural provisions against Law No.6428, the tax law is even violated to provide additional privileges to the project company. All these findings indicate that the private party's interests are prioritised contrary to the public interest.

CHAPTER 4

REFLECTIONS OF HEALTH PPPs IN THE FIELD

A social phenomenon could be better understood in its natural setting. Thus, a better way of having a more comprehensive understanding of a topic is to conduct a field study. It can be performed in different methods, qualitative or quantitative, following the nature and purpose of the research. This study has covered heretofore how the PPP model has transformed healthcare service delivery in Turkey by referring to the literature. To better understand the repercussions of health PPPs in practice, this chapter will give place to the content and outcomes of qualitative field research.

4.1. Methodology of the Field Research

As Hakim (2000) asserts, qualitative research has many advantages, including providing the individuals' own accounts of their attitudes, motivations and behaviour; offering richly descriptive reports of individuals' perceptions, attitudes, beliefs, and meanings given to events and things; displaying how these are put together, more or less coherently and consciously, into frameworks which make sense of their experiences; and illuminating the motivations which connect attitudes and behaviour, the discontinuities, or even contradictions between attitudes and behaviour, or how conflicting attitudes and motivations are resolved in particular choices made. In other words, it provides a more comprehensive sense of perceptions of concerned parties.

To better understand the repercussions of health PPPs in service delivery, it is of paramount importance to get the views of service providers. In that respect, the interview is applied in this study as one of the most common types of qualitative

field study. The study prefers a semi-structured interview technique in which key themes rather than specific questions are addressed to provide respondents with a certain degree of flexibility. The interviews are exploratory about testing hypotheses, making connections between other elements of the research, ensuring the strategic fit, and progressing the research findings forward (Macdonald & Headlam, 2009).

In this line, interviews with seven doctors, two nurses, two administrative officers from the Ankara City Hospital and two members of the Turkish Medical Association, City Hospitals Observation Committee were conducted. The interviewees from the Hospital consist of health officers coming from closed hospitals in Ankara, appointed from hospitals out of Ankara and managers in the administrative building.

The study embraces the snowball sampling technique as the sampling methodology for the interviews. It is based on the selection of a sample and expanding the range with the help of the initial sample. For the TMA, it was easier since there is a specific unit, the Observation Committee for City Hospitals, whose members have relevant knowledge regarding the purpose of the study. Besides, the network of health officers in the Ankara City Hospital was benefitted after getting in touch with the initial contact for the interviews. Most of the interviews were held face to face within the hospital. Yet, alternative methods such as online tools (Zoom, Google MEET etc.) were also applied, when deemed necessary, due to the Covid-19 pandemic restrictions.

The study was prepared during the pandemic. Therefore, reaching a place declared as a pandemic hospital was quite risky and challenging due to pandemic precautions. Moreover, the bureaucratic procedure required for the field study in the Hospital further exacerbated conducting the study. The application to and getting approval from the Ankara City Hospital Ethics Committee was a lengthy and complicated process that entailed allocating significant time and energy.

Profile: Ankara City Hospital

Ankara City Hospital is located on a vast area in Bilkent neighbourhood with 1.312.358 m² closed and 674.000 m² ground area. It is consisted of 7 branch hospitals with a 3810 bed capacity. These are;

- General hospital: 562 beds
- Cardiovascular hospital: 441 beds
- Neurology Orthopedics hospital:506 beds
- Children’s hospital:599 beds
- Maternity hospital:542 beds
- Oncology hospital:588 beds
- Physical Medicine and Rehabilitation hospital: 300 beds

In addition to these main hospitals, there is a high security forensic hospital with 100 beds capacity, main mass (72 beds), dialysis centre (38 beds), chemotherapy centre (127 beds) and iodine treatment clinic with 10 beds. 696 of beds are used in intensive care units.

The management of the hospital is multi-partite. In all branch hospitals, there is a chief physician and deputy chief physicians. Besides, there is a coordinator chief physician and associated deputies. The hospitals’ chief physicians are responsible for organising service delivery inside the hospital, deliver the needs to the coordinator chief physician and share the problems with him. On the other hand, the coordinator chief physician is the exposed face of the hospital and runs the external relations with the Ministry, Provincial Directorate of Health, the Company (CCN Holding) and other relevant authorities. He is also responsible for procurement affairs which is outside of the company’s authority.

There is robust coordination between the coordinator chief physician and hospital chief physicians through regular meetings and different communication channels.

The management of such a vast structure requires a strict control over each process. Therefore, there are various units which are responsible for flawless operation of the affairs. These are:

- Coordination centre for emergency
- Procurement unit
- Press and communication unit
- Rights and security of employees unit
- Environment and waste management unit
- Discipline and law unit
- Pharmacy unit
- Education coordinatorship
- Rights of patients unit
- Workplace health and security unit
- Quality and efficiency unit
- Spiritual support unit
- Health tourism unit
- Medical social service unit
- Web unit
- Clinical engineering unit

These units, except procurement, have offices in branch hospitals and a centre at administrative building. The centre determines main working principles and procedures and evaluates the needs and problems delivered by the units.

The construction of the hospital, the foundation of which was laid on September 18, 2013, started in 2015. Some parts of the hospital were opened in October, 2018 while the construction was ongoing. The construction was completed in 2019 and official opening was conducted on 14 March 2019. Initially, Atatürk Training and Research Hospital, Yuksek İhtisas Training and Research Hospital and Numune Training and Research Hospital moved to the City Hospital between February-May 2019. They were followed by Dışkapı Children's Hospital (August 2019), Zekai Tahir Burak Maternity Hospital (September 2019), Ankara (Altındağ) Physical Medicine and Rehabilitation Training and Research Hospital (March 2020). The hospital campus also hosts Yıldırım Beyazıt University Faculty of Medicine.

The presence of such a vast hospital constructed and operated with public private partnership model has inevitably significant implications for healthcare service delivery. The purpose of interviews with health officers is to understand the changes in healthcare provision operation. In this vein, a set of draft questions were prepared in line with the insight provided by the preliminary study.

The initial draft questions are;

1. What kind of deficiencies in the health system led to the emergence of the city hospitals project?
2. What are the advantages and disadvantages of the Ankara City Hospital in terms of healthcare delivery compared to the previous hospital where you worked?
3. How has the presence of a private actor in service delivery affected the healthcare provision?
4. How are administrative affairs conducted? What kind of strategies are developed to manage such a vast hospital?
5. How are work relations affected by the presence of many health officers coming from different hospitals? Similarly, how does the presence of public and private sector personnel together affect work peace?
6. What are the advantages and disadvantages of the new hospital structure in terms of circular fund management?
7. How do you evaluate the moving process from closed hospitals to the Ankara City Hospital? How was this process planned? What kind of problems did you experience during this process?
8. How does the new structure affect education and training activities?
9. Does the Hospital show good progress in being a centre of attraction for health tourism as propagated?

10. How do you evaluate the contribution of the Hospital to the management of the pandemic?

These are open-ended questions which are open to being improved with follow-up questions during the interviews. As expected, the draft questions changed based on the feedback from the interviews. Also, many follow-up questions were directed in line with the flow of the interviews. Most of the questions were common for all participants. Yet, some questions were directly related to policy making process; therefore, they were not directed to health officers in the Ankara City Hospital. Similarly, some questions, such as those relating to the moving process, could be directed only to health officers with work experience in closed hospitals.

4.2. Findings of the Field Research

A thematic analysis was applied based on the interviews. Hence, relevant themes that emerged from discussions were identified, and conclusions were reached on several themes. The following section will present these findings.

a) The need for city hospitals: One of the purposes of the study is to understand why the PPP model was preferred in healthcare. Therefore, the first question directed to the participants was why city hospitals were needed. In this context, the answer of health officers to the "why" question clearly explains the discrepancy between needs in the healthcare system and purposes of health PPPs.

Many of health officers highlighted that there is a need to improve the health infrastructure in Turkey. The increase in population and rising demand for healthcare services enforce the presence of new hospitals and more hospital beds. However, most participants indicated that the city hospitals do not respond to these needs. First of all, they refer to the fact the bed capacity of hospitals in provinces where city hospitals are constructed remains nearly the same, albeit with slight

differences since new hospitals are constructed on the condition that the public hospitals in the province are closed and moved to city hospitals. Furthermore, officers coming from the closed Ataturk Hospital asserted that their hospital was not in need of renovation in contrast to Numune and Yuksek Ihtisas. Therefore, closing such a relatively new hospital does not serve to meet the need for infrastructural renovation in the healthcare system. It addresses the deficiency in planning the health PPPs.

If city hospitals are not designed in accordance with the sectoral needs, then the question arises: what was the rationale lying behind the planning of health PPPs? Most of the participants did hesitate to answer this question since it is mostly a political decision and out of the scope of healthcare delivery. On the other hand, the members of TMA have clear answers in this realm. They claimed that the city hospitals did not arise from the needs of the health system but emerged as a need of capital. This bears an assertion of the arguments given in the section on political economy, indicating that the city hospitals are planned as a way of a reallocation of resources to the government-affiliated groups. The TMA members suggested that the renovation of health infrastructure should have been planned based on a well-designed cost-benefit and feasibility analysis and constructed with a correct financial model, respectful to the urban fabric, reflecting principles of science.

Another focal point of participants concerning the planning process is the asymmetry of information and transparency. Good governance highlights that well-planned PPPs entail ensuring full agreement of all parties engaged and conducting an appropriate consultation process. Nonetheless, the arguments of respondents reflect an opposite case. The TMA members commented that they were excluded from all stages of decision making and planning processes, and the Ministry tossed their concerns off. Similarly, they claimed that tendering process was not transparent and conducted in utmost secrecy. They relate the current problems regarding the operation of city hospitals to deficiencies in the planning process.

b) The issue of scale: The physical infrastructure is an important factor that determines the quality of services in many sectors, including healthcare. In this respect, all interviewees from the Ankara City Hospital appreciated the infrastructural aspects of the Hospital. They highlighted the advantage of modern and qualified physical infrastructure, equipped with the latest technology in the Hospital. In this respect, health officers from the Hospital emphasised that although the bed capacity is almost the same when considering the close hospitals, the quality of beds has increased remarkably. The more spacious and comfortable rooms are better for both patients and officers.

The physical characteristics of the hospital generate the most crucial part of criticisms towards the city hospitals at the same time. After mentioning about the advantages of the new infrastructure, doctors and nurses from the Hospital, but not the administrative officers, commented on the scale of the Ankara City Hospital as the largest one among the currently operational hospitals. According to participants, the vast scale of the hospital creates an accessibility problem for both patients and hospital personnel, thereby making the operation problematic. It seems to assert the findings of the WB, indicating that the ideal operation capacity for effective and efficient hospital management is 200-600 beds.

Both statements of participants and personnel observation while conducting the study asserted that for the side of patients, the accessibility to treatment takes time and is problematic for, especially those who have difficulty in moving. According to interviewees, the hospital gives the opportunity to reach all departments at the same time. A patient can get an appointment from two departments at most within a day, albeit with the possibility of visiting further departments with the approval of the doctor. They stated that it is an advantage because it was not always possible to find all departments in the closed hospitals, and the patients had to be directed to other hospitals. One of the ex-officer in the Dıskapı Children’s Hospital stated that the old hospital did not have other branches such as cardiovascular; therefore, doctors had to demand consultation from Yıldırım Beyazıt Education and

Research Hospital. In the Ankara City Hospital, this problem is eliminated. It is not needed to carry children with an ambulance to other hospitals anymore. However, health officers participating in the study asserted that it is difficult to visit two different branches on the same day due to physical conditions despite the technical possibility. Although they are on the same campus, the distance between departments is far, and the transition is difficult for patients. They mentioned the attempts to solve this problem, such as shuttles between buildings; however, they indicated that these vehicles have limited capacity and patients have to wait for them.

Another problem referred to by interviewees was that patients are sometimes forced to move between buildings for treatment. An example given by one of the participants was that a patient who broke his arm and came to an emergency or orthopaedics hospital might be directed to the radiology of cardiovascular hospital according to density. He should use shuttles, but he has to wait. He can choose to use a wheelchair. Then, his companion should take a wheelchair in return for an identity card, and when they complete their accounts, they should turn back to get the identity card. So, it is too demanding for patients.

Similarly, interviewees commented that accession to necessary places as part of treatment, such as blood tests, radiology etc., within a department is difficult and time-consuming due to the vast and complicated character of the buildings. In this case, the elevators create problems regarding time management. Health officers stated that there are four elevators serving the floors, but they are not sufficient since the hospital is too large and crowded. Thus, they have to wait for elevators while going to services.

Another area of difficulty that health officers underscored was the adverse effects of the scale on access to the patient for consultation. Doctors and nurses have to spend a lot of time and energy to reach patients. They underlined that their colleagues with physical difficulties in movement experience significant problems

in this realm. Furthermore, according to participants, the scale makes urgent operations difficult when there is a need for support from other departments. A doctor from Children's Hospital stated that when the support of a cardiologist is needed urgently for an operation conducted in Children's Hospital, the arrival of a related health officer takes time, which generates a significant problem in cases for which even seconds are pretty valuable. The shuttle services can make accessibility faster; however, they are not for personnel. The personnel are not allowed to use them; therefore, they must walk between different buildings. As can be seen, the vast scale and vertical structure of the Ankara City Hospital adversely affect healthcare service delivery.

c) The involvement of a private actor in hospital management: Another realm of difficulty that health officers emphasised is the new operational structure in which the private sector is located at the centre. There are various repercussions of the presence of the private sector. The first and foremost issue underlined by doctors and nurses is the procurement process.

In city hospitals, the procurement process has two folds: the medical consumables are bought with open tendering in accordance with the regulations of the MoH, and the fixtures are obtained by the company. Here, there arise some problems according to interviewees. For instance, the company may not approve the number or amount of the fixture demanded and initiate tender for less.

Moreover, the separation of fixtures and medical consumables may sometimes be complicated. One of the doctors stated that the microscope as a main medical instrument is defined as a fixture, and they are not provided in sufficient numbers. In addition, the problems concerning the procurement of medical consumables address the issue of scale again. According to health officers, the need for medical consumables is high as parallel to demand and bureaucracy in procurement cannot sometimes catch up the same path, leading to deficiencies in obtaining medical consumables. One of the nurses approved that they experience problems in

obtaining even ordinary medical equipment such as sponges. Moreover, interviewees also highlighted that accession to medical instruments has also changed in city hospitals. When a department needs an item, it is required to make an application through the phone line "911" or online system. If this application is approved, a company officer comes and accompanies the department personnel to the storage. Thus, procurement has become a cumbersome process in city hospitals.

Another emphasis of interviewees concerning the involvement of the private sector is on the effects of the hoteling mentality introduced into the hospital management. They claimed that the urgency requirement in healthcare services is not compatible with the hotel management mentality of the private sector. An example given by a doctor is that, in old hospitals, all patients were called to anaesthesia early in the morning. When a patient does not have the necessary health conditions to get anaesthesia, the other patient can take it without waiting. However, in the Ankara City Hospital, the appointments are arranged based on the principle of exact timing. If a patient cannot get anaesthesia, doctors have to wait for the other patient's appointment time. This example indicates that flexibility, promoted by pro-neoliberal arguments, cannot be ensured despite the presence of a private actor. Though the public sector has always been criticised due to bureaucracy preventing flexibility, in the case of city hospitals, there is a vice versa situation.

According to health officers, the hotel management logic based on customer satisfaction prevents flexible on-the-spot actions that ease the operational process. For instance, one of the doctors stated that they arrange their lunch time according to workload. If six patients are waiting for MR and their accounts end at 2.00 pm, then doctors go to lunch at that time. However, in the city hospital, the private sector personnel conducting MR services work on a strict working schedule. They go to lunch at 12.30; therefore, reflecting the same flexibility is impossible. Another example given in this realm is concerning the secretariat services. After

doctors controlled the patient in old hospitals, they directed them to the department secretary for an MR appointment with a written note concerning the priority. There is no chance to do the same in the current system since there is a strict division between privately held secretariat services and publicly held treatment services.

On the other hand, administrative officers do not share the health officers' views regarding the procurement process. They focused on the advantages of private involvement and underlined that the quality of fixtures and medical equipment increased extensively. They indicated that working with a private actor provides more flexibility under the PPP model since the private party wants to maintain good relations with the public side and deals with demands with utmost care.

d) Unnecessary bureaucracy: According to health officers, there is an unnecessary bureaucracy in each account, which does not suit the need for fast operation in service delivery. One of the doctors exemplified this argument by stating that when there is a need for blood during the operation, doctors should apply to the secretary and demand blood by filling out a form and wait for that. It takes too much time. However, in the old system, it was quicker and required less bureaucracy. These are all emanating from the scale and service mentality of the private sector. Several participants stated that they try to overcome this bureaucracy with on the spot actions in order to prevent time loss. However, they underlined that they face problems when they do so. For instance, a doctor stated that their team had to use a blood gas device without getting a barcode in an urgent situation. In return, they got a warning from the company stating that the device should be taken back since they didn't follow the necessary procedure. The participants relate this situation to the payment mechanism under the PPP model. The use of an application system is vital for the company since the service payment depends on the volume of the services delivered. As a result, health officers have to endure unnecessary bureaucracy for the sake of the company.

e) Personnel regime: The personnel regime is one of the most emphasised issues during the interviews. Both health officers in the Ankara City Hospital and TMA members indicated that support personnel play an essential role in pre and post-treatment affairs, such as transferring patients to the operating room on time before and after an operation. The absence of permanent support staff in departments creates problems. In the Ankara City Hospital, and other city hospitals, there is no permanent staff in departments; instead, there is a pool of staff employed by the company who serve departments on call when needed. According to participants, the system sometimes functions quite fast and effective, but sometimes their demand is not met immediately due to the lack of a sufficient number of personnel and high demand, which paves the way for delays in operation. They also indicated that such a pooling system also leads to problems in terms of institutional memory. Since the support staff changes daily, they cannot gain a deep understanding of department operation and expectations of doctors and nurses, which is another factor that prevents flawless operation of daily affairs.

f) Coordination problem: Public private partnerships have changed the administrative structure within the hospital. As participants asserted, there is a dual management system: chief physicians in each branch hospital on the one hand and coordinator chief physician in the administrative building on the other. The responsibilities of a typical chief physician in old hospitals are divided between these units. According to interviewees, the most significant change is on the side of chief physicians in branch hospitals. They have limited responsibilities compared to the old system. They are like department heads who deal with operational problems inside each hospital. They are not involved in the procurement process as well. It can be claimed that even locating a separate building as administrative building and not giving a representation for chief physicians there indicates that chief physicians do not have general administrative functions outside the hospital building that they lead.

As understood by statements of the participants, the core administrative affairs are conducted by the coordinator chief physician. He is the representative of the hospital in relations to out of the hospital. The coordinator carries out the correspondence with the Ministry and other relevant institutions. There is a similar situation regarding procurement. Chief physicians in departments deliver a demand to the coordinator, and he manages all stages of the procurement process. At that point, the interviewees indicated that when the vast capacity of the hospital is considered, the heavy burden of the coordinator chief physician increases the margin of error and delays in operation. To eliminate this problem, robust and continuous coordination between the coordinator and chief physicians is inevitable under this structure. Therefore, they held regular meetings. However, as one of the doctors transmitted, the heavy workload of the coordinator makes it inevitable for him to embrace a perspective whether you did what I said or not against the chief physicians. In other operating city hospitals, this may not be a significant problem since the number of hospitals moved is less, but the vast number and capacity of hospitals moving to the Ankara City Hospital makes the relations between chief physicians and coordinator complicated.

In addition to the presence of the coordinator, another factor that declines the power of chief physicians is the delegation of authority to private actor. According to health officers and TMA members, in the old system, the decision of the chief physician was determinant. One of the doctors stated that when they could convince the chief physician for the necessity of a new programme for MR, it was possible to get if there was no financial problem. The compact structure did allow the solution of some problems immediately. However, there is a company working based on profitability concerns in city hospitals. Thus, it is more difficult to be on the same page concerning priorities. An example given by the same doctor reflecting this reality is the absence of a sufficient number of reporting stations in radiology departments. Since there are more doctors than estimated at the beginning, there is not enough number of computers for reporting. Hence, not every doctor has a station, and they sometimes have to wait for their order. The

company does not establish a new one because the number of appointments exceeds the initial arrangement decided in the contract; thus, it is not a requirement for the company. As a result, even if a chief physician thinks that obtaining a new programme or equipment is necessary for the effective delivery of healthcare, it is not possible to exceed limitations sourced from the contract.

g) The problem of institutionalisation: As all participants emphasised, the most important difficulty in the Ankara City Hospital is the excessive number of hospitals moved there compared to other city hospitals throughout Turkey. The same department of different hospitals came together. For instance, the cardiology department from Ataturk, Numune, and Yuksek İhtisas Hospitals are working under the Cardiovascular branch hospital within the Ankara City Hospital. The health officers and TMA members indicated that this situation led to significant problems, particularly at the beginning.

First of all, the breakdown of hierarchal order paved the way for disturbances among health officers. There is one administrative chief and education chief in each department in the current situation. Therefore, some department chiefs in old hospitals lost their title, but they continue to behave as if they held the same position. When one of them became administrative chief, s/he faced resistance from others. As one of the doctors claims, the new chief sometimes led to the exacerbation of clashes by not giving policlinic, operation date etc., for other cliques, thereby breaking down the effectiveness of operations. In fact, this problem reflects a cultural phenomenon. There are similar practices in abroad, as well. In university hospitals in Europe, doctors from different universities may temporarily serve in the same hospital to create a common mind in their fields. However, there is not a consolidated team spirit in Turkey. Everyone wants to work with their old friends and secure their previous power. The social fabric based on “our community” understanding has ramifications in every aspect of social life, including the working atmosphere in hospitals.

The participants indicated the potential of knowledge transfer within the current structure and asserted that the Ankara City Hospital would become a world mark if there is a division in terms of expertise and everyone cooperates regarding their fields of expertise. Yet, they also underlined that existing cliques prioritising old teams prevent such a development. Doctors and nurses underscored that there are differences between branch hospitals in terms of cliques. This problem did not appear in some branch hospitals since there is dominancy of one hospital. For instance, in Children's Hospital, the Dıskapı Children's Hospital and in Cardiovascular Hospital, Yuksek İhtisas Hospital is dominant. Therefore, instead of cliques, there is a majority-minority relation. On the other hand, most of the interviewees also highlighted that there has been progress in the formation of institutional identity as time passes. One of the doctors appointed from another hospital than the closed ones indicated that the increase in the number of personnel coming from other hospitals than the moved ones contribute a lot to the breakdown of the power of cliques. As the new institutional identity under the Ankara City Hospital has improved, new cadres and a new working style formed, it will be more probable to eliminate the cliques.

The doctors and one of the TMA members commented that another reason for problems regarding adaptation is related to the fact that all closed hospitals had deep treatment and education traditions. When they moved to a new hospital without such a tradition, they wanted to maintain their practices instead of cooperating with other groups. As a result, organising different traditions under the same roof has become complicated. They emphasised that this situation not only led to the elimination of breakthrough health traditions in old hospitals but also created chaos in the new hospital.

Another focus point that health officers in the Ankara City Hospital are concerned with regard to the institutionalisation problem is the new personnel regime. Public personnel providing core health services work together with private personnel serving for the delivery of non-core services. The health officers asserted that this

is not a new situation since there were some privatised areas in the old hospitals. With the rise of the neoliberal wave in Turkey, some services in the public hospitals, mainly security, cleaning and meal, had already been held by private actors. However, they indicated that there was a dominant institutional culture in the old hospitals and private sector officers had to adapt themselves to be a part of this structure. In other words, institutional identity could absorb these personnels and train them in line with the institution's culture. Yet, as a new hospital, the Ankara City Hospital lacks such a culture that creates problems concerning the consolidation of team spirit between public and private actors and a sense of solidarity.

The interviewees underlined that the division between public and private personnel does not cause fundamental problems in healthcare delivery but affects work peace. The difference in status is an essential factor contributing to this problem. The doctor emphasised that working conditions and payment system are disadvantageous to private sector personnel. They work hard as their public counterparts and get less payment.

The issue of circular payment was another issue that affects work peace, as mentioned by doctors and nurses. They stated that they could not get payment during the first six months. Then, circular fund payments started. Since there are more patients compared to old hospitals, the payment is better in the city hospital. However, there is a huge discrepancy between doctors and other health officers. The nurses interviewed asserted that they can get payment quite less, and private sector officers cannot at all. However, it should be highlighted that this inequality is not specific to city hospitals but a general problem in the health system.

h) Management of moving process: An important indicator of deficiencies in the planning of city hospitals is the management of the moving process. The health officers coming from the closed hospitals commented that the moving had always been mentioned since the hospitals to be closed were clear. However, it turned to

gossip among officers as time passed since no precise date was explained. The announcement was made nearly one month earlier. According to a nurse involved in planning the moving process from Yuksek Ihtisas Hospital, the process started when buildings within the new city hospital were allocated to the closed hospitals. As the hospital management was informed about that, managers of the closed hospitals began regular visits to the Ankara City Hospital in order to make necessary arrangements. The arrangements for room planning were delivered together with the company. The company guaranteed to make all necessary infrastructure ready.

However, this ideal process did not proceed like that in all cases. The members of old Ataturk and Numune Hospitals claimed that movings from these hospitals were sudden and disorganised. The health officers from these hospitals experienced difficulties in finding medical consumables at first; therefore, some of them were brought from the old hospitals. They stated that some fixtures were not available, as well. The lessons learnt from these processes became an important input for other hospitals waiting to move. For instance, an ex-officer of Dıskapı Children's Hospital asserted that they determined insufficient equipment and brought them from old hospitals after the visits during the planning process. The company did not want the old equipment but had to accept it after the disinfection operation. The interviewees also mentioned about the situation of remaining medical equipment in the closed hospitals. They were distributed to other hospitals, but there may not be officers who have expertise in their use. So, the situation of old equipment in closed hospitals has become a source of waste.

Another side effect of the moving process is the situation of personnel working for sub-contractors. TMA members referred to the government's step for the status of subcontracted workers in public institutions with a decree within the force of law (no.696) to give them a permanent cadre. In this vein, workers employed in health institutions whose activities were terminated due to moving to new facilities before December 7, 2017, and to be closed after this to move to new city hospitals

have also benefited from the provisions of this decree. However, they were not appointed to city hospitals since support staff is provided by the company in these hospitals. Rather, they were appointed to other health institutions under the Ministry of Health in the same province or another province if there was no appropriate cadre in the province where they worked. Moreover, workers for whom there is no available cadre and evaluated as supernumerary were appointed to other public institutions by the State Personnel Administration. However, there were some exceptions and specific conditions to be accepted to the permanent cadre. In this vein, some workers could not benefit from this decree. For instance, as one of the doctors asserted, the laborants were dismissed when Ataturk hospital was closed since a private actor conducted laboratory services, and they were not given a cadre. Moreover, the personnel regime in city hospitals creates a dichotomy with the purpose of this decree (no.696). Most of the affairs are conducted by subcontracted workers in these hospitals, thereby increasing the practice of sub-contraction rather than eliminating it.

Another point that TMA members particularly focused on was the status of closed hospitals' buildings. It was initially unknown how these buildings would be used after the moving process. Later, it was understood that these buildings were left to the bidding company for private use. The TMA brought a lawsuit against this article, and the Council of State cancelled it. After that, a new regulation has not been made regarding the status of these buildings so far. It is known that during the early stages of the Covid-19 pandemic, some buildings of the closed hospitals were used as quarantine hospitals. Currently, they are empty and left to decay. The destiny of closed hospitals is an essential indicator of the disorganised dimension of the moving process and short-term characteristics of the city hospitals project.

i) Education and training: All participants asserted that internal education and training determine the future quality of healthcare services. The main concern regarding the education and training activities is whether they have a secondary role or not, as the logic of operation is to be patient-oriented.

Doctors participating in the study stated that Ankara City Hospital has a great potential in increasing both the quality and quantity of education activities. To support this idea, they referred that city hospitals are designed as training and research hospitals affiliated with the University of Health Sciences, like all other city hospitals. In addition, Ankara City Hospital is also affiliated with the Yıldırım Beyazıt University. The Hospital has common use agreements with both universities, which make education activities more intense.

In addition to a solid academic cadre, doctors addressed the advantage of bringing together different hospitals with strong education and training traditions, such as Yuksek Ihtisas and Numune Hospitals. Furthermore, since most of the hospitals in the city centre are closed, all patients are directed to the Ankara City Hospital, which increases the possibility of experiencing quite interesting medical cases. All these factors contribute to strengthening the quality of academic studies in the City Hospital.

On the other hand, the doctors interviewed also mentioned several problems pertaining to education activities within the new structure. The most frequently addressed issue is the effects of deficiency in institutionalisation and fragmented structure among different cliques on the emergence of integrated education activities. To illustrate, officers may prefer working with the same cadre from old closed hospitals instead of those with the same field of expertise coming from different hospitals. This inevitably affects the quality of studies. Moreover, several doctors referred to the Hospital's priority as managing patient circulation, not the education. As a result, the needs of university students were neglected. One of the doctors claimed that there is not enough class, the sufficient number of rooms for case analysis as well as equipment such as chairs, computers, and slide projections. Therefore, new arrangements in the physical infrastructure that respond to students' basic needs come to the forefront of the infrastructural problems in the Ankara City Hospital.

j) Pandemic: The Covid-19 pandemic has become an essential test for the Ankara City Hospital as well as the whole health system in Turkey. When the moving process of most of the hospitals was completed, and the institutionalisation of the new structure was in progress, the pandemic started in Turkey in March 2020. The Ankara City Hospital was declared the pandemic hospital in Ankara and has become the centre of the struggle against the pandemic in the city. For the hospital's role during that period, there are two different views among health officers.

The majority of participants highlighted the sound contribution of the Hospital to the management of the pandemic process in Ankara. The most important advantage that has made the operation easier is the vast capacity of intensive care. Moreover, the bed capacity of the hospital, in general, has also been beneficial since some buildings could totally be allocated to pandemic services while general medical services could continue in the remaining units. In this way, urgent operations could go on while dealing with the pandemic simultaneously. Similarly, wide single-person rooms that can be divided as the number of patients increases provided better isolation conditions and flexibility in terms of capacity.

Despite less in number, some participants underscored significant difficulties that Ankara City Hospital led during the pandemic. First of all, although urgent operations continued, the routine controls and elective operations were mostly cancelled and postponed during the early stages of the pandemic. Therefore, many patients who got their treatment from the Hospital before the pandemic could not maintain their treatment. In some cases, even the departments served, patients did prefer not to visit the Hospital for their treatment due to concern on enduring Covid-19. In this context, all health officers and TMA members emphasised that chronic patients experienced difficulty in accessing coronavirus-secured health services, which explicitly created serious problems reaching death, which is defined as a secondary effect of the pandemic.

The TMA members also highlighted that the closed hospitals could have been used in this period, as implemented in some cases. For instance, the old Zekai Tahir Burak Maternity Hospital was re-opened as a pandemic clinic affiliated to the Ankara Education and Research Hospital. The use of other closed hospitals in a similar way could provide a secure environment for the City Hospital for chronic patients. Moreover, the location is another point of criticism for declaring the Ankara City Hospital a pandemic hospital. Since it is far from the city centre, those who do not own a private car have to use public transport to get a test or necessary treatment, which increased the diffusion of the virus. Last but not least, all health officers highlighted that heavy working conditions during the pandemic knocked them out remarkably.

All in all, the findings of the field study indicate that most of the problems are related to the scale of the Ankara City Hospital, a new management structure based on a division between public and private actors, and bringing together different hospitals. All these factors assert that the planning process was not managed with the utmost care, and the outcomes of those steps, such as closing hospitals and compounding them under the same structure, were not considered. The repercussions of unplanned steps have become visible and created difficulties in healthcare delivery within the Ankara City Hospital.

CHAPTER 5

EVALUATION AS CONCLUSION

Reform is a keyword which has always been used in many sectors in Turkey. The health system is one of them. The reforms reflect the zeitgeist. During the early Republican era, the health system was tried to be established and disseminated to all country like other services. Then, a statist period came through the 1960s, which made healthcare services free and accessible for all. After the 1980s, the health system got its share of the neoliberal transformation in the country. Private health services started to become common, and the financialisation of health services appeared. In this context, market tools such as PPPs entered into healthcare services delivered by the public.

The health PPPs are a part of neoliberal transformation on the one hand but a tool for the creation of new economic elites on the other hand. The JDP government has used infrastructural services to provide capital for the newly emerging oligarchy, which is dependent on the state since they lack significant capital accumulation and well-known credit history. As a result, a wave of privatisation began for some services. Furthermore, for the sectors that cannot be privatised totally, PPPs have been embraced as a way to feed the oligarchs. It is applied to the health sector since the healthcare provision is restructured by PPPs with the city hospitals project. In this vein, this study underlines that the city hospitals project is not well-planned since it has not considered the needs of the healthcare system but rather prioritised the needs of capital owners. The findings from the literature review and field research strengthen this argument. Beyond that, the backward shift by the government in terms of the use of the PPP model in the construction of new city hospitals also indicates that capital flow from the budget within these projects led to an irrecoverable cost that cannot be sustained anymore.

While explaining the reason why MoH gave up the PPP model in the construction of new city hospitals, the Minister of Health confessed that it has a cost which indicates the non-feasible character of these projects as well as their failure.

If city hospital projects reflected the needs of the health system in Turkey, they should have implemented principles of good governance as their ideological bases. However, as addressed throughout the study, there are various dimensions that city hospitals which are not in line with the principles of New Public Management and good governance. According to the Guidebook on good governance in PPPs, the starting point for effective management of the PPP process is ensuring transparency in all stages (UNECE, 2008). It starts with the presence of a fair and transparent selection process by which governments develop partnerships. The UNECE report underscores that information about the PPP procurement, procurement policies and practices, contractual administration regime and individual PPP opportunities should be made available to all interested parties. The procurement process should be managed in such a way that everybody should believe that the selection process is neutral and non-discriminatory.

At the same time, the right of access to information concerning the procurement process is crucial. In this regard, the city hospitals project has failed to present the main components of transparency. Tenders were mostly held among invited participants rather than open tenders, and tender documents were not declared. In addition, the main stakeholders, including the public, were not informed as the principle of commercial confidentiality has been attributed more prior role than transparency. Even the Court of Accounts, responsible for analysing financial accounts of public institutions, could not obtain original tender documents. In a similar way, stakeholders are not also informed about amendments in the contracts. In addition to being far from transparency, the substantial changes such as assigning physiotherapy services, initially owned by the private actor, to the public sector, bring questions to whose benefits and whose expense these amendments are made. Moreover, these amendments are also signs of the fact that

the coordination between public and private actors is not built on a strong foundation and is open to confidence-shattering developments. Thus, the non-transparent characteristics of the city hospitals projects raised concerns around the main base of the project is the flow of capital to government-affiliated groups.

Another dimension of good governance is to embrace a participatory approach that addresses the degree of clarity and openness of decisions as well as the degree of stakeholders' engagement. It entails the involvement of relevant stakeholders in policy making process. As UNECE asserts, projects which are well planned based on the full agreement of all parties engaged, following proper and ongoing consultation, have less of a chance of unravelling. Therefore, a comprehensive consultation before the start of the project would be a good way of eliminating criticisms. Yet, the government did not take into consideration the importance of the participatory approach in taking correct and effective decisions. The relevant stakeholders like TMA, medical chambers etc., were not involved in the policy making process, and their criticisms were not paid attention. In fact, this is not surprising because eliminating institutional opposition in the area of healthcare is a part of neoliberal health policies and an implicit target of HTP.

An essential dimension of transparency and accountability is to define the public interest. Governments will wish to define how PPPs can promote the public interest and what this means in terms of PPPs (UNECE, 2008). The management of the city hospitals projects is not promising in this regard, as well. The project was promoted with the argument that people can get healthcare services at private hospital standards free of charge. In other words, the government perceived putting people first as making propaganda of the project. However, the public should be informed regarding the content and probable outcomes of the project. Therefore, the democratic governance that refers to plurality in the decision making process and the responsibility of political actors against society in their acts did not reflect in health PPPs in Turkey.

Efficiency and effectiveness are the main mottos of all neoliberal approaches preparing the ground for PPPs. It requires using human and financial resources without waste and providing services at high quality with lower prices. There are significant steps in various stages of PPP projects to ensure such kind of management. For instance, risks should be identified at the start of the projects. The public side, in cooperation with relevant actors, should prepare a risk matrix. Then, it should determine mitigation strategies in case of the realisation of risks. Unfortunately, there is no such study presented by the MoH. The amendments in the contracts and the return to the general budget for the construction of new hospitals highlight that the government did not conduct a comprehensive feasibility analysis at the beginning of the city hospitals projects to identify risks. The criticisms concerning the location of city hospitals also address the same problem. Healthcare is a social issue which has repercussions in various realms such as transport. Nonetheless, these characteristics of healthcare were ignored at the beginning, and the government followed a make-it-up as-you-go-along strategy. The outcome of this policy became a huge financial cost for the operation of hospitals and additional costs for ensuring accession of people.

The feasibility problem hits most at the issue of scale as highlighted by the participants of the field study as well as main proposals by the WHO and WB indicating that effective management would become possible in hospitals with 200-600 bed capacity. Although the difficulty of managing such large hospitals is known from the beginning, the construction of hospitals with over 3500 beds, such as the Ankara City Hospital, proves that the city hospitals project is capital-oriented. As the findings of the field study assert, the infrastructural problems in healthcare could be solved with more moderate steps such as the renovation and construction of boutique hospitals rather than giant health campuses. The city hospitals renovated the health infrastructure for sure; however, they paved the way for problems in terms of accessibility, work peace, procurement and difficulty in decision making within the hospital.

What is new in city hospitals is not only the building but also the administrative culture. As indicated in Chapters 3 and 4, the administrative structure introduced by the co-existence of public and private actors is totally new for the healthcare system. Before that, some services within public hospitals, such as cleaning and security, were handled through private actors. Yet, private actors were not decision makers but service providers. In health PPPs, the roles changed between public and private actors, which complicated decision making and operation within the hospital. The extensive changes in the management structure of hospitals and personnel regime hamper the integrity and flexibility of services.

The reverberations of city hospitals have extended beyond the PPPs model and affected the existing structure of healthcare delivery with the closure of public hospitals, mostly located in the city centre. The existing public hospitals were closed and moved to the newly constructed city hospitals. Chapter 4 highlighted the distinctive character of Ankara City Hospital in this regard due to the high number of closed hospitals compared to other city hospitals in Turkey. It paved the way for various problems as indicated by Chapters 3 and 4, including problems in the planning of moving process, the difficulty in accession to and within hospital compared to the closed hospitals both for health officers and patients.

Beyond these, the most important repercussion of the new structure is institutionalisation. The consolidation of an institutional identity takes long years but eliminating it is easier. Thus, the formation of a new institutional identity under the Ankara City Hospital could not be achieved yet. The reason for that is the resistance of traditions in closed hospitals. The new city hospital did not eradicate them immediately but did not allow their survival as usual since various traditions coexist. Therefore, the administration of various groups with different traditions under the same roof complicates the governance. If the focus of the reform was not the capital, there would be a solution that paved the way for the maintenance of the old hospitals. Yet, the capital flow to the operating company through service payment depends on the magnitude of services provided to the vast number of

people; therefore, the demand should be canalised to the city hospital. The moving of well-known and most preferred hospitals with experienced cadres is a guarantee to make the city hospital a centre of attraction.

It is essential to overcome the problem of developing a new institutional culture despite the difficulty due to the fragmented and vast structure of the hospital. The creation of a new hospital culture cannot be allocated only to hospital managers; instead, all members of the hospital should be a part of it. Beyond that, cooperation with relevant national and international institutions for capacity building activities should be considered. In this vein, Ankara Gaziler Physical Therapy and Rehabilitation Training and Research Hospital generates a good example. During the establishment process, the Hospital signed bilateral agreements with the MedStar National Rehabilitation Hospital and the Centre of Excellence to build the capacity regarding the management of the hospital with team spirit. It will be beneficial to transfer such kind of best practices to the Ankara City Hospital to establish and consolidate a new institutional identity.

All these issues mentioned heretofore underline the fact that the interests of public and private actors mostly contradict. Therefore, their coexistence in a project would not guarantee good governance; instead, it may lead to the dominance of one party over another. In the case of city hospitals, it is clear that the dominant actor whose interests are more prioritised is the private party. Since the healthcare delivery is reorganised through city hospitals that consider the capital interests, the new system could not be well-planned in a way to respond to the requirements of the health system. The outcomes given throughout the study indicate that the ramifications of the non-effective planning will extend throughout the contract period in terms of the delivery of public healthcare services.

The good news is that Turkey will not construct new city hospitals on PPP models. The payment to companies has created an excessive burden on the budget of the Ministry of Health. Then, the PPP model was given up with the logic of better lose

the saddle than the horse. It is inevitably an achievement to take a step back from a huge mistake, albeit with significant problems already created in the health system. Hence, the focus should be on how to eliminate the negative impact of currently functional health PPPs. They will be operating throughout the next 20-25 years, and the country will burden their cost. One way to escape this burden is to make an agreement with contracting companies for the transfer of operation to the Ministry in return of the payment of the cost that the company has bear so far. Or the pandemic could be used as a force majeure for expropriation, and the matter can be delivered to arbitration at the end of which huge compensation might appear. The decision will absolutely be on the governments of the period. Unfortunately, the study could not reflect the future prospects of the political actors concerning the city hospitals; since the members of political parties who are communicated with did not show an interest. But, it is clear that the burden of payment will be on citizens' shoulders as long as these projects are ongoing.

To put in a nutshell, the dynamics that have shaped the city hospitals project were part of the neoliberal transformation in Turkey. In this vein, representation of capital interests came into appearance in the healthcare sector like many others. The dissemination of private health services coincided with the health PPPs to ensure capital transfer from public to private actors. However, the Covid-19 pandemic has asserted the significance of universal public healthcare. To this end, it is of paramount importance to secure the "public" character of healthcare services. The health PPPs have impeded this characteristic to most extent; thus, a new approach is needed for a health system putting the public interest first.

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APPENDICES

A. Human Subjects Ethics Committee Approval

UYGULAMALI ETİK ARAŞTIRMA MERKEZİ
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Sayı: 28620816 /

26 Temmuz 2021

Konu : Değerlendirme Sonucu

Gönderen: ODTÜ İnsan Araştırmaları Etik Kurulu (İAEK)

İlgi : İnsan Araştırmaları Etik Kurulu Başvurusu

Sayın M.Yılmaz Üstüner

Danışmanlığını yürüttüğünüz Murat Küçükkahraman'ın "Kamu-Özel İşbirliği modelinin sağlık sistemine etkileri: Şehir hastaneleri örneği." başlıklı araştırmanız İnsan Araştırmaları Etik Kurulu tarafından uygun görülmüş ve **316-ODTU-2021** protokol numarası ile onaylanmıştır.

Saygılarımızla bilgilerinize sunarız.

Prof.Dr. Mine MISIRLISOY
İAEK Başkan

B. Approval of Provincial Directorate of Health of Ankara

T.C.
ANKARA VALİLİĞİ
İL SAĞLIK MÜDÜRLÜĞÜ
Ankara Şehir Hastanesi Başhekimliği

Sayı : E-72300690-030.04.01
Konu : Murat KÜÇÜKKAHRAMAN
(Tez Çalışması) Hk.

İL SAĞLIK MÜDÜRLÜĞÜ
(Sağlık Hizmetleri Başkanlığı)

İlgi 19.08.2021 tarih ve 146008257 barkod numaralı yazınız.

Kamu Özel İşbirliği modeli ile ihalesi yapılan 13.07.2012 tarihinde ***"Kamu Özel İşbirliği Modeli ile Ankara Bilkent Entegre Sağlık Kampüsü Yapım İşleri ile Ürün ve Hizmetlerin Temin Edilmesine İlişkin Sözleşme*** "'si imzalanmıştır.Bu doğrultuda, imzalanan sözleşme kapsamında Hastanemiz bünyesinde 18 adet hizmet işi firma uhdesinde yürütülmektedir.

Bu kapsamda ilgi kayıtlı yazınız incelenmiş olup Hastanemiz işleyişini aksatmadan ve pandemi kuralları çerçevesinde olması kaydıyla; Adı geçen öğrencinin "Kamu-Özel İşbirliği Modelinin Sağlık Sistemlerine Etkileri: Şehir Hastaneleri Örneği" konulu tez çalışmasını yapma talebi İdaremizce olumlu değerlendirilmiştir.

Bilgilerinize arz ederim.

Dr. Öğr. Üyesi Aziz Ahmet SUREL
Koordinatör Başhekim

Bu belge, güvenli elektronik imza ile imzalanmıştır.
Belge Doğrulama Kodu: 406c73e6-c601-4a2b-87ba-e3d7d6b3ab35 Belge Doğrulama Adresi: https://www.turkiye.gov.tr/saglik-bakanligi-ebys

C. Turkish Summary / Türkçe Özet

Kapitalizm doğuşundan bugüne çok farklı dönemlerde farklı veçhelerle varlığını sürdüregelmiştir. Her bir veçhede sistem kendi varlığını sürdürmeye olanak sağlayan araçlar üretebilmiştir. Bu çalışma kapitalizmin neoliberal safhasında kullanılan araçlardan biri olan Kamu-Özel İşbirliği (KÖİ)'ye odaklanmaktadır.

KÖİ modeli, kapitalizmin sosyal refah devletinden düzenleyici neoliberal safhaya geçişinde devlet-sermaye ilişkilerini etkileyen önemli bir araç olmuştur. Bu model farklı sektörlerde giderek artan bir oranda kullanılmaya başlanmış ve başta ulaşım olmak üzere toplumsal hayatı doğrudan etkileyen sektörlerde belirleyici bir rol oynamaya başlamıştır. KÖİ, uygulandığı sektör için sadece yeni bir finansman modeli sağlamakla kalmamış, o sektördeki işleyişe de etki eden bazı sonuçlar doğurmuştur. Bu çalışma, bu sektörlerden biri olan sağlıkta KÖİ uygulamalarını ele almaktadır.

Çalışmanın odak noktası olarak ağlık sektörünün seçilmesinin nedeni insan sağlığı için hayati rolünün yanısıra, 2020 başından bu yana yaşanmakta olan Covid-19 pandemi sürecidir. Yaşanılan bu dönem, başta Türkiye olmak üzere tüm dünyada ücretsiz ve nitelikli sağlık hizmetlerine erişim hakkının ne denli önemli olduğunun bir kez daha idrak edilmesine vesile olmuştur. Ancak neoliberal dönemde giderek artan özelleştirme furyası ile özel sağlık hizmetlerinde de yaşanan artış; buna ilave olarak sağlıkta KÖİ uygulamaları sağlık hizmetlerine erişim hakkının sınırları açısından önemli tartışmaların gündeme gelmesine neden olmuştur.

Bu bağlamda, bu çalışma Türkiye'de şehir hastaneleri adıyla uygulamaya konulan sağlıkta KÖİ uygulamalarını makro düzeyde sosyo-ekonomik düzende yaşanan gelişmeler ışığında ele almayı amaçlamaktadır. Çalışma Türkiye'de yeni inşa edilen şehir hastanelerinin hizmet kalitesini yahut kullanıcı memnuniyetini ölçmeyi değil, bunun ötesinde eski hastanelerin kapatılarak şehir hastanesi adı altında tek bir merkezde toplanması şeklinde cereyan eden süreci Türkiye'nin

siyasal iktisadi yapısıyla ilişkilendirmeyi amaçlamaktadır. Çalışma, Türkiye'de şehir hastaneleri projesinin iyi planlanmış bir süreç olmadığını, zira planlamanın sağlık hzmetlerinin ihtiyaçları doğrultusunda değil sermayenin öncelikleri doğrultusunda başladığını iddia etmektedir. Bu iddianın önemli göstergelerinden biri inşa edilen hastanelerin ölçeğidir.

Kapatılan butik hastaneler yerine Ankara Şehir Hastanesi gibi yatak sayısı yaklaşık 3500 yatak kapasiteli büyük hastanelerin açılması Adalet ve Kalkınma Partisi (AKP)'nin kendisine müzavir sermaye grubu yaratmak ve bu gruba kaynak aktarımı amacına hizmet eden bir mahiyet arz etmektedir.

Çalışma bahsekonu sava dayanak oluşturmak amacıyla tümdengelimci bir yöntem benimsemiş ve genelden özele giden bir yaklaşım ortaya koymuştur. Bu minvalde, öncelikle KÖİ ile alakalı kapsamlı bir literatür araştırması yapılmış ve KÖİ ile ilgili genel kavramsal çerçeve sunulduktan sonra dünya genelinde bu modelin sağlık sektöründeki uygulamaları ele alınmıştır. Ardından, KÖİ'nin Türkiye'deki serüveni benzer bir yapıyla ele alınmış ve genel KÖİ uygulamalarının analizinin akabinde sürecin sağlık sektörüne nasıl evrildiği incelenmiştir. Kapsamlı literatür çalışmasını sağlıkta KÖİ uygulamalarının sağlık hizmeti sunumuna etkilerinin irdelendiği saha araştırması bölümü takip etmektedir. Ankara Şehir Hastanesi'ndeki sağlık çalışanları ve Türk Tabiple Birliği (TTB) Şehir Hastaneleri İzleme Komitesi üyeleri ile gerçekleştirilen görüşmeler sonucu elde edilen bulgular bu bölümde analiz edilmiştir. Çalışma, tüm çıktıların eleştirel bir yöntemle analiz edildiği sonuç bölümüyle noktalanmaktadır.

Çalışmanın amacı ve yöntemi hakkında bilgi veren giriş bölümünü izleyen kısımda KÖİ'nin kavramsal çerçevesi kapsamlı bir şekilde analiz edilmiştir. KÖİ'nin tarihsel arka planı verilirken, modelin sağlık sistemine nasıl entegre olduğu dünyadan örnekleriyle anlatılmıştır. KÖİ modelinin analizinde karşımıza çıkan en önemli güçlük kavramın tanımlanmasıdır. Bu model farklı ülkelerde farklı amaç ve yaklaşımlarla uygulandığı için kavramın yorumunda da bazı

farklılıklar bulunmaktadır. Bu konuda literatürde genel olarak iki yaklaşımın varlığından söz edebiliriz. KÖİ'yi Yeni Kamu İşletmeciliğinin ilkeleri doğrultusunda bir iyi yönetişim aracı olarak görenler ilk grubu oluşturup KÖİ'nin farklı sektörlerde yaygın kullanımını desteklerken, bu modele karşı çıkanlar KÖİ'yi basit bir kelime oyunu olarak değerlendirmiş ve özelleştirmeden pek bir farkı olmadığını vurgulamıştır.

Yaklaşım farklılıklarından dolayı KÖİ'nin farklı tanımları olsa da her bir tanımda ortak olan özellikler dikkate alındığında KÖİ'nin 5 temel unsurundan bahsetmek mümkündür. Bunlar:

- Kamu ve özel sektör arasında ortak bir amaca ulaşmak için yapılan işbirliği
- Kamu ve özel sektör aktörleri arasında projenin amaç ve içeriği hakkında varılan bir uzlaşma
- Kamu ve özel sektör tarafından proje için oluşturulmuş bir ortak finansman modeli
- Kamu ve özel sektör arasında kaynak ve vazife dağılımı hususunda somut bir anlaşma
- Kamu ve özel sektör aktörleri arasında verimli bir risk paylaşımının mevcudiyeti.

Çalışmada KÖİ basit bir kelime oyunu olarak özelleştirmenin eşdeğeri olarak ele alınmamakta, tam aksine özelleştirme ve gelenksel kamu alımlarına alternatif yenir bir model olarak tanımlanmaktadır. Zira, KÖİ modelinin özelleştirmeden önemli farkları bulunmaktadır. Bunların başında KÖİ'nin birçok türünde hizmetin ifa edildiği alanın sahipliğinin kamuda kalması ve KÖİ ile ifa edilen hizmetlerin çoğunlukla doğal tekeller olması gelmektedir. Ayrıca, KÖİ modelinde hizmetlerin içeriği ve maliyeti bir sözleşme ile sabitken, özelleştirmede hizmetlerin ifası bazı düzenleme ve lisans verme işlemleri aracılığıyla kontrol edilmektedir. Buna mukabil, her ne kadar eleştirel yaklaşımın KÖİ'yi özelleştirme ile eşdeğer gören bakış açısı paylaşılmasa da bu yaklaşımın KÖİ modeline yönelik açıklamalarının

daha isabetli olduğu görüşü çalışma boyunca vurgulanmıştır. Nitekim gerek özelleştirme gerek KÖİ de nihai sonuç kamu hizmetlerinin metalaştırılması olmaktadır.

KÖİ'ye ilişkin farklı yaklaşımlar dolayısıyla farklı KÖİ türleri ortaya çıkmıştır. Yap-İşlet, Yap-İşlet-Devret, Yap-Kirala-Devret, İşletme Hakkının Devri gibi uygulamalar arasında çok küçük farklılıklar bulunmakla beraber aralarındaki esas ayrımı özel sektörün projelere katılım seviyesi oluşturmaktadır.

KÖİ modelinin taraftarları genel olarak üç temel hususun altını çizmektedir. İlk olarak, KÖİ çok büyük finansman gerektiren altyapı projelerinin yapım aşamasında hazineye yük olmadan inşa edilmesini sağlamaktadır. KÖİ ile ilgili sıklıkla vurgulanan diğer bir husus paranın değeri yaklaşımı doğrultusunda KÖİ ile hizmet kalitesinin taplam maliyet ile en iyi şekilde dengelenmesi sağlanabilmektedir. Son olarak, KÖİ ile projenin hacmiyle eşdeğer riskler kamu ve özel arasında dengeli bir şekilde paylaşılabilmekte ve bahsekonu riskler, onları en iyi sırtlanabilecek aktör tarafından üstlenmektedir.

Öte yandan, KÖİ modeline eleştirel yakllaşım, KÖİ'nin dezavantajlı yanlarına vurgu yapmaktadırlar. Bu hususlar genel olarak iki kategoride değerlendirilebilir. Öncelikle KÖİ'nin sıklıkla vurgulanan 3 avantajının -finans, paranın değeri, risk transferi- aldatmaca olduğu belirtilmektedir. Her nekadar yapım aşamasında hazineye yük olunmasa da proje süresi boyunca hazineden çıkan toplam meblağın çok büyük rakamlar olduğu dolayısıyla bu modelin finansman açısından bir avantaj sağlamadığı; paranın değeri yaklaşımında objektif bir ölçüm yapılmadığı için bu projelerde maliyetin optimum dengesinden söz edilemeyeceği; özel sektörün riski üstlenmek istemeyeceği, üstlendiği riskler için de kar marjını düşünerek ekstra maliyet yükleyeceği dolayısıyla adil bir risk paylaşımının mümkün olamayacağı vurgulanmaktadır.

KÖİ modeline karşı çıkanlar KÖİ'nin avantajları olarak lanse edilen hususlara yönelttikleri eleştirilerin yanısıra KÖİ modelinin kendine içkin problemleri olduğunu da vurgulamaktadırlar. Bu problemlerin temelinde kamusal hizmet sunumuna özel sektörün dahil olmasıyla beraber kamu hizmetlerindeki sosyal fayda ilkesinin yerini giderek karlılığa bırakması, özel sektörün hizmet sunumunda giderek artan rolü nedeniyle kamu hizmetlerindeki demokratik kontrol mekanizmasının işlememesi, hizmet sunumundaki kamusal sorumluluk anlayışının aşınması ve KÖİ'nin teknik boyutu nedeniyle özellikle sözleşme sürecinde kamuda giderek özel danışmanlığa olan ihtiyacın artması yatmaktadır.

KÖİ modeline ilişkin genel bir analizin ardından çalışma sağlıkta KÖİ uygulamalarının genel bir analizi ile devam etmektedir. 1990'larla beraber nüfus artışı, tıpta meydana gelen gelişmelere paralel olarak ortalama ömür süresindeki artış, yaşam tarzında yaşanan değişimin sonucu olarak ortaya çıkan yeni sağlık sorunları ile çevre kirliliği vb. sebepler nedeniyle oluşan hastalıklar ve tıpta teknolojik gelişmelere bağlı olarak ortaya çıkan yeni tedavi sistemlerinin finansmanında yaşanan sorunlar gibi nedenler dolayısıyla dünya genelinde sağlık sektöründe yeni arayışlar başlamış ve KÖİ de bu doğrultuda başvurulan araçlardan biri olmuştur.

Bu süreçte ilk olarak gelişmiş ülkeler hastane altyapılarını yenilemek için KÖİ'ye başvurmuşlardır. Bunun öncülüğünü Özel Finansman Girişimi adıyla İngiltere yapmıştır. Ardından sağlıkta mevcut altyapı açığını kapamak isteyen ancak gerekli finansmandan yoksun olan gelişmekte olan Hindistan, Güney Afrika gibi ülkeler bu modeli sağlık sisteminde uygulamaya başlamışlardır. Bu ülkelerde uygulanan model altyapının özel sektör eliyle yapılması ve işletilmesi ve inşa edilen altyapı içerisinde kamu eliyle çekirdek sağlık hizmetlerinin sağlanması şeklinde olmuştur. Bunun dışında geleneksel KÖİ uygulamalarından farklı bir yöntem benimseyen İspanya, Alzira modeli adını alan yöntemle çekirdek sağlık hizmetlerini de özel sektöre devretmiş ve hizmetin yürütülmesi için hizmet alıcısı başına para ödeme şeklinde bir yola başvurmuştur.

Dünya genelindeki bu uygulamaların, küresel sermayeye 1980 sonrası giderek daha güçlü bir şekilde entegre olan Türkiye'ye de kaçınılmaz yansımaları olmuştur. Çalışmanın 3. Bölümü bu politika transferini ele almaktadır. Gelişen ekonomiye uyumlu olarak inşa edilmesi gereken altyapı için gereken finansmanın sağlanması konusunda Türkiye de önce özelleştirme, ardından da KÖİ modelini giderek daha çok uygulamaya başlamıştır. Ancak Türkiye'de devlet-sermaye ilişkilerinde 1980 sonrası yaşanan süreç Cumhuriyetin kuruluşundan bu yana var olan temel bir sorunun gölgesinde gelişmiştir: devletçilik ile ahbap-çavuş kapitalizminin içiçe geçmesi ve patronaj ilişkilerin egemenliği.

Devletçi politikaların egemen olduğu dönemde Türkiye'de devlet eliyle üretilen material faydanın patronaj ilişki ağı aracılığıyla farklı kesimlere aktarılması şeklinde cereyan eden politikalar, neoliberal dönemde de benzer bir şekilde gelişmektedir. KÖİ'lerin yoğun olarak kullanıldığı 2000'ler sonrası süreçte bu modele AKP'nin kendisi ile işbirliği içerisinde hareket eden sermaye gruplarına kaynak aktarma yolu olarak başvurulmaktadır. Başta ulaştırma sektörü olmak üzere büyük altyapı projelerinin finansmanında kullanılan KÖİ ile belli sermaye grupları 20 yılı aşkın süreyi kapsayan sözleşmelerle garantili kaynak aktarımına kavuşmakta ve sektörlerinde daha da başat bir hale gelmeye başlamaktadırlar.

Türkiye'de KÖİ'lere ilişkin yasal mevzuat 1980'lerin ortalarından bu yana peyderpey gelişmiştir. Daha çok ihtiyaca dönük yasa hazırlama nedeniyle, KÖİ'nin hangi sektörde hangi türünün kullanılacağına göre hukuki ve siyasi gelişmeler yaşanmıştır. Öncelikle Yap-İşlet ve Yap-İşlet-Devret modeli ile başlayan süreç, farklı türde KÖİ projelerinin gündeme gelmesiyle daha da çeşitlenmiştir. Bu durum, tek bir KÖİ mevzuatının ve kurumunun olmaması, dolayısıyla her KÖİ ütür için ayrı bir mevzuatın ve her proje sahibi bakanlık bünyesindeki ayrı KÖİ biriminin varlığı şeklinde parçalı bir yapının ortaya çıkmasına neden olmuştur.

Türkiye'de KÖİ'nin yaygın olarak kullanılmaya başlandığı sektörlerin başında sağlık gelmektedir. AKP'nin iktidara geldikten sonra ilk kapsamlı reform paketlerinden olan Sağlıkta Dönüşüm Programı ile KÖİ'nin sağlık sisteminde uygulanmaya başlayacağı belirtilmiş ve akabinde Şehir Hastaneleri projesi kamuoyuna duyurulmuştur. Bu projelerin sağlıkta Türkiye'ye çağ atlatacağı şeklinde propagandası yapılmıştır. Özellikle iktidar mensupları hazineden tek kuruş harcamadan özel hastane konforunda sağlık tesislerinin inşa edilerek ülkedeki sağlık altyapısının iyileştireceğini vurgulamışlardır. Bu konuda tekrarlanan diğer söylemler, kamunun kendi kaynaklarıyla yapacağı yatırımların daha uzun sürede bitebileceği ancak KÖİ ile özel sektörün aynı işi çok daha kısa bir süre bitirdiği, sağlık hizmeti sunumunda çok önemli bir kalite artışı yaşanacağı ve bunun finansal açıdan çok daha verimli bir şekilde gerçekleştirileceği şeklinde olmuştur.

Bu söylemler doğrultusunda inşa edilmeye başlanan şehir hastanelerinden ilki 2017 yılında Mersin'de açıldı. Ardından Yozgat, Isparta ve Adana Şehir Hastaneleri ile devam eden süreç 2018'de yaklaşık 3800 yatak kapasitesine sahip Ankara Şehir Hastanesi'nin açılmasıyla yurt genelinde daha görünür hale geldi. Özellikle de Ankara'da Bilkent ve Etlik'te açılacak iki şehir hastanesi için şehrin farklı noktalarındaki 13 hastanenin kapatılacak olması o güne kadar Şehir Hastaneleri'ne yönelik dile getirilen eleştirilerin daha da artmasına yol açtı.

Şehir hastanelerine dönük eleştirilerin odağında şehir hastanelerinin bir avantajı olarak lanse edilen finansman konusu yatmaktadır. Şehir hastaneleri için işletici firmaya sözleşme süresi boyunca hem kira hem de hizmet bedeli adı altında iki ayrı ödeme yapılmaktadır. Türkiye'deki sözleşmeler inşaat süresi dışında yaklaşık 25 yıllık bir süreyi kapsadığı için bu durum uzun vadede hazineye muazzam bir yük getirmektedir. Mevcut durumda Türkiye'de faaliyet halinde 13 ve inşaatı devam eden ve yakın zamanda operasyonel hale gelmesi beklenen 5 hastane ile birlikte toplamda 18 şehir hastanesi bulunmaktadır. Bu hastaneler için yıllık yapılacak ödeme mevcut fiyatlarla Sağlık Bakanlığı'nın yıllık bütçesinin yaklaşık

olarak %40'ına tekabül etmektedir. Ayrıca bu tutarlar, enflasyon ve döviz kurundaki artışa göre her yıl güncellenmektedir. Türkiye gibi özellikle döviz kurundaki dalgalanmalar açısından ziyadesiyle kırılgan bir ekonomide maliyetin giderek artacağı ve bunun birkaç kuşağı ağır bir vergi yükü altında bırakmak durumunda kalacağı sonucuna varılmasına neden olmaktadır.

KÖİ modeli sağlık sisteminde yeni uygulanmaya başlanmış bir yöntem olduğu için Sağlık Bakanlığı nezdinde bu konuda önemli bir tecrübe eksikliği bulunduğu aşikardır. Bu tecrübe eksikliğine KÖİ sözleşmelerinin çok yönlü ve uzun süreli olmaları nedeniyle son derece karışık yapıya sahip olmaları hususu eklendiğinde bilgi asimetrisinin özel sektör lehine çalıştığı ve Bakanlığın sözleşmeci firmaya ve özel danışmanlık hizmetlerine daha çok bağımlı hale geldiği haliyle sağlık yönetişiminde kontrolü kaybetmeye başladığı söylenebilir. Bu bağlamda, Sağlık Bakanlığı'nda politika belirleme sürecinde özel sektör mantığıyla çalışan bir danışman kadrosunun giderek etkisini artırdığı söylenebilir.

Sağlık hizmetlerinin en önemli özelliklerinden biri erişilebilirlik konusudur zira birçok vaka acil müdahaleyi gerektirmektedir. Şehir hastaneleri erişilebilirlik açısından önemli eleştirilere konu olmuştur. Bunun nedeni şehir merkezinde daha rahat erişiliebilir hastanelerin kapatılarak bir çatı altında toplanması ve o çatının, özellikle bazı vakalarda, şehir merkezinden çok uzakta konumlandırılmasıdır. Erişimin zorlaşması, Ankara özelinde şehir merkezinde kalan üniversite hastanelerinin yükünü artırmış ve bu hastanelerdeki poliklinik hizmetlerinin eğitimin önüne geçer bir hale gelmesine yol açmıştır.

Şehir hastanelerinin yer seçimi şehrin dokusunu etkileyen sonuçlar da doğurmuştur. Hastane gibi sosyal hayat için önem arz eden yapıların, inşa edildikleri alanları bir cazibe merkezi yaptığı gerçeği göz önünde bulundurularak şehir hastanelerinin inşasında yer seçiminin ihtiyaca ve erişilebilirliğe göre değil de yatırımların canlandırılması durumuna göre yapılabilmesi gibi bir durum ortaya çıkarmıştır.

Şehir hastaneleri sözleşmleri mevcut AKP iktidarı tarafından imzalanmış olmakla beraber 25 yıllık bir süreyi kapsadıkları için önümüzdeki dönemde farklı iktidarlar olması durumunda onlar tarafından da uygulanmak durumundadır. Farklı politika tercihleri söz konusu olduğu takdirde bunun sözleşmelerden kaynaklanan birtakım hukuki sonuçları olacaktır. Örneğin, sözleşmelerin iptali gibi bir yola başvurulmak istendiğinde yüklü tazminatlar ödenmesi gerekecektir. Bu ağır sonuçlara maruz kalmamak adına gelecekteki hükümetlerin bu sözleşmeleri uygulamaya devam etmek zorunda kalmaları sözleşmelerdeki demokratik açık gerçeğini ortaya çıkarmaktadır. Nitekim sağlıkta KÖİ modeline yapısal olarak karşı olabilecek bir siyasi partinin iktidarı söz konusu bile AKP bugünkü gücüyle gelecek adına da karar verdiğinden demokratik iradenin pratiğe yansıması mümkün olmamaktadır.

Son olarak şehir hastanelerine dönük en önemli eleştiri, ki bu çalışmanın temel savını doğrulayan en önemli gösterge olarak, hastanelerin ölçeğidir. Bu hastaneler Dünya Bankası ve Dünya Sağlık Örgütü raporlarında da belirtilen yönetim açısından ideal hastane boyutlarının (200-600 yataklı) çok ötesinde olmaları dolayısıyla önemli yönetim ve koordinasyon sorunlarına yol açmıştır. Ayrıca hastane içerisinde hem sağlık çalışanlarının hem de hasta ve yakınlarının bir yerden baka yere erişiminde yaşanan güçlükler sağlık hizmetlerindeki aciliyet ilkesinin hakkıyla uygulanmasına engel bir durum teşkil etmektedir.

Çalışmada literatür taraması sonucu ulaşılan bu sonuçlar bir saha çalışması ile test edilmiştir. Bu bağlamda, çalışmanın 4. bölümü Ankara Şehir Hastanesi sağlık çalışanları ve Türk Tabipler Birliği Şehir Hastaneleri İzleme Komitesi üyeleriyle gerçekleştirilen mülakatların sonucunda elde edilen çıktıları ortaya koymaktadır.

Katılımcılarla yapılan görüşmelerde en çok vurgulanan husus hastanenin ölçeği meselesi olmuştur. Sağlık çalışanları böyle bir yapı içerisinde kendileri açısından hastaya erişimin güçlüklerinden dem vurmuş, ayrıca hastanın hizmete erişimi açısından da ortaya çıkan güçlüklerin altını çizmişlerdir. Bu denli büyük bir hastane yapısının sağlık sisteminin ihtiyaçları doğrultusunda inşa edilmediği, zira

esas ihtiyacın butik hastane yapısını korumak, altyapısı eski hastaneleri restore etmek ve ihtiyaca göre aynı ölçekte yeni hastaneler açmak suretiyle mevcut altyapıyı iyileştirmek olduğunu vurgulamışlardır.

Şehir hastanelerinde eski sisteme kıyasla özel sektörün işin merkezinde olması idareye ve işleyişe dair bazı sorunların ortaya çıkmasına neden olmuştur. Bunların başında, demirbaş ve malzeme temininde yaşanan sorunlar, tedarik sürecinde artan bürokrasi nedeniyle acil müdahale gerektiren operasyonlar için dahi bazı işlemlerle uğraşmak zorunda kalınması, özel sektörün daha etkin ve etkili bir yönetimde kilit rol oynayacağı savını desteklememektedir.

Ankara Şehir Hastanesi örneğinde görüldüğü üzere şehir hastanelerindeki yönetsel yapı karmaşık bir hüviyet arz etmektedir. Özel sektörün varlığı ve kamu-özel sektör aktörleri arasındaki ilişkinin nasıl yürütüleceği sorunsalının yanısıra, her bir branş hastanesinde bulunan başhekimlerle koordinatör başhekim arasındaki iletişimin nasıl hızlı ve etkili bir şekilde sağlanacağı önemli bir sorun olarak karşımıza çıkmaktadır. Çalışmanın katılımcıları yönetsel çokbaşlılığın sağlık çalışanlarına çok fazla etkisi olmadığını belirtseler de bu durumun başta tedarik olmak üzere yarattığı sıkıntılardan dolaylı olarak etkilenmekte olduklarını da ifade etmişlerdir.

Şehir hastaneleri kamu ve özel sektör çalışanlarını biraraya getiren yeni bir personel rejimi getirmiştir. Hastanelerde çekirdek sağlık hizmetleri kamu çalışanları tarafından, destek hizmetleri ise özel sektör çalışanları tarafından yürütülmektedir. Farklı özlük haklarına sahip olunmasının iş barışı üzerindeki etkileri, şirketin kendi çalışanları üzerinde kurduğu baskı, taşeron işçiliğe yoğun şekilde başvurulması gibi temel sorunların yanısıra, servislerde daimi personelin olmaması, şirket personeline ihtiyaç halinde 911 numaralı hat üzerinden istek yapmak suretiyle erişilebilmesi ve bazen bu erişimin çok uzun sürebilmesi hem işleyişi yavaşlatmakta hem de kurumsal hafızanın oluşumu açısından engel teşkil etmektedir.

Şehir hastaneleri eski hastanelerin kapatılması ile faaliyet başlayan hastaneler olması nedeniyle birden fazla hastaneyi biraraya getiren değişik bir yapı arz etmektedir. Ankara Şehir Hastanesi'nde olduğu gibi taşınan hastane sayısının fazla olması başta taşınma sürecinin koordinasyonu olmak üzere çeşitli sorunlar doğurmuştur. Bu konuda katılımcıların en çok vurguladığı husus eski hastanelerin kendi geleneklerini yeni hastanede sürdürme isteğinden doğan gruplaşma ve bunun yeni hastanenin kurumsal kültürünün oluşması önünde yarattığı engel olmuştur. Bu gruplaşmaların işleyiş açısından da kaçınılmaz sonuçları olduğu vurgulanmıştır. Bu sorunun aşılması için zamana ihtiyaç olduğu, kapatılan hastaneler dışında başka yerlerden gelen sağlık çalışanları ile göreve yeni başlayanların sayılarının zamanla artması sonucu Ankara Şehir Hastanesi'nin kendi kurumsal kimliğini inşa sürecinin bir ivme kazanabileceği, ancak mevcut yapıda "önce bizim mahalle" diye özetlenebilecek kültürel dokunun hastanedeki işleyişi etkilediği söylenebilir.

Tüm bu sorunların yanısıra saha çalışmasının çıktıları arasında Ankara Şehir Hastanesi'nin yaptığı iki önemli katkıdan bahsetmek gerekmektedir. Birincisi Ataturk, Numune, Yuksek İhtisas gibi yılların birkimine sahip hastanelerin biraraya gelmesinin yanısıra Yıldırım Beyazıt Üniversitesi'nin hastaneye akredite olması Ankara Şehir Hastanesi'nde eğitim faaliyetlerinin yoğunlaşması sonucunu doğurmuştur.

Her ne kadar hizmet garantilerinden ötürü poliklinik hizmetleri ön planda olsa da Ankara Şehir Hastanesi eğitim faaliyetlerinin sistemli şekilde yürütüldüğü bir sağlık tesisidir. Hastanenin diğer önemli katkısı pandemi sürecinde olmuştur. Hastanedeki yoğun bakım yatak sayısının fazlalığı, tek kişilik geniş hasta odalarının varlığı pandemi sürecinin yönetimini kolaylaştırmıştır. Ankara'da pandemi hastane ilan edilerek pandeminin yükünü sırtlanan hastane fiziki altyapısı sayesinde bu süreci iyi bir şekilde yönetebilmiştir. Ancak bahsekonu avantajların mahiyeti şehir hastanelerinin yarattığı sorunların yanında kayda değer görünmemektedir.

Sonuç olarak, KÖİ modeliyle inşa edilen şehir hastanelerinin sağlıkta Türkiye'ye çağ atlatacağı propagandalarıyla başlayan süreç 2021 yılında henüz sözleşmesi imzalanmamış olan şehir hastanelerinin KÖİ ile değil genel bütçeden yapılması kararıyla sona ermiştir. Ancak bu zaman zarfında 13 hastane faaliyetlerine başlamış, 5 hastanenin de inşaatında son aşamaya gelinmiştir. Bu hastaneleri arasında Ankara-Bilkent, Ankara-Etlik, İstanbul-Başakşehir gibi yatak sayıları 3000 in üzerinde olan hastanelerin varlığı, Sağlık Bakanlığı üzerinde önümüzdeki 25 yıl boyunca bu hastanelere yapılacak ödemeler dolayısıyla oluşacak finansal baskının şiddeti hakkında önemli fikir vermektedir. Sözleşmeci firmalara 25 yıl boyunca aktarılacak kaynak nedeniyle diğer kamu hastanelerine ayrılacak kaynaklar ile yeni yapılacak sağlık yatırımları için kullanılması gerekecek kaynakların mahiyeti önemli bir soru işaretidir.

Şehir hastaneleri finansman kolaylığı yanında etkin ve etkili bir yönetişimin anahtarı olarak da lanse edilmekteydi. Ancak finans boyutunua benzer şekilde, bu hususta da istenen sonuçlar alınamadı. Her şeyden önce karar alma ve planlama süreci şeffaflık ve katılımcılıktan uzak bir şekilde yürütülmüştür. Başta Türk Tabipleri Birliği olmak üzere sağlıkta KÖİ lere eleştirel yaklaşan kesimler bu süreçten dışlanmış; ihaleler davet usulü yapılarak eşit rekabet ilkesine aykırı davranılmış; dahası sözleşmelerin detayları ticarı sır gerekçesiyle kamuoyuyla paylaşılmamıştır. İyi yönetişimin temel unsurlarından şeffaflıktan uzak bir anlayışla yürütülen bu süreç kaçınılmaz olarak kamu aleyhine sonuçlar doğurmuştur.

Gerek çalışmada yer verilen kapsamlı literatür incelemesi, gerek saha araştırmasının bulguları, çalışmanın temel savı olan şehir hastaneleri projesinin iyi planlanmamış bir süreç olduğu zira sağlık sisteminin ihtiyaçlarını değil sermayenin çıkarlarını önceliklendirdiği iddiasını doğrulamaktadır. Yeni şehir hastanelerinin inşasında KÖİ modelinden vazgeçilmiş olması da bu kötü planlamanın sonuçlarına daha fazla katlanılamayacağını göstermesi açısından önemlidir.

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