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Research Article

CITY HOSPITALS: THE LAST ATTIRE OF PRIVATISATION IN THE TURKISH HEALTH SYSTEM

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ABSTRACT
As the health system has been sharply undergoing a series of changes in Turkey and the rest of the world, critical political and economic arguments are required to assess the capitalist relationships that exist behind the scenes of such changes. In this respect, the Health Transformation Program, implemented by the Justice and Development Party (AKP) since 2003, will be the focal point of the study. This research will also examine how the Public-Private Partnership (PPP) model has been penetrating the health system while leading the transformation in the provision of public services. The latest example of the privatisation of healthcare is the City Hospitals built under the PPP model as part of the second phase of the Health Transformation Program. The study comprehensively explores the City Hospitals' legal, political, and economic context. The article, fundamentally, concluded that the City Hospitals continuing to be built by the Public-Private Partnership contracts do not mean the right to equal access to healthcare because these are the lucrative areas of investment and capital transfer for the contractor companies.

Keywords: Health Transformation Program, healthcare, neoliberalism, public-private partnership model, AKP

INTRODUCTION

The private service in healthcare had been confined to the private practice of doctors for many years in Turkey. In other words, the state limited the commodification, marketisation, privatisation, and financialisation of healthcare as health was considered to be one's social, economic, and human right. During this time, the state was responsible for both the provision of healthcare and medicine. Since the outset of the privatisation of healthcare began in core capitalist countries, particularly during the 1990s, healthcare has been drastically becoming the area of capital accumulation in periphery countries such as Turkey. The healthcare industry has been opened to investment with the suggestions of the World Bank (WB) and the International Monetary Fund (IMF). As a result, the hospital chains, the private polyclinics, and the private insurance companies have since emerged as a vast industry (Sönmez, 2017).

There are several discussions regarding privatisation in academic literature. Liberalisation is defined as the market penetration of more than one actor to provide service. Thus, the preferential right that consumers decide on anybody among different suppliers is significant for the rationality of the market. On the other hand, privatisation is explained as the transfer from the public to the private sector. It means that public entities and public wealth are assigned to the market. However, privatisation should be approached like two faces of the same coin, especially in social services that can be rarely marketed and competitive. This is because advocates of liberalisation and competition try different methods in areas such as health. Both often seek alternative methods to achieve similar effects. The healthcare sector stands out because it encompasses a wide variety of processes that imply a shift towards marketisation, including the promotion of vendor-recipient relationships and prices, the pricing and

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individualisation of risks, the adoption of preference, and even consumer behaviour. Further, as the healthcare administrative sector is also becoming privatised, the use of the public-private partnership (PPP) method is rising and boosting the number of private capitalists thanks to the privatisation of public entities. The common point of all these developments is that they contribute to making health markets, which predisposes to the commodification and commercialisation of healthcare services (Herman, 2010).

The privatisation in health is essentially realised in two ways. One of them is the production of services, and the other is the monetary aspect. The management of the hospital is the best concrete example in the production of services area. The primary healthcare services have not been able to survive as they have begun struggling with the rise of private entities in the last few years. On the other hand, the private insurance business has become a "finance option" that users have been adopting de facto with increased contribution (Belek, 2016).

Policymakers have been excessively willing to privatise healthcare due to the bias concerning the benefits of privatisation since the beginning of the neoliberal era. The governments have been directed by international institutions and capitalist actors within the significance of privatisation throughout various reports and suggestions. "Bias" here indicates that privatisation is a holy concept belonging to the free market rationality put forward by the liberal perspective.

Within this framework, the main goal of privatisation depends on increasing the movement area of the market in the context of health. The pharmaceutical industry and medical technology have already been traditionally under the private sector. In addition, with the Health Transformation Program put into practice by the Justice and Development Party (AKP) in 2003, the privatisation operation has been directly targeting medical care, hospital services, and the insurance sector for the last few years. It is widely believed that change and transition are based on two fundamental points. First is the financing of healthcare services, named the Public-Private Partnership model. The second is the provision of healthcare. In this article, the privatisation journey of the Turkish healthcare system will distinctly be emphasised in reference to the City Hospitals.

PUBLIC-PRIVATE PARTNERSHIP MODEL

The need for infrastructure services has been increasing worldwide. For population growth, urbanisation, and natural wear, more and more expenditures are made on infrastructure investments such as hospitals, airports, bridges, and roads, which pave the way for long-term economic growth. Therefore, a dilemma emerges out of the growth appetence of the neoliberal strategy that harms the environment and applauds the "sustainability" of the very same strategy (Konuralp, 2020).

While developing countries need to renew their outdated infrastructure investments, developed countries want to expand their infrastructure networks. A study conducted for PricewaterhouseCoopers states that the annual infrastructure investment expenditures, which reached 4 trillion USD worldwide in 2012, will exceed 9 trillion by 2025 (Abadie, 2014). Another consulting firm, McKinsey, predicts that in the 17 years between 2013 and 2030, 57 trillion US dollars will be needed to finance the infrastructure investments needed (Mc Kinsey & Company, 2013).

In order to meet such high resource needs for financing infrastructure investments, governments are increasingly turning to project finance from the private sector. Between 1998 and 2008,

there was a five-fold increase in private sector financing for infrastructure (Abadie, 2008). In 2010, a 4 billion USD Public-Private-Partnership agreement was signed in the health sector worldwide (Roehrich, Lewis, & George, 2014). When the sectoral distribution of public-private partnership projects implemented in the European Union (EU) countries in 2021 is examined, as shown in Figure 1, it is seen that 397 of 1799 projects are in the field of healthcare (EPEC, 2021).

Although so far PPP has been solely discussed in the neoliberal era and globalisation fact as a part of commercialisation and privatisation, notably since the 1990s, some instances can be evaluated as PPP in the history of the world. The beginning point of PPP can be regarded as the road construction projects in England in the 1660s based on the participation of the private sector. Especially after the industrial revolution, with the canal and railway projects, the implementation of the public-private partnership model reached the highest level in the 1860s; however, many investors have gone bankrupt with the economic crisis in Europe. In addition to the UK, the PPP model was also applied by the United States and France. Further, the Suez Canal Project, which the Governor of Egypt also supported, is evaluated as a product of public-private partnership (Boz, 2013).

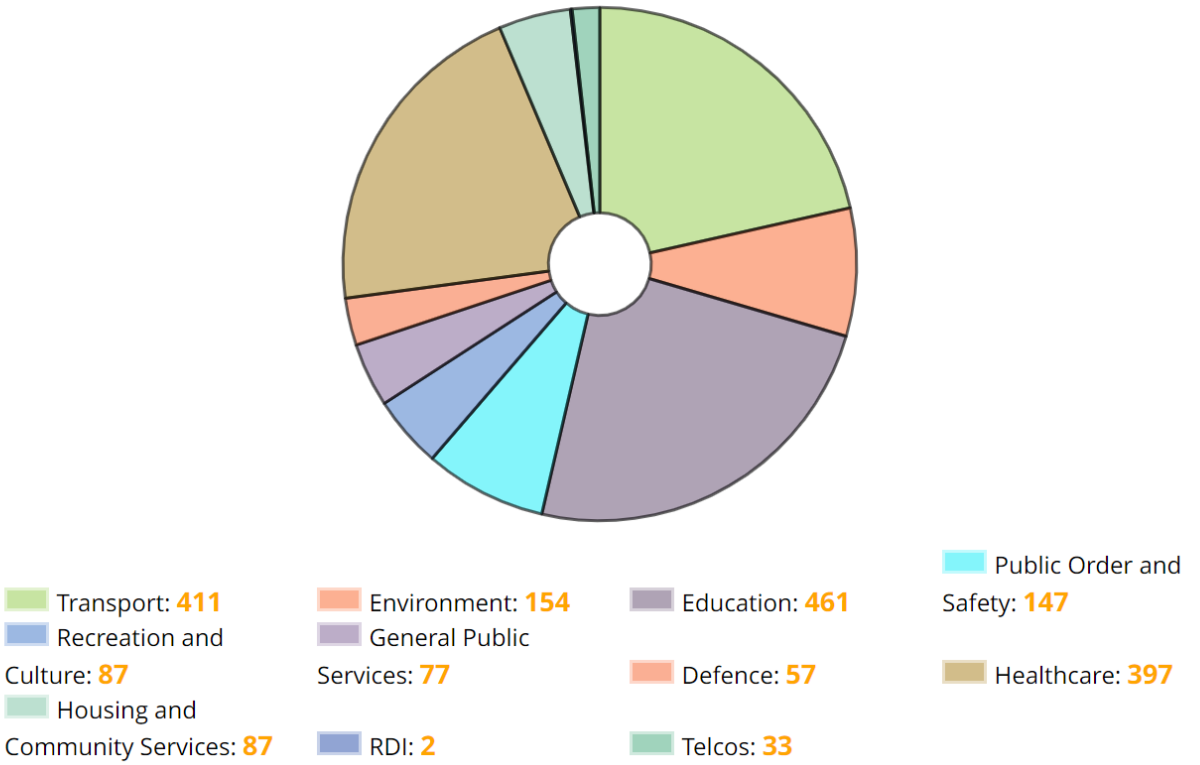

Figure 1. The Number of European PPP Projects by Sector.
Source: EPEC Data Portal (2021).

The involvement of the private sector in public services is the implementation of "joint venture" that have widely used, onwards early periods in America. The public-private partnerships were expanded owing to the "Private Finance Initiative" (PFI) initiated by John Mayor in 1992 in England and the "Best Value" projects in the Blair period (Yeşiltaş, 2020).

The public-private partnership model has no specific definition commonly held in international consensus. It can be generally defined as long-term contracts signed by cooperation between the state and private sectors (World Bank, 2014). The private sector has been undertaking risk

management and earning income in proportion to its service. The service remuneration is paid by the users and/or taxpayers – public enterprises/authority. For example, in the case of Turkey, the service remuneration of the City Hospitals, which are built by PPP contracts, is paid by the budget of the Ministry of Health (Emek, 2018). Even though "partnership" is new, similar models – such as the Build Operate Transfer, Cooperation between Public and Private in Turkey and Public Finance Initiative in England – have been implemented in various areas since the 1980s. The primary purpose is to invest in uncommercial areas; more specifically, privatisation is not only to sell public resources but also the transfer of public budget to private actors. PPP is just an instance of this.

A contract is considered a full contract if it can anticipate and differentiate all future developments. In such a case, the courts and/or third parties that will execute the contract can fully understand/interpret the provisions of the contract and the intentions of the parties. However, problems in PPP contracts arise from long-term and incomplete (complex) contracts written in the uncertainty of the future. Incomplete contracts may contain gaps, uncertainties and incomplete provisions; therefore, they must be revised during the implementation process, either through negotiations between the parties or by the courts (Baker & Krawiec, 2005).

Briefly, it can be as regarded as that the PPP regime is a form of privatisation. When we think of the health sector, the public authority delegates the management of a public hospital to a private company (franchising). The private company builds institutions according to the needs of the public. It also finances fixed capital investments. Thus, it takes over the management of this institution. The government guarantees to get services for a certain period on the condition that the ownership of the institution remains with the private company. This period is usually 30 years. The government takes back the ownership of the institution when the term expires. The private company builds the hospital, operates it for a certain period, and then transfers it back to the state. In other words, the private company builds the hospital, operates it, and gives it back at the end of its term in the contract (McKee, Edwards, & Atun, 2006).

The strategic rationale for choosing PPP contracts in healthcare is the access to private sector resources and cost savings. Although both privatisation transactions and PPP contracts aim to involve the private sector in delivering public services to increase efficiency, they are very different from each other. Private hospitals establish their relations with patients independently of the state. The government is responsible for regulating price, quality, and safety that concern patients. Apart from these, it does not undertake any risk of the project. In this framework, privatisation transactions are based on the "full contract" approach, which recognises those market imperfections that result from adverse selection and moral hazard problems (Emek, 2017).

However, the government, particularly the public treasury, has undertaken a liability based on rental allowance regarding hospitals built by private companies and payment concerning particular services provided by the private companies. Therefore, it is a different point of classical privatisation rituals that is holly for the free-market rules, by containing huge and long-term concessions and incentives, and at which point, it cannot be depicted as three partnerships between the citizens, state, and the private actors. This is because there are two actors in the frame of PPP – the rulers and the private companies. The rulers have been deciding how the public budget is used for the sake of private activities. Therefore, it also ought to be evaluated on reorganised of the capital and reproduction of the capital. More clearly, unique areas such as health that should be accessible to all have been opened up to investment opportunities in all aspects. This is not classical privatisation. Further, it is a more comprehensive privatisation attack on public healthcare services.

International institutions, such as the IMF, pay special attention to how the countries the PPP model has been vastly adopted influence the states' budget. This is why the IMF suggests that PPP should be limited to a particular point and period. The IMF, in its report published in 2016, underlines the adverse effects of such long-term contracts by giving examples across the globe:

> Large fiscal costs and fiscal risk have arisen from PPPs in both developing and advanced countries. Both traditional procurement and PPPs share common project risks, such as construction and demand risks. However, the above government bias and possible manipulation of PPPs add an important layer to the common project risks. An inadequate budgetary and/or statistical treatment may allow governments to ignore the impact of PPPs on public debt and deficit. In practice, governments often end up bearing more fiscal costs and risks than expected in the medium and longer term. (Jin & Rial, 2016)

The EU (2014) also draws attention to four points in its analysis of public-private partnership in health service delivery. (1) A measurement-based discussion is required in the PPP model. (2) It is considered whether the investor should bear more risk for future contracts without increasing costs and discouraging investments. (3) PPP contracts must consider the reality of increased health expenditures. (4) Requesting more government support for PPP projects is not a long-term solution.

In addition, as a result of the widespread and rapid development of PPP models, notably since the 1990s, the European Commission has worked on these models, and accordingly, in April 2004, it published *Green Paper on Public-Private Partnerships and Community Law on Public Contracts and Concessions*. The principles related to public contracts and concessions are determined in the study.

The EU commission emphasises the four main defining features of PPPs. Firstly, a planned project requires a long-term partnership relationship with a public partner and a private partner at different stages. Secondly, a project will be financed partly by the private sector, sometimes through complex arrangements between various actors. Thirdly, the significant role of the economic actor involved in the different stages of the project – design, construction, implementation, financing – has been mentioned. Within this context, the public partner should mainly focus on determining the targets to achieve public interest, the quality of public services provided by the other actor, and the price policy. Besides, the public partner should monitor the working process suitable for the targets. Fourthly, in the distribution of risks between the public partner and the private partner, the factor of shifting the risk from the public partner generally undertaking to the private partner is emphasised. However, while the private partner does not have to shoulder all the risk, or even most of the risk involved in the project, the decision on whom to bear the risk differs from project to project, based on the partners' agreement (Commission of the European Communities, 2004).

PPP has been a widely used method in healthcare globally since the late 1990s. In the UK, the private sector, one of the public-private partnership stakeholders, has been included in clinical services since 2003. It is the first step in this respect worldwide. Such public-private partnerships provide access to malaria vaccines in Africa, primary healthcare in Valencia, Spain, and cancer treatment in Germany. In 2011, Italy ranked third after Canada and the UK in the capital investment ranking to realise the projects with public-private partnerships in health services (Hamilton, Kachkynbaeva, Wachsmuth, & Masaki, 2012). Considering the public-private partnership practices of other countries, the reasons why stakeholders prefer them in the provision of health services, for example, in Pakistan's Sindh province, were evaluated as corruption in existing public hospitals, lack of responsibility in public services, poor inspections causing inefficiency, and public-private partnership arrangements providing

better service delivery in existing primary health care units. In addition, it was stated that the main obstacle in front of public-private partnership practices is the resistance of health personnel (Khan & Puthussery, 2019).

Moreover, there are differences between countries in experience, use, and national government support for public-private partnerships. It is seen that professionals in Canada adopt the idea of performance-based management of the public-private partnership, Dutch professionals value close cooperation with the private sector stakeholder, and Danish professionals attach more importance to the management freedom of the private sector stakeholder (Warsen, Greve, Klijn, Koppenjan, & Siemiatycki, 2020).

Despite its proven weaknesses in other countries, "in Turkey, the 'public-private partnership' model, named as *City Hospitals*, was proposed as a version of the build-operate-transfer model in which the building and maintenance of healthcare facilities are done through private investment in return for service and usage charges during the term of the contract" (Konuralp, 2021, p. 662). In this respect, along with transportation and energy investments, healthcare is a significant area that the PPPs concentrate (The Presidency of the Republic of Turkey Directorate of Strategy and Budget, 2021).

In this context, as the second phase of the Health Transformation Program, City Hospitals has been constructed throughout PPP. The Public-Private Partnership is mainly based on a long-term contractual relationship of the government with a group of companies, as mentioned. The subject of the contract is the construction of the health facility to be provided with healthcare services by private companies and leased out to the state. Thus, the scope of public service is also narrowed. The government is only responsible for core services at these facilities. The private sector provides the rest of the services and profits from it. The treasury lands on which the facilities were built are allocated free of charge. In other words, one of the partners, the state, uses taxes to pay the "rent" to the other. Therefore, this situation should be considered a resource transfer rather than a partnership. Besides, the scope of core service is so narrow that the private activity in City Hospitals is too broad (Erbaş, 2021). It is seen that the primary goal of City Hospitals built with Public-Private Partnership is profit maximisation when their focus really should be towards providing first-rate healthcare services. This is because "commercial area revenues" such as medical support and support services in the hospital are left to private companies. Companies will be paid for all these, including the rental fee, for 25 years. Moreover, a 70% bed occupancy rate guarantee is given to the companies that won the tender. In other words, if the beds are not filled, payment will be made from the public budget for the bed that the 'customer' does not use. It clearly means that the citizens in the social state are being treated as "consumers" even in healthcare. A neoliberal citizenship regime is not a case in this study; however, it should be studied from the perspective of transforming citizenship. In addition to all these, despite the use of public resources, the tender details are not disclosed to the public on the grounds of a "trade secret" in Turkey (Pala, 2018).

As the IMF emphasised, the high costs are hidden in Turkey's City Hospitals context. In the case of Bilkent City Hospital, additional costs emerged from The Analysis of Value for Money stated by the Ministry of Health. In addition, the government assumes the exchange rate risk as the rental fees are based on the exchange rate. Thereby increasing costs even further in the long-term (Pala, 2017).

Public authorities defend City Hospitals by marketing them as a way of increasing the capacity of hospitals. However, it seems that public hospitals have been closing as the implementation of City Hospitals is on the rise. In reality, the capacity of hospitals and their number of beds

has not been increasing. According to the report belonging to 2U1K Engineering and Consultancy Company, to build the Etlik and Bilkent City Hospitals, twelve Public Hospitals are planned to be closed in Ankara (2U 1K Mühendislik ve Danışmanlık A.Ş., 2014). Six of them have been closed by 2021, just in Ankara. Despite this, Turkey has been widely choosing to make Public-Private Partnership contracts to construct City Hospitals.

CITY HOSPITALS OF TURKEY

The first regulation to allow public health facilities to be built for rental purposes was through the addition of an article to the Health Services Basic Law in 2005 enacted by the Motherland Party (ANAP) government in 1987. In addition, owing to the regulations in 2006 and 2013, the scope of the lease agreements was determined in detail. According to the regulations, the treasury land will be transferred free of charge to the companies that receive the tender. The building will be built for rent. Rent payments will also be covered by the revolving fund of the state hospitals that will be moved to the buildings. A treasury guarantee is given if the Revolving Fund cannot make payments. The contract period is up to 49 years (Yılmaz, 2017). Besides, businesses which are worked and constructed under Public-Private Partnership contracts are also exempt from Stamp Duty.

Although comprehensive regulations such as the road to public-private partnership regarding privatisation took place during the AKP era, similar arrangements were also made by the previous coalition government of the Democratic Left Party (DSP), Nationalist Movement Party (MHP), and Motherland Party (ANAP). The concept of privatisation was entered into the Turkish Constitution as an article title first time in this period. That is why these regulations are prototypes of privatisation (Erbaş, 2021).

Two constitutional amendments were discussed in the Grand National Assembly of Turkey (TBMM) in August 1999. One was related to human rights, and the other was regarding preparing the infrastructure of the public-private partnership financing model. On 13 August, a four-item proposal package was approved by the overwhelming majority of the deputies in the TBMM. The owners of the proposals were Bulent Ecevit, Devlet Bahceli and Mesut Yilmaz. It shows that Turkish political actors coming from left to right were on the same page concerning privatisation (Erbaş, 2021)

The most significant point is that these concession agreements are accepted to be subject to Private Law Provisions. Moreover, the way to international arbitration opens. More vividly, within this context, it should be noted that what dominates in case of disagreement is the contract itself, not the legislation in the Anglo-Saxon law. In other words, the ruler is only the contract (Çal, 2018). In addition to international arbitration, the phrase which was “the case has to be heard in Turkey” contained by Article 3 of Law No. 6639, which the Grand National Assembly of Turkey (TBMM) accepted on 27 March 2015, has been removed from the text of the article. Thus, in case of any dispute, national court decisions to protect the national interest are blocked.

Within this context, the process of privatisation and commercialisation in health has started to gain momentum in the era of the AKP, which inherited regulations of the previous coalition government. First and foremost, the AKP declared Health Transformation Program after it won the general elections in November 2002, and immediately after, the tender of the City Hospitals started to make as the second phase of the program. In other words, it is a road to commercialisation and comprehensive privatisation of health. The private actors start enjoying profits in the field of healthcare.

Within this framework, private activity has been expanded from construction to business for the long term. The commercial area revenues in the City Hospitals that the private actors construct belong to the company. During the contract period, the companies will make payments in the form of utilisation fees and service fees. The utilisation fee includes maintenance/repair and rental fees. The service fee includes medical support services. It is expected that hospitals' revolving funds will cover these costs. However, it is a question mark whether they can pay these costs as they are very high. For example, a total of 3 billion and 443 million TL will be paid for the Kayseri City Hospital in 25 years (Turkish Medical Association). However, the tender for Erzurum City Hospital (1200 bed capacity) has ended with 193 million TL. The estimated cost is 260 million TL. In other words, Erzurum City Hospital, with 1200 beds, can be built with the 1.5-year rental price of Kayseri. In other words, it is seen that there is no classical and central tender method. This clearly shows the extent of the capital transfer and the inefficient use of public resources (Pala, 2018).

Another critical issue regarding City Hospitals is the number of beds. The number of beds in hospitals is an essential indicator of efficiency. In general, the number of beds is ideal for efficiency between 100 and 600. The work of researchers such as Roh, Moon and Jung shows that a 126-250 bed capacity is more efficient in the USA (Roh, Moon, & Jung, 2013). In Denmark, the most suitable bed capacity for public hospitals was found to be 275 (Kristensen, Olsen, Kilsmarkand, & Pedersen, 2008). These studies clearly show that the high number of beds in City Hospitals is an example of inefficiency. However, unexpected changes in the healthcare landscape will require re-evaluating the current systems in place. This is evident especially during these times with the worldwide COVID-19 pandemic. Clearly, there is a doubt to this as the Ankara Numune Hospital and Dışkapı Child Hospital were forced to re-open after the start of the COVID-19 pandemic.

The efficiency indicator is the average bed capacity and the bed occupancy rate. The ideal proportion of utilisation concerning bed capacity is regarded as 85%. The utilisation rate under 85% means that the number of beds is unnecessary. A higher number of unused beds results in higher costs for the hospital due to revenue loss, the maintenance of these beds, the cost of the closed space for beds, housekeeping of the closed space, and staff. It is not preferred that the rate of bed utilisation is over 85% as well, due to the fact that empty beds have to be ready in the case of an emergency. Besides, the rate of bed utilisation over 85% leads to an increase of infection. The Ministry of Health of the USA recommends that bed occupancy is over %70. It mentions that if the rate is under %60, it suggests low efficiency (Marzieh Marahem, 2018).

It is clear that the rate of efficient capacity utilisation ought to be at least 70%. We can not speak to the bed occupancy rate hereafter; however, we have data from 2020 during the COVID-19 pandemic. According to the data presented by the Minister of Health, Fahrettin Koca, the bed occupancy was 51% throughout Turkey in 2020 (Anadolu Agency, 2020). He actually highlighted that the bed occupancy is adequate to struggle against the Covid19. We do not know precisely the bed occupancy statistics for all City Hospitals. However, considering that the city hospital's occupancy across Turkey has an overwhelming number of beds, we can determine that overall the City Hospitals are inefficient and could benefit from downsizing or perhaps reallocation.

The rate of bed occupancy has already been low in Turkey. In addition, even if the rate of bed occupancy in private hospitals in Turkey has been increasing in years, it has always been low, even during a global pandemic. In other words, the beds in hospitals in Turkey are not used efficiently. Figure 2 shows the numbers up to 2019 since 2020 and 2021 are not publicly declared. However, Figure 2 does not give the exact picture of the private hospitals since City

Hospitals are included in the public hospital category built under the Ministry of Health's name. This is because the private actors construct the City Hospitals and borrow them in the name of the public. Therefore, it seems that bed occupancy is also under 70% in City Hospitals. The details of the contracts of the City Hospitals are not available publicly due to trade secrets, but we know that the contractors are guaranteed a 70%-bed occupancy (Pala, 2018). In addition to the high costs associated with the implementation of City Hospitals, the expenses are further increased as the contractors are paid for any unused bed occupancy under the 70% threshold. Evidently, healthcare has been a lucrative instrument to accumulate capital, thanks to City Hospitals.

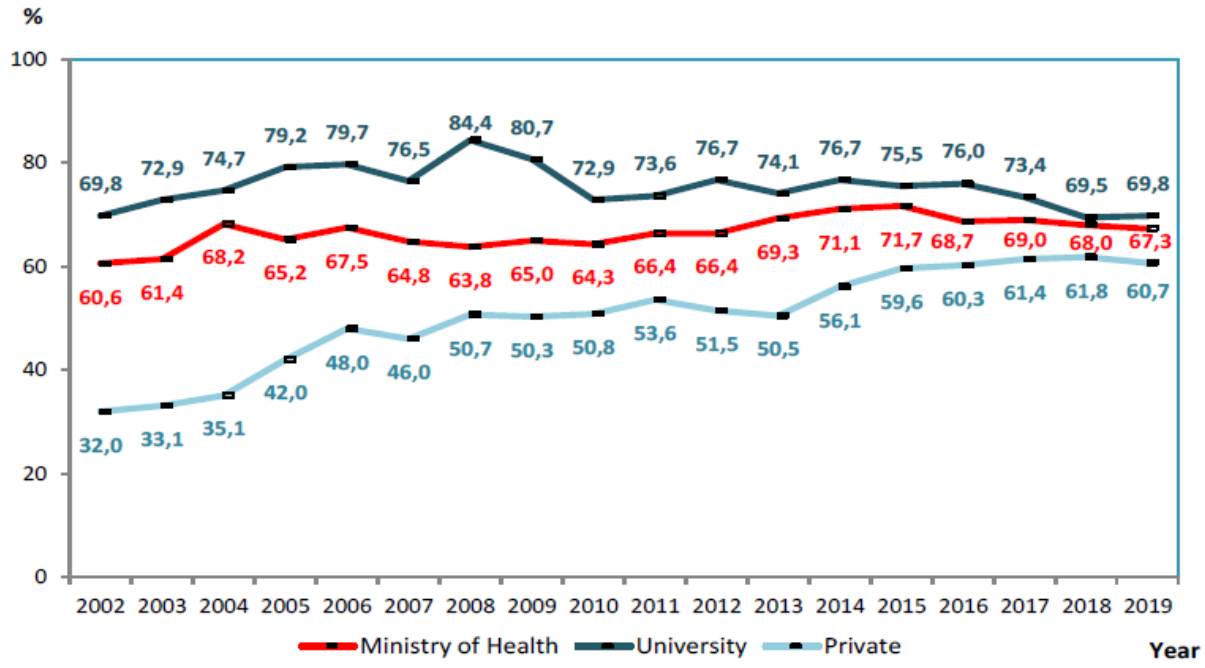

Figure 2. Bed Occupancy Rates by Years and Sectors, (%).
Source: The Republic of Turkey the Ministry of Health (2019).

Moreover, the contracts of the City Hospitals are signed over the dollar rate. In other words, an increase in the exchange rate leads to an increase in costs. For this reason, the Ministry of Health has to make additional payments every year (Pala, 2018). It shows vividly that the debts will be increasing every year. The audit report of the Court of Accounts in September 2019 conveys that the administration has made the public budget a commitment for the sake of creditors. The Court of Accounts says clearly that the state budget regarding City Hospitals contracts has been shouldering the lion shares of the cost.

What is more, this is unauthorised. Since the public-private partnership's accounting records related to City Hospital contracts cannot be reached, there is no transparency, and the public interest has been eradicated as a result (The Court of Accounts, 2019). The people in a tax-paying democratic society should have access to the public budget and be able to see what exactly their collective funds are being allocated.

As shown in Table 1, City Hospitals' contracts have been signed and constructed since 2009. Thirteen City Hospitals have been completed to build and come into service in thirteen different cities across Turkey. These are respectively Adana City Hospital, Mersin City Hospital, Isparta City Hospital, Yozgat City Hospitals, Kayseri City Hospital, Manisa City Hospital, Elazığ City Hospital, Ankara Bilkent City Hospital, Eskişehir City Hospital, Bursa City Hospital, Istanbul

Başakşehir Çam ve Sakura City Hospital, Konya Karatay City Hospital, Tekirdağ City Hospital. These City Hospitals have different bed capacities. The highest bed capacity is 3711 in Ankara Bilkent City Hospital. The lowest bed capacity is 475 in Yozgat City Hospital. Furthermore, it is expected that five more City Hospitals will be completed and coming into service by the end of 2021. These are Kocaeli City Hospital, Kütahya City Hospital, Ankara Etlik City Hospital, Gaziantep City Hospital and İzmir Bayraklı City Hospital. Considering the rising annual rent of City Hospitals and the total number of City Hospitals, the financial burden is apparent and will show an upward trend due to incentives and guarantees in the framework of public-private partnerships. Therefore, the number of new hospitals does not only represent abundance, wealth, and accomplishment of the administration but also prompts a disproportionate amount of financial destroy. In addition, each put into service City Hospital means more financial liability. In order to pay for these expenses, it is the potential of the close of public hospitals like in the example of Ankara. The fact that we do not know contracts' contents supports that argument. The City Hospitals are already not a public investment that is done by classical method. Therefore, the tangible situation that the public is renter cannot be regarded as a public investment.

Table 1. The City Hospitals in Turkey.

No	The Project Name	Bed Capacity	Targeted Date	Expiration
1	Adana City Hospital	1550	on service	
2	Mersin City Hospital	1294	on service	
3	Isparta City Hospital	755	on service	
4	Yozgat City Hospital	475	on service	
5	Kayseri City Hospital	1607	on service	
6	Manisa City Hospital	558	on service	
7	Elazığ City Hospital	1038	on service	
8	Ankara Bilkent City Hospital	3711	on service	
9	Eskişehir City Hospital	1081	on service	
10	Bursa City Hospital	1355	on service	
11	İstanbul Başakşehir Çam ve Sakura City Hospital	2682	on service	
12	Konya Karatay City Hospital	1250	on service	
13	Tekirdağ City Hospital	486	on service	
14	Kocaeli City Hospital	1210	2021	
15	Kütahya City Hospital	610	2021	
16	Ankara Etlik City Hospital	3624	2021	
17	Gaziantep City Hospital	1875	2021	
18	İzmir Bayraklı City Hospital	2060	2021	

Source: The Republic of Turkey the Ministry of Health (2021).

Even if the market activity has increased, it might not always threaten publicness. This is because the public purpose has been realised. In other words, even though the market desires its benefit, private institutions follow the public purpose and contribute to the public outcomes in that way. This is what another publicness is. At that point, the Turkish Healthcare System has important and interesting content in the regulatory environment. This is because the private activity has been sharply increasing while enforcing a comprehensive health insurance program included under the Health Transformation Program. Policymakers created a mixed provision for healthcare services, and thereupon, an internal market that is created works for its own profit maximisation (Yılmaz, 2020). Thus, the capital transfer from the public budget to the market has been realised.

Therefore, the City Hospitals model is a significant part of the capital transfer. The public purpose still exists thematically; however, the organisation that provides services and keeps its benefits has been private companies. We can see in the interview of policymakers publicly. The discourse has always been based on their service for the citizens. In reality, the fact is that the money that the private companies have been earning is enormous thanks to the Public-Private Partnership model. This situation is called a "hybrid system" (Yılmaz, 2020), and in the Turkish context, it results in destroying social citizenship in the framework of the regulatory environment because the understanding of public service has been drastically decreasing.

Invaluable things such as health must not be regarded as the subject of the market. The acceleration always slips for the sake of the market, as had been seen hitherto. Briefly, private activity does not ally with welfare according to nature. At least in Turkey's case, publicness environment and the balance of the focus between public and private has not been possible.

CONCLUSION

Healthcare is a vast sector, and thus it attracts the capitalists' attention to invest and accumulate capital. This article analysed the Turkish healthcare sector by looking at the PPP model.

Within this context, the first focus was on the financing of healthcare. Financing of health services and the share of health expenditures in the level of economic development of countries are discussed in every country and are among the most critical issues on the agenda of those who determine health policies. Whatever financing and delivery methods are adopted, the primary purpose should be the equitable and efficient delivery of health services in every country at an acceptable level of quality and access. For this reason, the increase in service use and health expenditures should not be considered as issues that should be put under pressure. However, if the increase in both issues occurs due to unnecessary use and inefficient use of resources, then the reimbursement mechanism has to take the necessary precautions for social benefit.

Secondly, the Health Transformation Program in Turkey was historically and economically examined. The Health Transformation Program includes a comprehensive neoliberal transformation from the delivery of health care to its finance. In this context, the main emphasis is that the Health Transformation Program means privatisation of health in Turkey.

On the contrary, Health Transformation Program had, at the same time, led to the expansion the access to health because of the fact that it destroyed the four-layer health and social security system in Turkey, such as the Social Security Fund (SSK), The Social Security Organization for Artisans and Self-Employed (BAĞ-KUR), The Retirement Fund of Civil Servants (Emekli Sandığı) and Green Card for poor people. That fragmented structure regarding access to health is united by Justice and Development Party thanks to the Health Transformation Program, and it has given rise to an equal package to all citizens called Social Security Institution (SGK). Thus, all the people now have to register the system and pay premiums to the SGK. As a result, the overwhelming majority of Turkish people have been covered by public health insurance. The scope of the system increased, and thereupon the government attracted the political interest of the poor people in the 2000s. In addition, the program has brought about that public expenses increased. In other words, public healthcare has expanded in an equal context (Dorlach, 2016).

Dichotomously and paralleled by it, private health financing has increased thanks to increased access to private health care providers. However, the scope regarding private health care is not equivalent for all citizens. The SGK does not pay for all services in private hospitals. This

means that getting higher quality health care requires spending money out of pocket and the ability to do so varies drastically across different levels of income. Even though the new system implemented by the Health Transformation Program is more accessible than it used to, with the increase in the number of private hospitals, health has become less accessible for the population that can not afford it.

Within this context, Dorlach explains that dualistic structure is a concept of "social neoliberalism" (Dorlach, 2016). That is the point of success of the AKP. To be clear, on the one hand, the AKP governments have been drastically pursuing a market-driven economy policy. On the other hand, they have been pursuing an egalitarian policy in productive areas such as health, education, etc.

Public-private partnership liquidates traditional public service production models where public projects are financed from taxes and services are performed by public officials. It establishes a long-term (up to 49 years) contractual relationship between the public and private sectors by linking public planning capabilities covering large-scale, integrated projects. It is an investment, service, and partnership system for the financing, construction, renewal, operation, and maintenance of infrastructure facilities and the provision of services. According to this system, hospitals that will provide public services will be built by private companies and leased to the state, and the state will both pay rent to companies and transfer services other than "core service" to be provided in this facility to these funds/companies.

The most striking aspect of the city hospital system is the high cost of hospital buildings and equipment to the public in terms of country resources. These operating companies, which have many privileges, will be exempt from VAT, stamp duty, and all fees. In other words, there will be tax loss as well on top of the rental obligation of the state. A full treasury guarantee is also given to the international loans companies take from abroad for financing. Suppose the company does not pay its loan debt, the state guarantees.

The bill of approximately 45,000 beds, and therefore the disruptions in the system, will go to the treasury; that is, new costs and taxes will be imposed on the public. Ultimately, the public will pay the actual high costs of City Hospitals. The need for modern public hospitals is an undeniable reality.

However, there are serious concerns about the need, demand and capacity planning while City Hospitals are being implemented. The experience of City Hospitals implemented in the UK and Canada in the past years has shown that such large hospital projects are both inefficient and difficult to manage. This model has been abandoned (Pala, 2018). However, The City Hospitals made by the PPP model have been built and seem to be continuing to be built in Turkey.

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