After 1980 with the implements of neo-liberal policies such as privatization and deregulation, both functions and organizational structure of the state have been re-determined. It has been seen that the alternative methods grounding on providing substantially from the market has superseded the traditional methods in production/delivery of public services in this period. Partnership/cooperation models which are founded in various ways and called as Public-Private Partnerships (PPP) in the widest sense are also accepted among the alternative methods (Flinders, 2005: 218). Utilization of private sector has been seen for many years in the organization of public services. Nevertheless, widespread of PPP model has been come into question from the beginning of 1990s when the “rise of contract in the public sphere” was experienced (Auby, 2007; Osborne, 2000: 1).

Is PPP, which is described as a third way, a public procurement, a type of organization, service delivery method, method to have public services provided by private entity, finance method?\(^1\) PPP is an inclusive definition that includes in some features of all of these ranged. In this respect, it is not true to regard PPP limited with any of the questions above. PPP is a model that a partnership in which private organizations from various sectors (such as construction, service and finance) exist the


\(^1\) Undoubtedly, PPP is a privatization method. PPP is described in the way that “public investments which will be made in future is privatized today” in the official reports of the Prime Ministry (Basbakanlik, 2008: 21).
partnership is included in the organization of public services with different roles (providing goods, services and construction work), administration relation is based upon the contract, with this aspect it embodies the distinctive features of contractual relation, and that foresees the flexible organization.

In relevant literature a great number of PPP has been discussed with different denominations. Among PPP models, “design-build-operate”, “design-build-finance-operate”, “design-build-finance-own-operate”, “build-operate-transfer”, “build-own-operate”, “build-own-operate-transfer” are ranked (OECD, 2008a). With its many features PPP differentiates from the methods of traditional delivering service or public procurement or concessions or other forms of private participation (e.g. outsourcing) which have been previously implemented. Provision of goods, services and construction work en bloc from one single organization, finance method, and the roles and the risk undertaken by the government and the market could be ranked at the first glance, among the features making the model different.

PPP preference is justified fundamentally with two basic needs. One is getting the private financial support to overcome budget constraints/limitations in the organization of public services, and the other is the utilization of the capacity and techniques of the private sector (LI-AKINTOYE, 2003: 3; OECD, 2010: 22; Council of Europe, 2004: 3). PPP which is brought into question with the aim of efficiency and reduction of public expenditures is, in fact, a production of the pursuit to extend and deepen commercialization and marketization in public services in a new phase following privatization and decentralization (Leys, 2011). PricewaterhouseCooper (PwC), consultancy-audit firm, described PPP model as a “revolution” (PwC, 2010: 1). In this case one question can come to one’s mind: What are the features of PPP model, unlike the previous procurement or organization methods, which cause the model to be called ‘revolutionary’? PwC defined the model as a profitable investment area, which has long-standing grand potential under government guarantee, in terms of the private sector in the very same report (PwC, 2010: 5). Standard & Poor’s performed the assessment of high profitability and low risk and recommended this model to investors (Standard & Poor’s, 2005: 14-16). In the USA, large-scale investments which will be made with PPP model have been described as “from dream to reality” by finance, construction and management-consultancy firms.2 As it is seen in these statements PPP model is a considerably profitable investment area with regard to the private sector. Consequently,

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due to the government guarantees low risk/high profitability ratio of the private sector has been put forth in many researches (Parker-Hartley, 2003: 97). PPP is stated generally with the “win-win” formula in relevant literature or the statements of governments implementing the model (Gerrard, 2001; Miraftab, 2004: 89). What kinds of acquisition we may speak for public sector? In this study we will try to look for an answer to this question from certain aspects specific to Turkey.

1. AIM OF THE STUDY

This study is aiming to analyze a large number of Integrated Health Campus (IHC) or city hospitals which are in the tender process in the health sector in Turkey, and which is to be constructed by public-private partnership model. In this study, analyses which focus on the administrative structure and process will be made in two interrelated levels. The first is macro level (organization of healthcare services in general); the second is micro level (organizational structure, process and relations in PPP hospitals in particular). The studies on both level will be made within the frame of policy process, decision making process, tender process, administrative values, organizational structure and relations (aspects of intraorganizational and interorganizational). The purpose of this study is to present, at a certain level, the points that PPP model differs from traditional public procurement or concessions.

In this study, the PPP projects are evaluated with a critical point of view also tested in terms of the hypothesis of neo-liberal organization theories that the model depends on.

The methodology of the study is based upon a detailed literature review, legal regulations, official documents and analysis of the PPP pilot projects. Data was obtained from publicly available sources. The data of projects are received for consideration. However, the analysis will be made basically on the most advanced projects. As we don’t have a PPP hospital entered into service yet, we can’t get any direct evidence of outcomes of PPP models. Therefore, the outcomes of the PFI model in UK (which is parallel to Turkish applications) will be analyzed in comparative perspective.

2. WHY PPP PREFERENCE IN TURKEY: NECESSITY OR POLICY TRANSFER?

PPP model has become rapidly widespread both horizontally (various sector) and vertically (in each sector) in recent years. PPP has been widely seen not only in the developed countries but also in
transitional economies (Yang & Wang, 2013: 1). PPP has been more and more widely implemented not only in the support services but also in the organization of basic public services (the core service). The implementations of Private Financing Initiatives (PFI) starting in the early 1990s have become rapidly widespread in other states in the forthcoming years. PPP model has become common in recent years in Turkey as well. In health, education, transportation and infrastructure sectors, PPP projects remain on the agenda with new legal regulations. PPP projects particularly in the healthcare field have become more prominent than other sectors concerning both in number and financial size.

How can we explain the preferences of PPP model in Turkey? PPP preference and widespread of the model should be thought regarding to policy transfer in terms of peripheral countries especially like Turkey. In his detailed research Holden draws a parallelism between widespread of PPP implementations in various states and health industry exportation policy of British government (Department of Health of UK, Her Majesty’s Treasury and the organization called as UK Trade & Industry) (Holden, 2009). It is possible to evaluate the onsite visits of the committee under the presidency of Minister of Health that examines PPP implementations in UK, within this scope. Developments in PPP model in Turkey, in the early years, have been directly connected with European Union as in many reforms. It has been criticized in Progress Reports of European Commission that a legal regulation on PPP pertinent to EU legislation has not been made, and in PPP implementations the expected point could not be reached. During the EU harmonization process, State Planning Organization has continued the preparations for the PPP law draft.

In recent years, governments have used some comparative analysis methods in point of being base for the choice concerning the method of providing the service; moreover, they have made a commitment to implement these methods. Nearly all of these methods dependent on cost-benefit analysis have been among the essentials of governments implementing neo-liberal program.3 For instance, Regulatory Impact Analysis (RIA) which attributes production of a public service, undertaking a new service, establishing a new public organization by the state to the result of a detailed cost-benefit analysis is one of these methods. Another method is Public Sector Comparator used to determine the

3 We have thought that such methods aiming that public policies will be determined according to an analysis on cost-benefit ground, excluding the social-political aspect totally and grounding on “technical rationality” should be discussed. The methods such as RIA put forward by neo-liberal organizational theories frequently appear as ‘scientific’ ‘technical’ legitimization means for the preferences of governments not to produce public service.
choices related to service organization in states such as United Kingdom and Australia (Grimsey-Lewis, 2005: 354; OECD, 2008a: 69; National Audit Office/NAO, 2002).

In Turkey, as required by laws, for the certain amount of expenditure and investments RIA is an obligation. In that case, have the recently tendered PPP hospitals been preferred because of the reason of value for money, as a result of RIA analysis? We shall look for an answer to this question by looking through decision process of healthcare PPPs in Turkey. According to PPP Law, Higher Planning Board (HPB)\(^4\) decides the healthcare premises which will be constructed with PPP model. The PPP law has foreseen that the Preliminary Feasibility Report containing the comparative financial analysis about feasibility, price, guarantee and risk shall be presented to the HPB by Ministry. However, when prefeasibility reports presented to HPB by the ministry have been analyzed, it has been seen that these reports do not contain a comparison between the methods by being based upon detailed calculation and analyzes. In the superficial reports, it has been given place mostly to implementations in the world and the benefits expected from the model. The lack of such analyzes make it difficult to establish a relation between the administration reality and applicability of the model.\(^5\)

It is possible to carry out the evaluation of “policy transfer” for nearly all the public administration reforms in Turkey. Policy transfer has been more specifically seen in the countries that the legal regulation and the implementation strategies have been prepared substantially with the method of copy like in Turkey. A great number of laws such as Public Finance Management and Control Law, (Law No. 5018), Law on Regional Development Agencies (Law No 5449) have been based largely on the translated texts. A similar situation is also effective for the New PPP Law. PPP model which have been implemented in the healthcare field in many countries for nearly 20 years is also not an authentic model for Turkey. PPP, one of the prominent targets of the government in the healthcare reforms, is not a method of delivering service, a financial method or a model of organization which was created for its own needs of Turkish healthcare system.\(^6\)

\(^4\) The Board composed of several ministers and bureaucrats under the presidency of Prime Minister.

\(^5\) Turkish Medical Association (abbreviated as TTB in Turkish) - a national professional association of physicians-made a comparison between traditional methods and PPP based on the data of the Ministry, and deduced that PPP model has higher costs. (www.ttb.org.tr)

\(^6\) As the PPP is a model shaped by policy transfer, it is significant to study the consequences of PPP implementations of the original country. In this study, it has been referred to the reports of various government...
The effects of PPP which have been made model and implemented by the developed countries have been quite different in the periphery countries (including Turkey, as well) having different economic and social organization forms. PPP has been intensely criticized by various organizations interested in the healthcare field such as World Health Organization\(^7\), British Medical Association,\(^8\) Turkish Medical Association,\(^9\) Turkish Dental Association with regards to notably its impacts on equal service, right to health, right to choose and social state, and its social grounds having the pro-market characteristic. In addition they criticize the rupture of the relation between tax revenue and public service, and ill working conditions of the healthcare workers.\(^10\) A considerable part of public union and labor unions has opposed as well. Three big opposition parties (CHP, MHP, BDP) have dissented to the PPP law during the assembly debates. As stated above, the Council of State lodged an appeal to the Constitutional Court on the ground that the previous PPP legal regulation conflicts with the Constitution. (This case has not ended yet). In regards of the components of services it has been seen that a significant part is against PPP model. The criticism of these organizations about the consequences of PPP model could not be ignored. In the same way, the critical views of the unions which have mentioned the adverse impacts of the implementation of the model over the labor

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\(^7\) In Bulletin, the periodical of World Health Organization, there are many critical articles about PPP model. For example, (Mckee et al, 2006).

\(^8\) House of Commons, 2011: 19-22; www.bma.org.uk.

\(^9\) TTB has criticized PPP projects in the healthcare field, and brought a great number of actions. See: www.ttb.org.tr

\(^10\) In the common report of OECD and the World Bank expressing that “strict global upper limit” should be set to the expenditures of the Social Security Institution, it has been mentioned that extra payments in respect to both the medical services and the hospitality services for the ‘fiscal sustainability’ should become widespread (OECD, 2008b: 115). It could be thought that when PPP hospitals enter into service within the framework of these policies, the citizens will face with the extra payments like patient share for the “comfortable” services according as in the other countries. In PPP implementations which the finance of service has been removed from the budget, benefiting equally from the healthcare service has become less possible (Ataay, 2008).
relations and the healthcare personnel’s rights should also be taken into consideration. Nonetheless, the government has given an influential political support to PPP model, particularly in recent months, despite the whole objections.

3. PPP IN HEALTH SERVICES IN TURKEY

The history of the regulations on getting private sector to render the public services in Turkey has dated back to old times. The Concessions Law enacted in 1910 is one of the examples of this. The first legal regulation on the build-operate-transfer model is the law enacted in 1984 (Law No. 3096). During 1990s, many laws were enacted like the Privatization Law (Law No. 4046). Involving private sector in delivering public services have become widespread particularly in the fields of energy, transportation and infrastructure when the provision that the build-operate-transfer and the alike contracts could be pursuant to the provisions of private law entered into the Constitution in 1999.

The Basic Act on Health Services (Law No. 3396) enacted in 1987 is one of the first important steps of marketization and commercialization in the healthcare field in Turkey. The autonomous health enterprises and outsourcing have obtained a legal ground through this law. The essential uptrend to become marketable in the healthcare field has been witnessed with the Justice and Development Party coming into power in 2002. The Health Transformation Programme published by the government in 2003 is the main policy document of the reforms in the healthcare field (MoH, 2003).

In 2005, an article has been added to the Basis Act of Health Services (Law No. 3396) with the Law No. 5396. The PPP model that we are dealing with has firstly entered into Turkish public organization with this Supplementary Article. In 2006, subsequent to this PPP Law, the Regulation came into force. Even if the legal regulation had been enacted in 2005, the first PPP tender process in the healthcare field has started in Turkey in 2009. The first PPP Project agreement was signed in 2011 (Kayseri IHC). From 2011 until now, many large-scaled PPP hospitals were put out to tender, and the contract was signed for some of them.

The legal basis of the PPP was only one article between 2005 and 2013 and this caused serious problems. Making large-scaled PPP tenders without any solid legal ground has been criticized. During

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11 Any progress concerning this project could not be made during the last two years.
the tender processes, many individuals and NGOs have brought an action for PPP. In the law suits brought for Ankara-Etlik, Ankara-Bilkent and Elazig hospitals by Turkish Medical Association adopted a motion for stay of execution, and applied to the Constitutional Court with the claim of unconstitutionality. The law suit has not been concluded yet.

In Turkey, since 2009 The MoH has been conducting tenders and contract negotiations for 19 PPP Health Projects with an investment amounted of approximately USD 5 billions.

PPP Health Projects: Present Condition (September 2013)\textsuperscript{12}

<table>
<thead>
<tr>
<th>Phase</th>
<th>Number of Projects</th>
<th>Number of Beds in Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Construction\textsuperscript{13}</td>
<td>4</td>
<td>9,850</td>
</tr>
<tr>
<td>Contract</td>
<td>8</td>
<td>11,628</td>
</tr>
<tr>
<td>Final Bid</td>
<td>3</td>
<td>4,170</td>
</tr>
<tr>
<td>Bid</td>
<td>1</td>
<td>1,180</td>
</tr>
<tr>
<td>Pre-Qualification</td>
<td>1</td>
<td>1,060</td>
</tr>
<tr>
<td>Pre-Qualification Tender Announcement</td>
<td>2</td>
<td>1,468</td>
</tr>
<tr>
<td>Total</td>
<td>19</td>
<td>29,356</td>
</tr>
</tbody>
</table>

\textbf{3.1. NEW PPP LAW ON HEALTHCARE SECTOR}

The government started to prepare a new law most likely to overcome the legal problems mentioned above. When we look at the legislation process of the new law, we can see that the opposition parties and professional organizations have not supported PPP projects. However, the New PPP Law was accepted in the Parliamentary in March 2013. \textit{(Law on Building and Renewal of Facilities and Procurement of Services through Public Private Partnership Model} by MoH) (Law No. 6428). Thus, PPP has obtained a new legal ground in the healthcare field with this new law.

Although it is broader than old law, and special to PPP, the New Law has many disputable matters. The existing legal ground in respect to PPP in Turkey has not been sufficient and solid from the investor’s


\textsuperscript{13} It has to be stated that no progress has been obtained in the projects under construction.
point of view. There are legal and institutional deficiencies and disparities in terms of PPP implementations. This situation has made PPP a potential conflict field.

According to the New Law, the definition and the scope of PPP model in the healthcare field have been as follows;

1. *Construction of the healthcare premise*: The real properties owned by the Treasury through establishing free of charge right of construction in favor of such real persons or private law legal entities for a period up to thirty years,

2. *Renovation of the existing healthcare premises*,

3. *Consultancy, research and development services to be received for these projects*,

4. *Getting some services, which require advanced technology or high financial resource*, rendered.

Under the New Law, as it was under the old one, all above mentioned works will be transferred en bloc to one single entity formed by various private organizations from various sectors (such as construction, service and finance). This entity is a joint venture and is called Special Purpose Vehicle (SPV).

In the former law, a distinction as medical services and non-medical (medical support and commercial) services was made and the medical services were not absolutely included in the services to be transferred. In the new law, in terms of services such a distinction was not made. A framework about PPP has not been determined. The medical services have the features mentioned in the item (4) above.

In the law, there is not any explicit provision whether the medical services will be among the services to be transferred to SPV within the context of this article. The government has not also made a statement on this subject. This article of the law has been submitted to the court.

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14 The Regulation for enforcement of this new law has not been enacted yet. However, tenders have continued.
According to the New Law, PPP contract will be subject to the provisions of *private law*. In the new law, the term of contract has dropped from 49 years to 30 years (except for the investment period). Direct government guarantees and exemptions have been obviously included in the new law.

The PPP Law has given decision-making authority to the High Planning Council (HPB) the construction of a new premise through PPP. HPB has allowed many PPP hospitals to be constructed on the condition that they will not “increase the number of bed”. It is not possible to state that the number of bed has increased with PPP hospitals because it has been foreseen that a great number of public hospitals will be closed with the implementation of the model. In this respect, it is more correct to call PPP hospitals as a renovation project rather than growth.

3.2. WILL THE MEDICAL (CORE) SERVICES BE TRANSFERRED TO PRIVATE COMPANY IN PPP PROJECT

The underlying acceptance of the neo-liberal reforms in the last thirty years is that the whole public services including the core service could be operated according to the principles of managerialism. Should the medical services be included in PPP model? The subject whether the medical service could be transferred to the private sector in PPP projects has been discussed in the relevant literature and in the reports of the international organizations playing a crucial role in formation of the model (Edwards et al, 2004: 16; OECD, 2008a). In many European countries, the medical services has been gradually included in PPP implementations. For instance, Alzira Hospital in Spain has been shown among the model implementations. In the oncology hospital constructed with PPP model in Germany, the medical services have been included in the project as well (PwC, 2010:8, 20).

The inclusion of the medical service in PPP model has been based on a pragmatist reason rather than being principal. The MoH has clearly exhibited its choice of becoming marketable in the *Health*

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15 Although it has been stated that PPP contracts is a ‘contract of private law’ in the new law, PPP is a kind of concession. For this reason, PPP contracts are subject to the public law (Karahanoğulları, 2011). The contract signed with the SPV will naturally include the provisions concerning right to health, organization of health services, and working conditions of healthcare personnel. All of these fields are directly the field of public service, and could not be regulated directly in accordance with the provisions of private law. In the case that the medical services are transferred to SPV, the legal status of these contracts will gain further importance.

16 For example, Article 8/a, has guaranteed the outsourcing over 500 million Turkish liras (about 250 millions USD) by the Treasury.

17 See: HPB Decision, 27.9.2009, B.02.1.DPT.0.05.01.233-3507.
Transformation Program that it is initiated in 2003. The Ministry has accepted transfer of the medical services in at the principal level, as well. Nonetheless, in the first PPP Law (2005) and the relevant regulations, the medical services were not included in PPP project. Consequently, in the tenders lodged during the period that the law was in force the medical service did not exist in the projects.

New PPP Law (2013), has not given place to the differentiation of ‘medical services-non-medical services’ as it was in the former law. Instead of this, a provision which vests the administration with broader discretion has been inserted. It has been resolved that “The services required advanced technology or high financial resource” could be included in PPP projects. In this case it could be said that the medical services having these characteristics could be also included in PPP project, and are enabled to be transferred to the private company. The government departments including the MoH have not made any statement on this subject. The government has frequently emphasized “public” hospital in its statements. If it is considered that the only link to maintain the continuity of PPP hospital as public hospital is the medical service, it could be stated that transfer of the medical services are not on the front burner, at least for the nonce.

From 2005 until today, the government had preferred not to include the medical services in PPP model, because of the maturity level of the market. The point, which has determined the preferences of governments concerning that the medical services have not been included in PPP yet, is the maturity level of the market.

Providing the medical services by public in the current PPP implementations in terms of current healthcare market has importance in the sense of internal cycle of the system. Furthermore, we could mention a necessity caused by the market. In the event that the medical services are transferred to the private company by including in the model as well, PPP model will be transformed into the method of “build-operate-transfer” implemented during the previous periods. In this case, PPP hospital will be indifferent from any private hospital in terms of healthcare enterprises. Transfer means that the private company undertakes a great number of risks particularly the risk of demand, and this situation is not attractive for the capital. However, continuance of providing the medical service by the government has removed the risk of demand of the private company in terms of the medical support.
services and commercial areas. In brief, there is a pragmatic preference regarding the maturity level of the market in respect to the transfer of medical service in the current situation.

The role of the MoH in the organization of healthcare services, the level of becoming marketable will change concerning whether or not the medical service in PPP implementation is transferred. In this respect, the use or non-use of the “authority of transfer” is crucial for the future of PPP model.

4. STRUCTURE OF ORGANIZATION AND RELATIONS OF ADMINISTRATION IN PPP MODEL

PPP is a model that will influence totally the production process of healthcare service through its dimensions such as organizational structure, intra-organizational relations, inter-organizational relations, working conditions of healthcare personnel and form of employment.

What kind of organizational structure will shape at macro (healthcare field as a whole) and micro (within the PPP hospitals) levels, after the tendered large-scaled PPP hospitals will enter into service?

In the current organizational structure, greater part of hospitals is in the organization of the MoH. Revolving fund enterprises exist in these hospitals at the status of public hospitals. In addition, hospitals do not have separate legal entity except for the university hospitals. In 2011 a new law on the organization of the MoH was enacted. With this law “public hospital unions” which gathers the hospitals in the same city, was founded. The unions in the structure of the MoH differentiate considerably from NHS Trusts in UK in consideration of the authority and the organizational structure. Even if the legal entity was given to the public hospital unions in the first drafts in the enactment process, the hospital unions were not bestowed with the legal entity. The relation between new huge-scaled PPP hospitals which will be constructed and these unions is still ambiguous. The third sector organizations in the form of community interest companies which run public service and at the same time could be engaged in commercial activities as in United Kingdom have not existed in Turkey yet. In this respect, while comparing PPP implementations in the healthcare field with United Kingdom, such structural and functional differences should be taken into consideration. However, it is necessary to indicate that a course toward structuring in the organization of healthcare similar to the structure in United Kingdom exists in the government’s plans.
PPP has been generally legitimized by the advocates and executors of the model without including its political purpose. The economic-based organizational theories such as new public management and governance have formed the ‘scientific’ basis for this justification. In the government field many notions, definitions regarding organization have been frequently seen in the neo-liberal organizational theories since 1980s. Among these; “getting free from bureaucracy”, “new organizational structures which are flexible, participative, responsive to the advanced technology, changes and innovations”, “extinction of the old-fashioned public-private dichotomy”, “the third way in the provision of public services”, “superseding of hierarchy by market/partnership/networks” and “participative contract governance” could be ranked (Grimshaw et al., 2001; Argyriades, 2010). It is possible to come across nearly all explanations in the literature concerning PPP model with the dimension of organization. Well, could these be explanatory for PPP model?

As can be seen in the data that we have already conveyed, integrated health campus (IHC) and city hospitals have brought growth and intensifying in work and transaction size and by extension have also brought scale-up with its administrative and financial dimension. When analyzing from the point of PPP hospital in the new large scale, the questions as follows come into mind: Have the optimal sizes related to the organization of healthcare services been regarded as standard in terms of these hospitals? What sort of outcomes could be shaped by scaling up in terms of healthcare services? Are PPP hospitals, which are large-scaled in terms of some dimensions such as planning, auditing, finance, personnel etc., at the size/scale to be able to be administered? When “small and efficient” structures and the delegation of authority have been argued with the approaches of new public management, and post-fordism particularly after 1980, the existence of these huge structures could be solely explained with the demand/expectation of monopolization. While bureaucratic structures were described as efficient and productive means of organization to reach the goals during the major part of the 20th century (Eisenstadt, 1959: 302), after 1980s in the neo-liberal organizational theories they have been indicated as the mainspring of unproductivity. New organization preferences, making big organizations smaller by splitting intended for debureaucratization have been grounded on the operation of services through small, flexible, project-oriented ad hoc structures (Argyriades, 2010: 275).
In that case, has PPP as a small, efficient structure asserted in the theories forming a basis for itself, debureaucratized? Is PPP rational organizational form grounding on effectiveness and productivity with its type asserted again by the theories on which it is based? It is difficult to state that in PPP implementations, expressions such as avoidance, alienation, and decrease in terms of bureaucracy have been carried out. The explanations given by administrative science studies upon the relation among growth, bureaucratization and centralization have formed a sufficient basis at this point. It should be noticed that the processes expressed with the notions which are used with negative prefix “de-” in some language to describe the new, alternative organizational structure (for example, debureaucratization or decentralization) after 1980s have reconstructed the process in the form without prefix. In PPP debureaucratization has not occurred, bureaucracy has not been removed contrary to what is claimed. In this structure we have been faced with a new bureaucracy and form of bureaucratization in which the administration relations including new control forms are. While it has been claimed that debureaucratization has been carried out through reconstruction of the secondary and tertiary public hospitals, in the new organizational structure based on PPP contracts a new bureaucratization which is possibly different qualitatively but not different quantitatively has been created. Bureaucratization (with the dimension of area, population, work, transaction size and relations) has also inevitably increased as a result of scale-up PPP hospitals. In PPP, organizational structure has not become smaller, on the contrary it has grown. If there is one thing which becomes smaller in PPP hospital, it is the public part of the hospital. The risk of ungovernableness is possible due to scale-up and split off PPP hospitals. In the same way, decentralization has not been experienced in PPP in terms of decision processes. Hospitals could not go beyond the contract executive of the MoH in the sense of PPP projects.

Creating a powerful center with the vision of decentralization is one of the typical features of ‘new public contract system’ on which PPP model is based. Another feature of this system is being quite inflexible in practice as a result of the contractual relation despite the discourse of flexibility developed against the inflexibility of bureaucracy. The main problem of the models/structures (including PPP) of the organization presented as alternative that they embody the contradictory principles/implementations within each other. This originates from the theoretical basis (neo-liberal organizational theories) on which the organizational structures have been based (Hoggett, 1996: 17-18; Vincent-Jones, 2007: 266). PPP is a model corresponding not to a many assumptions of new public
management (small, efficient, decentralized organization), but to the final purpose (attaining a place in the market). PPP hospitals are not appropriate for NMP in consideration of structure or scale. However, PPP hospitals are convenient for the taylorist organization based on the sense of rational work processes and industrial productivity. In this respect, PPP hospitals are the construct corresponding fairly to the targets of neo-liberal organizational theories on the grounds that PPP hospitals partake of a factory (Leys, 2011: 41; Sönmez, 2011: 13).

In PPP hospitals the private company (SPV) is a huge structure that dominates nearly the whole horizontal administrative processes of the organization. SPV has a power to transform the whole working conditions and relations in PPP hospitals including also the medical service by force of its authority and organizational institutionalization. The physicians and the other healthcare personnel have to maintain intensive and direct contact with this managerialism oriented company while delivering the services. Before this managerialism oriented structure, the alienation of the public elements of the hospital (healthcare personnel and hospital administrators) from the principles of administrative and occupational practice, is inevitable.

What will be the role of the MoH in PPP model that the whole service and commercial areas except for the medical service are devolved to the SPV? What sort of relation will be between the Ministry and PPP hospitals? We shall look over the roles of the organizations and the interorganizational relations of administration in PPP model.

4.1. THE ROLE OF THE MINISTRY OF HEALTH IN PPP: EXCESSIVE CENTRALIZATION

In Turkey there is not any department at the central level which governs directly PPP implementations. A unit related to investments in the Ministry of Development has undertaken some duties concerning PPP. In the relevant law, authorized body has been determined in various service fields. For instance, in the healthcare field the MoH is authorized.

In Turkey, The MoH has been naturally in the position of main actor of the system with the special authorities concerning PPP implementation that have been given to it. Some of duties and responsibilities stated in the Law are as follows: Decision (determining which services and commercial
areas shall be handed over, leasing term and annual payment amount); Preparation (preparation of preliminary project); The Whole Tender Process; Regulation-Supervision (determining procedures and principles concerning the scope of contracts and the other procedures, setting the fundamental standards regarding project design, construction, maintenance of healthcare premise, and how the commercial areas and service areas apart from the medical areas in the premise shall be administered, conducting supervisions, providing to recover the losses to be incurred from the actions and transactions of the contractor during the term of the contract, imposing penal sanctions for this); Providing Guarantee-Taking Preventive Measure (providing income support for the revolving fund enterprises to guarantee the lease payments and in this connection taking all the measurements, undertaking the risk of demand).

PPP is a convenient model for the regulatory-supervisory role foreseen for the MoH. Along with the transition to this model, the structure of the MoH, its organizational form of healthcare services and its relations with the organizations operating healthcare services have taken the form that the contractual relation requires. The MoH has transformed into a huge tender department with the PPP model. Although annual lease payments of the hospitals will be rendered by the revolving fund enterprises, as the final responsible, the MoH has become a huge debt management department again. One point should be thoroughly scrutinized. In terms of internal logic of the neo-liberal reforms it is not consistent that the same actor becomes simultaneously policy maker, provider, financier, regulator and supervisor in an organization of service. On the one hand the argument of autonomy and, in this context delegation of authority argued, on the other hand all of the 25 year and longer term PPP projects being put out to tender by the Ministry, which has a say in the contract administration, is a total contradiction.

In the forthcoming period the Ministry could delegate some operational authorities, which have been entitled to it, concerning PPP projects to the hospitals. However, the authorities of the hospitals in executing the contract will be quite limited since each and every detail has been resolved and have been signed for long term in the contracts. Delegation of authority in real terms as claimed will be out of question except for the simple operational works which are not important. In this model the most critical matters of decision (tender-contract) have been already centralized at the outset of the project. Paradoxically, the discourse of delegation and the tightening of the supervision of central authority
over the sub-units, coexist in the model. The vision of decentralization and gaining autonomy has indeed functioned as concealing centralization for the strategic decisions occur simultaneously.

It is not realistic to think that the Ministry will completely be out of the system and will recede from the critical decisions in PPP implementations in Turkey as in some countries. The preferences about the mode of neo-liberal organization adopted by the government will not allow this, as well. As mentioned before, ‘powerful center” exist contrary to what has been claimed in the spirit of the approach of neo-liberal organization theories including the discourse of decentralization. It is obvious that PPP is not an outcome of the pursuits of making the big organizations smaller by splitting, and the organization of services as small, flexible, project oriented. PPP is the implementation of new style of centralization.

4.2. INTEGRATED HEALTH CAMPUS – CITY HOSPITALS

IHC and city hospitals which have entered into Turkish healthcare system with PPP projects are new organizational structures. Why have the large-scaled integrated organization structures which consist of several branch/specialty hospitals been needed in the healthcare services? In regard of administration process, is an integrated service organization aimed with IHC in PPP projects as it been given place in the organizational theories during the 20th century? It should not be thought through PPP hospitals a return into hierarchy-based integrated public service organization has been targeted. Well, what has been integrated then? For instance, the hospital which will be constructed in Bilkent, Ankara is an IHC that will sit on 1.200.000 m2 land, will includes eight different branch hospitals and has 3660 inpatient bed availability.

There is not any information on the administration of IHC in the current legal regulations. It is unclear whether this organization will be autonomous, and have a separate budget. It is also ambiguous what sort relation of this organization will have with the Ministry, hospitals in the campus and SPV.

Considering the current legal status, the administration of IHC will be in the organization of the MoH. However, it does not seem possible that these huge-scaled hospitals are administered under the same conditions with the existing public hospitals. As mentioned before, the authorities of PPP hospitals on
the implementations of the contract are quite limited in accordance with the provisions of the comprehensive and detailed contract signed just at the beginning of the project.

In the organization of healthcare which have reconstructed as required by the contractual relation, the administration of hospital has been passivated in terms of the basic decision subjects of an organization such as doing its own planning, auditing the organization by virtue of both the essentials of contract determined centrally (MoH) and powerful influence area of SPV.

PPP contracts have an imposing characteristic in terms of the hospitals which run the service itself. Beyond being execution unit in the operational subjects, the hospitals have hardly any authority in the organization of healthcare service. For instance, in the current structure, the public hospitals themselves determines their own needs the grade of goods and services to be provided and terms of contract. They provide their procurement requirements with the short-term outsourcing tenders. However, the authorities on all of these subjects in PPP hospitals belong to the Ministry.

In many countries the main actor in PPP system is the autonomous organizations. For instance, the authorities concerning PPP tenders in UK have been carried by the unions of hospital each of which is autonomous healthcare enterprises (NHS Trusts) (NAO, 2010: 38). In other words, the MoH or the National Health Service in the position of the operator of healthcare service has scarcely had authority. Even if it has been legally foreseen that the lease payments should be rendered by the revolving fund enterprises of the hospitals, in Turkey the PPP system has been completely executed under the tutelage and control of the MoH. PPP implementations have not dominated over the autonomous healthcare enterprises.

In The Health Transformation Programme (2003) of the MoH it has been stated that all of the hospitals will be given administrative and financial autonomy (MoH, 2003: 32). In the past decade, the government has not carried out this policy. Even if they have been included in the Draft Law as autonomous structure, the Public Hospital Unions Law (2011) has not given autonomy to the unions. The existing new law has not any regulation on autonomy for PPP hospitals as well. Although the discourses of decentralization and autonomy are frequently included in the policy texts, PPP model of the government, and its centralization preference and implementations should be scrutinized additionally.
In the existing PPP law and the other laws, the public hospitals have not been given autonomy yet. Even though PPP hospitals will be given administrative and financial autonomy in the forthcoming years, these hospitals do not have administrative and financial tools, authorities for autonomy. Because the movement area of these hospitals has been already determined centrally and more precisely limited at the beginning of project with the 30 year-contracts signed by the Ministry.

Although the contracts have been signed by the Ministry, PPP is not an investment or an expenditure which will be covered from the budget of the Ministry. (In the New PPP Law it has been stated that when required the fund could be transferred from the budget of the Ministry to the revolving fund enterprises of hospitals. This could also be regarded as a government guarantee). The most important pillar of PPP in terms of financial dimension is the revolving fund enterprises. The New PPP law has not drawn a parallelism between tender prices of the healthcare premises to be constructed through PPP and the financial opportunities and the rules of budget. When the 25-year term of contract is considered, it is difficult to foresee the revenues of the revolving fund enterprises. The main source of revenues of the revolving fund enterprises is patients. In order that the revolving fund enterprises of hospital could render the annual rental and its other payments to SPV, the number of patient should not drop below a certain level. Otherwise, the hospitals which could not generate sufficient revenue, as in the examples in many countries, like UK (House of Commons, 2011: 221), will have to adopt new methods which will bring additional payment for citizens in the billing of services, or dismiss the healthcare personnel from employment, or reduce the number of beds.

4.3. EN BLOC PROVIDER OF PROFITABLE INVESTMENT AREA: SPECIAL PURPOSE VEHICLE/JOINT VENTURE

We could consider the state of SPV, from two aspects in PPP projects in Turkey. First one is related with the administration processes of PPP hospital, and the second one is the commercial dimension that concerns the citizens benefiting directly from service.

In comparison with the existing public hospitals, PPP hospitals are larger-scaled private organizations that will exist before the administration of hospital.
The long term en bloc provision of a great number and variety of goods and services, and managements of commercial areas, by a single organization has led to significant consequences in the relations of administration in hospitals. It is a fact that every organization will generate its sphere of influence in proportionate to its scale (from the organizational or the financial aspect) and its institutionalization. In the present condition, except PPP, outsourcing tenders have some features as follows. Tenders have been separately made for different services (for example, cleaning, catering, medical imaging, and laboratory). Term of the contract is short, generally two years. The scale of tender is not considerable. Generally the small and local companies are awarded. Due to legal regulation the administration of the hospital is powerful over the awarded companies.

When PPP tenders are evaluated from the aspect of all these points, main differences occur. The scale of tender is major. It does not give any opportunity to the local and small companies to bid. In the present condition, in comparison with the private company providing service through the contract, SPV (joint venture) being the en bloc provider has more significant rights and authorities. SPV formed particularly for PPP project with great capitals has a crucial power. As we have mentioned before, autonomy of the hospital administration is considerably limited in PPP hospitals with the dimension of the relations of administration. By reason of the powerful provisions of contract and the sizes of capital, the SPV have ‘extensive’ and furthermore ‘excessive’ autonomy in some ways.

SPV settling in the whole elements of the organization of the hospital has attained a significant power on the one hand in the hospital by being the main component of the relation of administration, and on the other hand in the healthcare market with the guaranteed advantages that this contract has provided. This power that the SPV has in the hospital could lead to a consequence to restrain the hospital administration from having control over the environment for which they are responsible. The research by D. Grimshaw et al. has shown that within that period the administration has lost not only its dominance over the organization, but also, and more importantly, lost gradually its control of service (Grimshaw et al., 2001: 425).

When we evaluate with its financial dimension, the SPV is an organization that provides service as monopoly under the great guarantees (such as Treasury guarantee, currency risk, risk of demand) which are included in the PPP Law and provided by the government. As we have mentioned before, a
great number of multipurpose or specialty hospitals which are located in various regions of the cities have been (or will be) closed because of the IHC. A major part of citizens has been or will be forced to go towards these IHC due to closures of the hospitals and also, the social security system. It is not difficult to estimate its natural consequence. Primarily, citizens’ right of choice on hospitals has been revoked. In case of an problems in the IHC (hospitals), this will cause a serious problem regarding the right to health since there will limited alternatives. Citizens have been subjected to single provider in terms of both the healthcare services and the commercial services in the structure that competition does not exist. IHC have been generally constructed uptown and in a large and isolated area. In this respect, nearly all people in the hospital are obliged to meet all their needs from SPV. The monopolize SPV, in terms of medical support service (such as imaging, laboratory) and management of commercial areas (not medical services at least for now), has obtained the opportunity to provide these services non-alternatively to the customer mass. With this form, PPP hospitals are the structures precisely similar to ‘shopping mall’. In this respect, there is not any risk of demand of the SPV. (Moreover, in the contracts government guarantee has been provided on the subject of demand).

PPP hospitals has made the administration and citizens “excessive dependent” on a single company, which provides a great number and variety of goods and services en bloc, for long duration (Mols, 2010: 242).

The emphasis of high profitable management of commercial areas, made by corporations related to PPP, gains importance at this point (PwC, 2010: 11). The most attractive sides of this model are most likely both the feature of being monopoly and absence of the risk of demand. It is obvious that these features which provide significant advantages to SPV will not provide the same consequence for citizens.

5. CONTRACT ADMINISTRATION

PPP is a model that arose in a structure defined as “the new public contracting” by some authors (Vincent-Jones, 2007: 265). In PPP model, the contracts which become nearly main regulatory form of the provision of service and the employment of personnel have surrounded completely the relation of administration. The contractual relation in PPP is intensive and deep enough to transform the value and the principle of organization belonging to the public service. With great numbers of PPP projects
conducted concurrently, the contract system in Turkey has become general (generalization of the contract system in public services) (Karasu, 2011).

PPP contracts are more complicated, comprehensive\textsuperscript{18} and longer term in comparison with the existing outsourcing contracts (The term of contract in Turkey is 49 years in the former Law, is 30 years in the New PPP Law). For this reason, in terms of such projects the implementation of contract, in other words the administration of contract has gained further importance.

In fact, there is not one single contract in PPP model. The contractual relation is not only between the government and SPV. SPV is a joint venture. A contractual relation exists between the companies forming the joint venture, as well. Another contractual relation is between SPV and numerous sub-contractors.\textsuperscript{19} The existence of a great number of actor and contract has posed one of the main administrative and financial risks of PPP model.

The comprehensive, complicated and long termed PPP main contracts, with too much components, cause too much uncertainty. In this kind of contracts, there are problems in controlling the detailed and intense work traffic. Inevitably, a great number of subjects which have been superficially regulated or unforeseen (for example, technological developments, changing social needs) have been included in the contracts. In such cases, negotiation has naturally formed a basis between the parties. The administration of negotiation-based contract has generated new control modes which give the private sector more power. It is difficult for the public sector to compete with the private sector in the field of the law and administration of contract as a particular field of specialization. There is clearly imbalance of power in favor of the private sector in the administration of contract between the public sector and the private sector (Hoggett, 1996: 9; Grimshaw et al., 2002: 477). As clearly stated in National Audit Office reports in UK, the private sector has been more institutionalized in the field of the law and administration of contract (NAO, 2011).

\textsuperscript{18} For instance, the contract of Kayseri IHC tender was formed of 600 pages with it annexes.
\textsuperscript{19} Sub-contractor companies have been mostly used in PPP projects. That causes serious problems (Council of Europe, 2004: 14). Widespreading of sub-contractor has led to adverse result directly over the financial and social rights of employees by bringing labor force to be employed without security. At the same time, it has broken the labor peace by creating a dual personnel system in the organization of hospital (Grimshaw et al., 2002: 478; Hall, 2004: 6).
In PPP projects, the points that SPV being the most powerful and deriving the highest profit, are the issues which have not been clearly regulated in the contract. Amendment requests of the administration which have not been ensured clearly in the contract in order to meet the new occurring needs could be also considered in this scope. It has been known that all of these are the elements of incremental cost. For this reason, it is not true to qualify PPP model as “win-win”, as well. After the experiences over 20 years, the assumption that PPP model “is efficient in terms of transaction cost” becomes groundless (Parker-Hartley, 2003: 107; Edwards et al., 2004: 9-10; NAO, 2011). The cost of project-consulting-law companies has constituted a considerable amount. The administration of contract itself is a significant cost element.

In fact, many points which have been put forth as ‘problem’ above are not intrinsic to PPP. Generally, it is possible to see the similar problems in all of the implementations based on the contractual relation. For instance, similar problems have been experienced in the implementations of involvement of private sector in delivery of public services through the methods such as contracting out, outsourcing. Besides, the problems originating from the contracts are much more in PPP due to being based on completely an intensive and deep contractual relation.

6. PPP IN TURKEY: SOME CONSEQUENCES

6.1. SCALE OF PPP TENDERS (CHOICE OF CAPITAL) AND COMPETITION

PPP has been defined as competitive model in many studies since its first appearance (OECD, 2008a). Nonetheless, a great number of researches in various countries have propounded that a competitive structure does not actually exist in PPP at all (HM Treasury, 2012; Mols, 2010: 242; Grimshaw et al., 2002: 484; Grimsey-Lewis, 2005). It is possible to mention a similar circumstance for PPP tenders in Turkey. One of the most main features of PPP implementations in the healthcare field which attract attention is that the exceeding growth of scale in comparison with the current contracting out or outsourcing tenders. Only limited number of firms could bid because the scale of tender is fairly high in PPPs in the healthcare field. According to the information obtained from the official web page of the MoH it has been seen that the same companies considerably have bided in PPP tenders in different cities, and the awarded companies have been substantially the same. This situation prevents the competitive structure, as well. The healthcare PPPs in the form of IHC and city hospitals have led to
monopolization in the healthcare market. It has been seen that with PPP small-scaled companies in the healthcare market have been wound up to a large extent.

The consequences of PPP model should be evaluated generally together with the horizontal and vertical integrations which have been seen in the healthcare market in recent years. It has been seen that the integrations through purchase and chain hospitals and the private hospitals have been also gathered under the control of several groups (Sönmez, 2011: 21, 77). For this reason, it could be stated that the intense support of the government for PPP model in recent years in Turkey has also reflected a political preference concerning the composition of capital in the healthcare market.

6.2. LARGE-SCALED HOSPITALS: SOCIAL AND ECONOMIC CONSEQUENCES

It is necessary to mention briefly two consequences of the implementation of large-scaled PPP hospitals which have been ignored usually, as well. As we have mentioned before, a great number of hospitals in various locations of cities will be closed for the new PPP hospitals. The circle of trade of the small-local enterprises around the hospitals to be closed will fade away. It is almost impossible that these small-local enterprises take part in the new PPP hospitals. This situation has led to adverse consequences with their social-economic aspects in terms of these segments.

Another consequence is related to the urban life. For instance, Ankara Bilkent hospital is a hospital that has 4376 beds, 3662 of which standard and, has 10.200 employees and 25 thousand-people capacity daily. Besides, a University of Health Sciences and Center of High Technology and the main building of the MoH will be also constructed in the campus. This campus is a life area that approximately 50 thousand people will move in a day. This mobility, which will cause to flock of people in certain region of the city, could pose serious problems in urban planning, transportation, environment etc.

6.3. POLICY FORMATION AND POLITICAL RESPONSIBILITY

Budgeting is the most important instrument doing policy which establishes a link between planning, decision making, responsibility and controlling. The “off-balance sheet” PPP model, disable this instrument and apoliticizes the future politics.
Around 20 large-scaled and long-term concurrent PPP contracts, put in pledge to policy choices of the predecessor governments, in both health and public finance; moreover it eliminates their right to choose. Considering the 28 years-long contracts, execution of the PPP model in regard to public policy, means to make a long-termed and comprehensive plan. With the tens of concurrent PPP projects, current government (MoH) has formed at least 30 years of Turkish healthcare system, from now on.

While PPP projects to with great amount annual payout are continuing, it is difficult for the future governments to make other choices of a new healthcare policy and organization in accordance with their own policies. At the same time, PPP models have also a characteristic that invalidates the political responsibility. The governments take make choice about the model will be naturally unable to take the political responsibility related to the implementation results of the model because the contracts are a very long-termed. In this respect, it could be said that PPP projects have created a consequence that makes the fundamental principles of the representative democracy with respect to the relation of budget-democracy-political responsibility unenforceable.

6.4. TRANSPARENCY AND PUBLIC OPINION

According to the PPP law, the administration has to provide transparency and public opinion supervision in PPP tenders. However, it is difficult to state that in Turkey the principles included in the law are actualized. For instance, the public opinion has not been informed about the details of projects. Moreover, information about the project (for example, the preliminary feasibility reports which form a basis for HPB decision and contain comparative analyses) has not been given to the professional organizations which are constitutional organizations on the grounds that it is “confidential”. In the law suit brought against the tenders, the Council of State has decreed that the Ministry should give the information (for example the preliminary feasibility reports) which is not trade secret. Transparency and public opinion supervision could be provided to some extent through the judicial decree. In this respect, “there has been a lack of transparency” in Turkey as well as in UK (HM Treasury, 2012: 5).

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20 During PPP tender process, the information about the tender has been demanded on the purpose of scientific research. However, the Ministry has not given this information.

21 The Council of State, Division 13, Interlocutory Decree, Docket No. 2011/3392.
Unlike other public procurement implementations, many exemptions are available for PPP tenders. For instance, the New PPP law has exempted PPP implementations from the Public Procurement Law and the State Bid Tenders Law on the contrary that the EU directives have foreseen.

7. CONCLUSION: PPP MODEL IN TURKEY – ‘EXTREMENESS’

The presentation of the PPP model under the name of partnership is “an influential marketing strategy of the new right” for enabling the embrace of the new roles provided to the state and the market (Linder, 1999: 35, 40). It has been seen that with PPP which have been intensively implemented for many years in UK, the transfer of risk to the private sector has not occurred as claimed at the beginning of project (HM Treasury, 2012). According to Shaoul, when in fact the public services are in question, the notion of the transfer of risk is “essentially imperfect” (Shaoul, 2003). PPP hospitals are a project of industrialization of health on the basis of commercial areas which have high profitability. The direct support of the government for the private sector in the healthcare has increased with PPP projects. Therefore, it is possible to describe the model as ‘public money for private profit’. Considering its consequences of government guarantees and exemptions on one hand, and the consequences of access to the healthcare services, charges and cost increases on the other hand, PPP is the model of privatization of gains and profits, publicization of risks and costs (Karasu, 2011).

In Turkey, PPP is not solely finance, public procurement, or concession mechanisms. PPP projects are a new style of bureaucratisation which has a new division of labour, structure, control modes and employment conditions, and which has centralisation and flexibility features at the same time. This model which spreads swiftly in health sector is an organization model based on new public contracting system which embrace and convert the administrational relationships. In PPP model, the private companies are not only an organization that provides healthcare service or supplies goods and services with only a contractual relation. PPP model is also enabling private companies (the capital) to directly take part or get involved in the whole administration of healthcare process.

Various national and international organizations in the healthcare field have made intense opposition to PPP. Moreover, in UK which is the owner of the model, the failure of the model has been registered in many official reports. Despite of all these things, intensively implementing this model which entered
into the public organization in the form of the “Trojan Horse” (Miraftab: 2004) in Turkey, has shown that the policy for this preference does not have any tie with the healthcare service itself.

With around 19 different large scale PPP projects, tendered concurrently, the preference of organization in health services for the next 30 years has been determined by the current government. (Excessive centralization). But after the launching of the hospitals the awarded joint-venture will be in very powerful position with the privileges acknowledged by laws and contract terms. MoH, IHC hospital administration and other public organizations have very little decision and control on the activities of the joint-venture, or it is very costly (Excessive autonomy for SPV in operations). The en bloc transfer of a large number of functions to a single provider for a too long period will cause an excessive dependence. The large scale of the tenders cause to lack of competition and this leads to excessive centralization and concentration of capital, which brings the monopolization. And the large scale of PPP hospitals will naturally result in excessive bureaucratization. In brief, it is possible to express PPP implementations in Turkey in a word: “Extremeness”.

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