APPROACH TO PUBLIC PRIVATE PARTNERSHIPS APPLICATIONS IN THE PROVISION OF HEALTH CARE SERVİCES: SURVEY OF UŞAK CITY[1]

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ABSTRACT

Due to their characteristics, health care services can be funded and provided in public and private economy. Providing them mostly in public economy due to its positive externalities can cause heavy pressures on public financing balances. In order to minimize public financing problems caused by health care services and taking the advantages of administrative and financial superiorities of private sector the tendency for the privatization of health care services is gradually increasing. Recently PPP applications, one of the privatization models, have been observed to be used commonly in health sector. At that point the objective of the study is defined as to identify the perspectives of public sector employees and health service beneficiaries about PPP applications. In the context of this purpose how PPP applications are perceived in Uşak city is researched by presenting the working principles of PPP models specific to health sector.

Within the scope of analyses the perception about the expectations from PPP applications in health sector is identified first. According to analysis results it was observed that health sector employees and health service beneficiaries do not have enough information about PPP applications and they are uncertain about whether they will provide the expected benefits or not.

Keywords: *Health Care Services, Public Goods, Public Private Partnerships (PPP)*

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1. INTRODUCTION

With one of its aspect health is a private but with another one it is a public goods. Health's private goods character is derived from its feature to be able to individualize the provision and finance of health service. Therefore, the necessary goods and services for the provision of health care services can generally be supplied from the market and the benefit and cost of the service can be charged to beneficiary of the service.

However, health care service being versatile as therapeutic and preventive has significant externalities. For instance, a good public health contributes to preventing job losses by increasing labor productivity. On the other hand, if the epidemic health problems are not prevented, incurring negative externalities can affect all of the world with its border excessing qualities. These negative externalities of health service cause this service to gain public quality (Binhan and Yaraşır, 2011:4). For instance, as in the examples of cholera in Peru in1991, plague in India in 1994 and Chile in 1995, ebola in Zaire and Gabon in 1996and Asian flu in Hong Kong and China in 1998, the fact that several epidemic diseases come up and spread out mostly in less developed countries requires a seek for solution and resource allocation in international scale to reduce these externalities (Ayşegül, 2006:54-55).If the provision and financing of health care services with private and public goods qualities can not be well planned and coordinated, effective service provision will grow difficult. When the international externalities are also considered, this problem becomes more important. About the health regarding as a global public goods several policies are tried to be established for the crises and problems that may happen in the future. A commonly accepted idea at that point is that provision and financing require a cooperation and financing ranging from the local to international scale (Kauland, 2001:869; Ener and Demircan, 2008:57-82).

For the solution of production, organization and financing problems caused by the specially expressed uncertainities in health care services, by determining health risks at each level from local to global information networks should be established and appropriate regulations and common policies should be identified for all sectors concerning health. To meet these requirements states are charged with important missions with "sovereignty responsibility" approach at national level (Selen, 2008:119). Sovereignty responsibility is the requirement of the countries to use the political sovereignty sensitively for their citizens at home and for the international community abroad. In this context, a health policy which will be prepared with sovereignty responsibility approach is expected to have the following features (Bloom,1998). These features are:

i. **To provide a qualified health service:** This objective is the headstone of building an effective health system. Public and private service providers provide services with different motivations. These motivations affect the externalities of health and the quality of the service. Reducing the negative externalities, increasing the positive externalities and improving the service quality should be the policy objectives.

ii. **To ensure benefiting treatment services equally:** The existence of income inequalityand private health service providers to make individuals healthier prevents people to benefit from all treatment types equally. Policies should consider the income inequality and have the quality to avoid discriminatory practices of private sector.

iii. **To provide effective health care services:** This objective is of vital importance. Because resource shortage for all countries causes the health expenses to be limited with budgetary means. Moreover, (here) the fact that public and private sector acts by different motivations and limitations causes a tendency to different resource allocations and differentiate in benefits and costs obtained from the health. To minimize this differentiation should be the main policy objective.

iv. **To make sustainable the financing of health care services:** Short term solutions create new problems in long term. For instance, policy makers offer the public financing of health care services with the political realities but this situation brings resource usage over the capacity with it. Determination of theoptimal service supply and financing in health care services is one of the main problems in terms of public economy and private sector. Providing sustainability of health service financing increases the service qualities of both sides and enables each two sectors to work complementarily. For that reason,the policies to provide sustainability of health service financing are needed.

Social needs in an economic structure can be fulfilled by the provision of goods according to their qualities in private sector and/or public economy. The goods with these features are generally provided and/or funded within public economy. Within the public economy, the provision and financing of the goods subject to natural monopoly and quasi market and full public goods are provided. As well as being private goods in economic sense due to their market failure, the goods subject to natural monopoly and quasi marketare included in public economy. *The fact that only one firm operates in the market in the fields of natural monopolies where minimizind average cost needs a large-scale production to will provide the efficiencyin economic sense.Since preventive health care services especially require large-scale investment health care services are accepted to be provided largely in public economy.* The goods subject to quasi marketalso have private goods qualifications and their provision happens in public economy due to their externalities and their financing is generally provided by the beneficiaries. In this composition, because of having the qualifications of both the public and private goods, health care services find the provision and financing opportunitiy in private sector and/or public economy. Table 1 presents a useful frame in understanding the roles of public and private sector in the provision and financing of health care services.

When Table 1 is analyzed, we can observe that the provision and financing of health care services change depending on the service quality. While preventive health care services like vaccination are implemented in public economy as a whole, individual treatment services can be provided by the private sector as a whole. Also another factor that determines the supply and provision of health care services is the political preferences. Political preferences enable the services to be produced by both public and private sectors together as in 2nd and 3rd regions. By remarking that effective and sustainable provision of common goods with management gap would be possible by PPP (Public Private Partnership) organization, Pattberg et all. emphasize that provision and financing of health care serviceswould also be implemented with public and private partnership.

The preferences concerning the provision and financing of the goods subject to quasi markets are observed to shift through the private sector as the domestic income increases.

While health expenses are mostly regarded as social expenses in societies with high domestic income, the provision of health care services is also observed to be privatized. In health sector, it is stated that privatization tends to be the privitization in financing proper to "beneficiaries pay" principle rather than the privatization in the planning, coordination and provision of health care services (Hanson and Berman, 1998:203). However, Murrey et allstudied the relationship between domestic income and public health expenditures in total health expenses through section analysis and as a result they indicated that if the domestic income increases, public sector share in total health expenses increases as well. This effect is derived from the fact that social insurance systems especially for the developing countries that are being provided by the public control and management (Hanson and Berman, 1998:201). For instance, social insurance service in Turkey is produced in public economy, soprivate health insurance system has also a developing market structure. In order to reduce the social insurance expenditures that increasethe public financing burden, todayin accordance with "*beneficiaries pay principle*" is commonly accepted. the tendency of privatization of health care services financing.

Table 1. Provision and Financing of Health care services

		Provision	
		Public	***Private***
Financing	**Public**	Financing and free provision by public in terms of use: National Health Service.(I)	Private sector provision depending on contract (II)
	Private	Direct support of user costs; special bed use in public hospitals. (III)	Direct charging or private treatment services by health insurance. (IV)

Source: Bloom, David E. (1998), *Public and Private Roles in Providing and Financing Reproductive Health Care,* Harvard Institute for International Development Harvard University, http://info.worldbank.org/etools/docs/library/48538/pubpri.pdf

Studies investigating the relationship between the domestic income and the share of private sector in health care services sector indicate that private sector is positively sensitive to the domestic income changes. According to a study results conducted by Hanson and Berman (1998) when the domestic income increases 10 %, the number of doctors working in private sector per one million people increases at 16.4 %. On the contrary, the number of doctors employed in public economy increases 9 % despite the same increase in income. These results indicate that there exists a substitution effect between public and private sector in terms of labour employed in health sector. On the other hand, in terms of total bed capacities they present that there exists a complementary relationship between public and private bed capacity(Hanson and Berman,1998:206).

As the domestic income increases, the expense amount for private doctors increases more and more and private health service can be assumed as a luxurious goods. However, the share of expenses to public health care services remains stable as the domestic income increases. Similarly, it can be observedthat private sector increases its revenue-generating bed availability faster than domestic income. While a 10 % of increase in domestic income is observed, bed availability increases to 11% level. However, increase of non-profit bed availabilities being slower than increase of domestic income harms this result. Therefore, the increase in total bed capacity takes place slower than the increase in domestic income (Hanson and Berman,1998:201).

These results show that the factor affecting health service demand is the health service perception of the society. As the education and consciousness level of the society increase a linear relationship between income and health expenses is observed (Murray et all, 1994:631). The increase in total health expenses in developed market economies can be explained as high health perception in those societies.

The relationship between health expenses and income can not be explained without considering the role of public economy in public financing of health expenses. Health expenses in public economy are affected by "health service demand", "health service perception" and at the same time " objective requirements" of the society. These three factors increase the need of health care services to be funded by public economy. While this situation causes the total public expenses to increase rapidly, the increasing role of the state about the financing of health care services is also tried to be limited with the economic growth rate.

Hanson and Berman (1998:203) state that while health expenses are rather regarded as social expenditures as the domestic income increases, the provision of health care services becomes more privatized. This is a significant determination. Although many developing countries take care of the policies provide public contribution to health care services financing, they do not attribute much imporance to the development of the provision of health care services by the private sector.

As well as the traditional provision methods PPP methods are used in order to increase the efficiency of the provision and financing of health care services which can be conducted by the public and private sector. In general PPP means " performing the investments and services via sharing project oriented costs, risks and revenues between public and private sectors depending on a contract." The most significant feature separating this method from the classical methods is that the cooperation with the private sector goes on not only in business stage but also in building stage and the formation of private sector building and business synergy.

While the mentality of the production of public services and some goods by the public is dominant in traditional mentality, participation of private sector to these activities has been accelarating recently. Private sector can participate in these activities in several forms. These applications which the private sector supports the goods and service production of the public by several methods are called PPP (Iossa and Martımort,2015:6). PPP is defined as the long term contracts of the centralized and local admistritive institutions with private sector service providers in the provision of some services. In this contract private sector takes the responsibility of the establishment of infrastructure investments, the provision of the financing of the investmentand the maintenance and management of facilities. According to Iossa and Martımort (2015) PPP applications depend on three factors. These are the definition of liabilities, risk transfers and long-term contracts.

i. *Assuming Liabilities:* PPPs typically define performing the operation of organization, financing and project within the cooperation with the private sector. Cooperation is responsible for the establisment of the firm that will deal with all aspects of the service and the management of the facility. Leaving the properties belonging to business infrastructure to public or private sector is in the question at the end of the contract.

ii. *Transfer of the risks:* When compared with the traditional supply methods, PPP enables to define the risks and responsibilities in a contract more clearly. A system

that defines the outputs are used. The government identifies the services and main standards, but the responsibility and control right are left to the cooperation concerning how the required standards and distribution of the services areperformed. With this construction establisment and operational risks are mostly transfered to the private sector.

iii. *Long-Term Contract:* A PPP is a long-term contract extending to 20-35 years. The payments to the private sector for the benefit from the service are made by the state (as in private finance enterprises) or (as in rather concession agreements) the beneficiaries. The potential problem about long-term contracts is the possibility of a change in long-term demand structure. Realization of this possibility will lead an obligation for the state to make under or over payment for a service with reducing demand.

By OECD PPP is defined as the regulations for the provision and financing of public services by using a fixed capital (OECD, 2012:3). These regulations include the project risk sharing between parties and binding the private sector services for public purposes harmonized for profit to a long-term contract between public and private sectors. The World Bank Institute (2012) defines PPP as the regulations which provide technical, administritive and financial resources of private sector to be transfered to the fields of main public services such as infrastructure, health and education. World Health Organization (WHO) evaluates PPPs as the development of health care services in the axis of commonly determined purposes and principles in health sector within the cooperation of a group of agents (Kickbusch and Quick,1998.p.69).

PPPs are one of the applications used for reducing the size of the state in economy through the applications such as outsourcing, deregulation and privatization. PPP models used traditionally in services such as transportation, energy and water are commonly used today in the fields such as waste management, education, health, jails, security, accomodation and information technologies.

PPP applications in EU began in England in 1992 as private finance enterprises. Until 2009 about 800 private finance projects with the value of 64 Billion EURO were signed. They also started to be commonly used in other EU countries and 1300 PPP contracts with the value of 250 billion were signed in 1990-2009 period. However, in the USA PPP is observed to be commonly used in highway and railway transport sectors, management of water resources and waste water treatment projects. Among the developing countries India attracts attention as the largest market in PPP field.

PPPs have been gradually growing in EU, Canada, the USA and in other developed countries as the applications used for increasing the private sector enterprises in the provision of public services. Iossa and Martımort (2015) consider the high conversion costsand unrealistic demand predictions as the factors affecting the success of PPP applications.

PPPs are regarded suitable for moving sectors. Especially in England performance failures were observed in PPP applications in information technologies. Current evidence show that PPP applications are commonly implemented as regulations in world scale.

In the establishment of PPP whether the sector is substituent or complementary is determinant. Whether public and private sectors are substituent or complementary was

considered in terms of education sector in literature. According to this, the size of private school sector was observed to be a function of quality perception of education service by the state and the opportunities to benefit from these services (James,1993). However, in health sector it was identified that there exists a substituent relationship in terms of the staff working in public and private sectors and a complementary one between bed availabilities (Hanson and Berman,1998:206). Depending on the income level in health sector, the share of private sector supply recedes compared to the share of the public sector. It indicates that employees in health sector have a significant and negative effect on public sector supply. This result indicates that there exists a subtituent relationship between public and private sectors in terms of health sector employees. Similar results were also obtained in a second model where the share of private sector employees is considered as the decrease in the number of public sector employees in total health sector employees (Hanson and Berman,1998:206).

Some of the examples of PPP applications implemented in Turkey are Build-Operate-Transfer, Transfer of Operational Rights and Build-Hire models. The first application of PPPs in Turkey were the Build-Operate-Transfer, Transfer of Operational Rights and Build-Operate models implemented in the field of electricity generation in 1984. Through these models it can be said that Turkey had a significant experience with studies in the field of infrastructure service productions by the private sector, such as, airport constructions, tunnel constructions as well as electricity generation. In Turkey totally 167 projects are being implemented in the sectors such as highways, hospitals, ports, customs facilities, airports and energy. 5 of these projects are in contract stage and their construction processes are continuing (Ministry of Development).

2. LITERATURE REVIEW

When the literature related to PPP applications in health sector is analyzed, it can be observed that legal infrastructure, practice model and types of PPP applications are emphasized in general. Remarking studies about the subject are listed below.

Engel et all (2006) argued whether private sector financing in PPP reduces the negative effects of taxes or not. In the study it is argued that private financing of public services does not cause an increase in deflector taxes. The increases in marginal investments by the private sector party to the contract reduce some deflectory effects of taxes. However, the privileged private sector partner has to make additional investments in long-term to make it. In this case, it is asserted that negative effects of the tax in long-term can be compansated by equaling excessive tax burden costs in future to the tax savingsin investment period.

De Bettignies and Ross (2009) also deal with the benefits of private sector partnerships in PPP structures. They remark that public sector continues unproductive projects with political motivations but private sector can make the conversions for these types of economic units to work productively. In this study it is emphasized that positive externalities of private sector acting with the motivation for the profit on productivity must be utilized and it is pointed out that PPP applications must be developed.

Sarısu (2009) emphasized that PPP applications for operating the public services and offered a model for Turkey. He argued that “Who must spend whose money and how?” model known as Freidman Matris can be used in PPP applications in Turkey.

In their studies, Şahin and Uysal (2008) analyzed the approaches of the developed and developing countries by presenting the development, basic concepts and initiatives of PPP

applications in historical process. In this context, main problems which can be handled were emphasized about PPP.

Acartürk and Keskin (2012) in their PPP models driven studies emhasized the legal infrastructure of PPP applications and health sector applications in Turkey. In the study an inquiry was conducted special for the health sector employees in Aydın city. According to the analysis results conducted special for the data obtained from the inquiry the fact that health sector employees do not have enough information about PPP applications was emphasized. It is concluded that necessary briefing about overcoming the lack of information and providing the transparency should be performed by the institutions and contracts should be clear and comprehensible.

Güngör (2012) in his study analyzed the PPP application in health sector. In the study a comparison model that can be used in the formation of the decisions about public private sector partnership to be established is presented. A public sector comparison model was developed for Turkey.

Tekin (2010) in his study analyzed a PPP policy as a financing method in health infrastructure investments in Turkey via policy mapping method. By analyzing how the feasibility of PPP policy will be affected according to possible changes in current circumstances with the help of developed scenarios, strategies to follow are evaluated in terms of reason, method and feasibility.

Karasu (2011) in his study mentioned PPP model and applications in health sector. Model is evaluated critically also by testing in terms of the assumptions of the theories of neo-liberal organization that it is based on. He argues that PPP model is derived from political preference but not from failure or unfeasibility and this model is not required for efficiency and productivity. Also, in the study it is presented that it may cause a problem on representative democracy due to the fact that certain amount has to be paid to the contractor companies each year because of long-term contracts and with these payments state takes on a heavy burden in long-term and also next governments may not take the political responsibility with the projects. Also, he presents that it is preferred by the governments since PPP expenses are out of budget and the payments of large investments are less reflected to their terms. For these reasons, it is criticizedthat the fact that while on one hand governments would like to realize the purposes of fiscal discipline through taking public expenses under control and limiting borrowings, on the other hand, they prefer a PPP model which is based on budget expenses leading to lack of control will be a contraversy.

A study of feasibility concerning the implementation of a 100-bed capacity hospital project with a PPP model was conducted by Teker (2008) and net cash flows were obtained by estimating all cash input and output of both the private sector partnerand the state during the designing, construction and operation process of the hospital and today's net values of these cash flows and internal efficiency rates for both private sector partnerand state were calculated. Moreover, after the calculation of the net value that the Project provide to the state in the case that the hospital Project funded and operated by the state, not by PPP model and outputs of PPP model were compared and it was presented that partnership model provided significant advantages for both sides. We conclude that the main problem in state monopolyandproject financing is that not having completed the planned building at issue on time and not being able to provide public services because of not operating the facility due to budget constraint at a sector which has primary importance both at its cost and quality, using private sector expertise will make the society more satisfied from this service.

Dewatripont and Legros (2005) in their study argued the superiorities between potential cooperations. In this context the excessive cost increase limitation power of the estimated competition that is predicted to occur in case of a third party participation to the current cooperation and partnership was argued. The argument was carried out on the assumption that supervision and observation of the current partnership by a third party would reduce the cost increases. Certain empirical findings about the fact that PPPs prevent the excessive cost increases or cause the excessive cost increases compared to traditional outsourcing methods could not be found. However, atinfrastructure projects that reduce costs, in the case that the quality, which has a highly determinant role on service demand and quality, and predicting the service demandand quality steadily and truly, PPPs would be useful (Iossa and Martımort,2015:31). In traditional outsourcing contracts constructing 73 % of public outsourcing projects in England public outsourcing prices exceeded the market prices that the private sector offered and projects were conducted with the costs over the budget. It was remarked that real costs were estimated between 2 % and 14 %.

A powerful trendis pointed out that a large scaled projects which create high employmentand arouse the economic activities should be conducted through PPP applications politically (Guasch 2004; Engel et al. 2006: 13-14). By drawing attention that theoretical and empirical studies are not much despite the intense political willingness about PPP applications Iossa and Martımort (2015) focused on how the efficiency of PPPs with a complex structure can be increased. Iossa and Martımort remarked that PPPs are not effective in nursing homes and schools where the service quality is determined by major investments in human capital or in the information technologies services where the demand improves rapidly in time. In the same study it is emphasized that PPPs can be more suitable for the transportation and water sectors where the infrastructure quality is important and the demand is relatively more stable. Iossa and Martımort, (2015:40) regard the success terms of PPPs as “the right perception of service quality”, “low demand risk”, “all risks to be distributed”, “state’s contribution to the capital” and “ low establisment capital”. Also it is expressed thatin case that a transparent structure is ensured to attract private financing sources, PPP applications would be useful at projects with high capital value.

Iossa and Martımort (2005) claim that PPPs which are based on long-term contracts and provide cooperation opportunities will get the efficiency in long term and optimize the gap between long-term projects and investments. This situation helps to prevent cost increases but it requires institutional structures supported by the power of sanction. If the institutional structures with opportunistic regulatory risk become determinant, the possibility to get the expected benefits from PPPs will diminish.

Nambiar (2009) in his study emphasizes that with the deficiencies in institutional structure, privatization-like applications will not provide the expected success by remarking that well structured institutional structures are needed in the provision of public services by the private sector.

Babar and Izham (2009) in their study on pharmaceutical sector indicated that if public price regulations are weak and there is a monopolization in market, breaking the contract and signing it again will cause greater disparities and consumer costs in PPPs. By considering the pre and post- privatization comparisons of medicine prices, Babar and Izham (2009) suggest that strict supervision of the government and PPP applications would be useful to create a stable market in pharmaceutical sector and to prevent excessive costs.

Colombini et all. (2012) in their studies aiming to determine the factors affecting the success of PPP applications present with an example that institutional and structural difficulties are the factors affecting the success. Not preparing a suitable working plan, not establishing a suitable follow-up system and not allocating enough resources caused the cooperation of a PPP application established by non-govermental organizations (NGO) in order to solve the problems derived from woman abuse to fail. As a result, it is stated that a desired success can not be provided from PPP applications where the responsibilities of the partners are not rightly defined and public financing support is not provided.

Similarly, Sundaramand Chowdhury (2009) remark that PPP applications in developing countries would not get the desired results since these countries have not the labour force and instititutional structure to comprehend the complex structure of PPP. PPPs are affected especially by the situations such as theft, favouritism and monopolization. Risks can be transfered to the private sector in a certain extent and the state can be obliged to intervene in the presence of some problems. PPP contracts can be regarded as reducing heavy investment costs of the state and improving its fiscal balances. However, state's obligation to make payment for the service purchases in the future and the other liabilities within the contract may cause some economic problem such as an increase in external debt stock. Therefore, PPPs can cause an increase in capital costs in long term.

Success and failure of PPPs depend on designing themselves strongly. For instance, İsmail and Ajija (2011) in their studies presented that five factors of decreasing rates determined the success of PPPs in Maleysia. These factors are in order " good management", "sharing the responsibilities and liabilities between the parties", "determining an appropriate legal framework", "reliable economic policies" and "an accessible financing market". On the other hand, the factors affecting the success in terms of private sector are ranged in order of importance as "good management", "an accessible financing market", "determining an appropriate legal framework", "sharing the responsibilities and liabilities between the parties", and reliable economic policies". Public interventions performed as " Political support"and "public warranty" were observed as the least important two factors. The most important factor affecting the success of PPPs was determined as "good management".

Phua, Ling and Phua (2014:512) explain that the factors affecting the success of PPP applications in health sector are "regulations", "transparency", "a clear policy guidance", "responsibility and clarity of operational processes" and "a correct evaluation procedure"and especially for PPPs established by non-governmental organizations "a sustainable financial support" and "firm commitment of policy makers to the cooperation". Phua, Ling and Phua remark that potential costs of PPPs should be guaranteed for not overshadowing or exceeding the benefits that is expected to be provided from the cooperation.

When the literature is evaluated overall, we observe that PPP applications were analyzed in their legal aspect and it focused on the issues concerning what the performance criteria were and how the service and financing efficiency could be provided. The perceptions of the producers and beneficiaries of goods and services provided within PPP about the issue were not emhasized much. This study which aims to identify the PPP perceptions of health sector employees and health sector beneficiaries determines to fill this gap to some extent.

3. DATA AND METODOLOGY

This study aims to identify the perspectives of health sector employees and service recipients, that are two important stakeholders of health service sector, towards the public

private cooperations. For this purpose health sector staff working in Uşak city and citizens benefiting from health care services were chosen as a sample mass. Size of the sample mass was determined as 151 surveys in health sector employees and 189 surveys in health sector beneficiaries. By giving introductory information in introduction part thinking that participants may have imperfect data about PPP, it was tried to increase the awareness of the participants about the subject.

In order to identify the PPP perceptions of health sector employees and the service beneficiaries, a scale with 23 statement was used. At the first part of the scale consisting of four parts demographic questions about the participants, in second part questions for determining the quality of health care services in Turkey, in third part questions aiming to identify the perception about provision quality of health care services were asked and at the last part statements about PPP were included. These statements were evaluated by 5 point Likert scale. In this scale 1 represents "I absolutely don't agree", 2 represents "I don't agree", 3 represents "I'm hesistant", 4 represents "I agree", 5 represents " I absolutely agree".

The used scale includes the same statements for both two sample mass. By collecting the data obtained from the scale were analyzed in SPSS 18 package program.

In order to determine whether it will be interpreted on grand total by combining the data of health sector employees and the beneficiaries of health service participating the survey, t Test whose results were shown on Table 6 was implemented. According to test results it is observed that there is a significant difference between participation levels of the participant groups to the statements. For that reason, the data obtained from health sector employees and the service beneficiaries in the study were analyzed separately.

4. ANALYSIS AND ARGUMENTS

Reliability of the scale used in the study was determined via reliability analysis and descriptive statistical analysis was performed after the reliability was determined. Both two analysis results are as follows.

4.1. Reliability Analysis

Reliability of the scale given to the participants in the study was measured by Cronbach's alpha (α) coefficient. This method is the avarage of weighted standard change and it is obtained by rating the sum of the variants of the questions in scale to the general variant. Alfa coefficient is between 0 and 1 and the reliability of the scale is interpreted as follows (Kalaycı,2010:405):

- If $0.00 \leq \alpha < 0.40$, scale is not reliable,
- If $0.40 \leq \alpha < 0.60$, reliability of the scale is low,
- If $0.60 \leq \alpha < 0.80$, scale is pretty reliable,
- If $0.80 \leq \alpha < 1.00$,scale is a highly reliable scale.

According to reliability analysis results, alpha coefficient (α) was 0.877 in the scale for health sector employees and 0.880 for health care services beneficiaries. However, when health sector employees and health care services beneficiaries are evaluated together, alpha coefficient (α) was 0.888. All analysis results indicate that scale is extremely reliable in terms of reference values.

4.2. Demographic Features and Descriptive Statistics

Concerning the sample mass, 73.5 % of the particiants who participated the survey are from the health sector employees consists of females and 26.5 % of them consists of males (Table 2). 41.8 % of the participants from health care services beneficiaries consists of females and 58.2 % of them consists of males. However, when we analyze as a grand total 55.9 % of the participants consists of females and 49.1 % of them consists of males.

Table 2.Gender Distribution of Participants

	Health Sector Employees		***Health Service Beneficiaries***		***Overall***	
	Frequency (n)	Rate(%)	Frequency (n)	Rate (%)	Frequency (n)	Rate (%)
Female	111	73.5	79	41.8	190	55.9
Male	40	26.5	110	58.2	150	49.1

Source: It is prepared by benefiting from data obtained from the survey.

However, when we analyze the age groups of the participants it is observed that there is an equilibrium distribution in general (Table 3). While the number of the participants in 18-23 age group in health sector employees is 9.9 %, it is 27.5 % in health care services beneficiaries and 19.7 % in general. While the number of the participants in 24-29 age group in health sector employees is 13.9 %, it is 27.0 % in health care services beneficiaries and 21.2 % in general. While the number of the participants in 30-35 age group in health sector employees is 23.8 %, it is 23.3 % in health care services beneficiaries and 23.5 % in general. While the number of the participants in 36-41 age group in health sector employees is 36.4 %, it is 12.2 % in health care services beneficiaries and 22.9 % in general. While the number of the participants in 42 and above age group in health sector employees is 15.9 %, it is 10.1 % in health care services beneficiaries and 12.7 % in general.

Table 3.Age and Educational Status Distribution of Participants

	Health Sector Employees		***Health Service Beneficiaries***		***Overall***	
	Frequency (n)	Rate (%)	Frequency (n)	Rate (%)	Frequency (n)	Rate (%)
18 – 23	15	9.9	52	27.5	67	19.7
24 – 29	21	13.9	51	27	72	21.2
30 – 35	36	23.8	44	23.3	80	23.5
36 – 41	55	36.4	23	12.2	78	22.9
42 and over	24	15.9	19	10.1	43	12.7
High School	45	29.8	39	20.6	84	24.7
University	99	65.6	125	66.1	224	65.9
Master's Degree	6	4	15	7.9	21	6.2
Doctorate	1	0.7	10	5.3	11	3.2

Source: It is prepared by benefiting from data obtained from the survey.

When the educational status of sample mass is analyzed 65.9 % of them are university graduate. Then it is followed by high school graduates with 29.7 % rate, master degree with 6.2 % and doctorate with 3.2 % rates (Table 3). High university graduate rate with 65.6 % in

health sector employees derives from the necessity of employing educated labor in health sector.

Table 4.Tenures and Experiences of Health Sector Participants

MISSIONS		Missions of Health Sector Employees	
		Sıklık (n)	Oran (%)
	Doctor	11	7.3
	Nurse	77	51.0
	Health Care Personnel	38	25.2
	Manager	5	3.3
	Officer	20	13.2
EXPERIENCE		Experience of Health Sector Employees	
		Frequency (n)	Rate (%)
	0 – 5	38	25.2
	6 – 10	26	17.2
	11 – 15	23	15.2
	16 – 20	34	22.5
	20 and over	30	19.9

Source: It is prepared by benefiting from data obtained from the survey.

However, when the tenures and experiences of health sector employees are analyzed,7.3 % of the participants are doctors, 51 % is nurse and 25.2 % is health care personnel. When the experiences of health sector employees are analyzed, 25.2 % of these people have got 0-5 years, 17.2 % has got 6-10 years, 15.2 % has got 11-15 years, 22.5 % has got 16-20 years and 19.9 % has got 20 years and over of experience (Table 4).

Hospital types of the participants of health sector employees and their missions in the hospital are shown in Table 5. When the sectors of the participants in health sector employees areanalyzed 70.2 % of the participants work in public hospitals and 29.8 % of them work in private hospitals. These rates are near to the avarege value in Turkey.

Table 5. Participation Level of Health Sector Participants and Mission Distribution According to Sectors

	Number of Participants	Rate (%)	Doctor	Nurse	Health care Personnel	Manager	Officer
Public Hospital	106	70.2	10	61	30	1	4
Private Hospital	45	29.8	1	16	8	4	16

Source: It is prepared by benefiting from data obtained from the survey.

Arithmetic means, frequency and rates of 23 statements for measuring the PPP perception of both the health sector employees and the health sector beneficiaries are presented in Table 6. Since 5 point Likert scale is used for the evaluation of the statements, the mean approaching to 1 shows the disagreement to the statement, the mean approaching to 5 shows the agreement and the mean approaching to 3 shows the uncertainity.

When the means are analyzedin terms of health care services beneficiaries, it can be said that the highest mean belongs to the 11st statement with 2.92 rate and the lowest mean belongs to the 8th statement with 2.14 rate. However, in terms of health sector employees extreme value for the means are observed in 7th statement with 3.57 rate and 8th statement with 2.01 rate.

In the study perceptions of the participants about the provision of health service provided by public and/or private sectors were researched. It is observed that health sector employees generally desire the health care services to be provided in public economy. It is observed that health sector employees tend to agree with the statement "*Health care services in Turkey must be completely provided by the state*" (7th statement) with 3.57 mean. The disagreement decision of the health sector employees to the statement in the scale is "Provision of health care services can be left to private sector." and 2.01 rate supports this comment. In other words, health sector employees do not want the health service to be left to private sector.

It can be said that health service beneficiaries like health sector employees generally prefer the health care services to be provided in public economy. The uncertainity in the statement "*Health care services in Turkey must be completely provided by the state.*" (7th statement) with 2.98 rate explains this fact. This uncertainity changes to disagreement with 2.14 rate when the 8th statement is analyzed. This mean can be interpreted as the health service beneficiaries do not want the health care services to be left to the private sector. These results show that active role of private sector in provision of health care services is not desired in terms of both by the health sector employees and the health service beneficiaries. An uncertain behavior on both sides was observed mean about the provision of health care services completely in public economywith 3.24. Therefore, it can be said that both sides think that health care services in Turkey must be performed mostly but not completely in public economy.

Perceptions of the parties about the quality of health care services tried to be measured through the first five statements in Table 7. According to the answers of the health sector employees and service beneficiaries, means in terms of health sector employees center up on 3.00 and it can be observed that they are uncertain. However, it can be said that the perception that quality of health care servicesis not too satisfactory in terms of health service beneficiaries is dominant. For instance, while health sector employees show an uncertain attitude to the statement "*Quality of health care services in Turkey is sufficient.*" (1st statement) with 3 mean, beneficiaries express that they do not agree with 2.48 mean. Addition to that, in terms of the statement "*Public is satisfied with the health care services in Turkey.*" (4th statement) health sector employees are uncertain about the public satisfaction from the service with 3.28 mean but they are closer to the satisfaction opinion. However, the beneficiaries are not satisfied with the provided health care services with 2.54 mean but it is observed that they come closer to the uncertainity. There are similar differences for the other three statements.

When the means of the statements of both sides are analyzed in terms of the statements measuring the perception about the quality of health care services, it is observed that both sides are not satisfied with the quality of the health care services. However, this dissatisfaction level is not too strong. These differences can be explained as the health sector employees do not want to make a negative judgement about the services they provide.

In order to determine the perceptions of the sides about how the cooperation will have an effect on service quality, the statement " *If health care services are provided by the private sector, qaulity increases.*" (10th statement) is included to the scale. According to practice results it is observed that health sector employees think that the provision of health service by private sector will not increase the quality. The disagreedanswers to the related statement with 2.28 mean support the judgement of the researcher.

Health service beneficiaries show a tendency of uncertainity to the 7th statement "Health care services in Turkey must be completely provided by the state" with 2.98 mean. In other words, besides service beneficiaries are uncertain about the provision of health care services by the state, it is observed that they do not want it to be provided by private sector. This result becomes concrete in the answers of disagreement to the statement "*Provision of health care services can be left to private service.*" with 2.14 mean. Namely, health service beneficiaries do not want the provision of health service to be left to private sector. At the same time it can be said that health service beneficiaries also think that provision of health care services provided by private sector will not increase the quality. The disagreed answers to the statement with 2.28 mean of health sector employees and with 2.48 mean service beneficiaries "If health care services in Turkey are provided by private sector, quality increases." support our judgement.

In the study the attitudes of service providers and beneficiaries towards the establisment of private sector cooperation in health sector were also investigated. When the descriptive statistics are analyzed, it is observed that both sides have uncertain attitudes with 2.50 – 3.00 means about PPP applications. Uncertainity of the participants concerning whether the expected benefit would be provided from PPP applications or not becomes concrete in the statements "*PPP will increase the productivity of the employees.*" and " *PPP application will increase provision quality of health service which is in fact a private goods.*". Participants agreed these statements with 2.73 and 2.78 means in order. Since these statements are close to 3, they can be interpreted as uncertainity. In other words, the participants do not have a certain attitude about whether there is a relationship between PPP application and the productivity of the employees and provision quality of health care services will increase or not.

PPP applications are legitimized with the expectations of tranfering private sector financing resources to the public sector and increasing resource usage activity. In this issue also sides have uncertain attitudes. It is seen that participants are uncertain with the statements "*PPP provides the inactive accumulated funds to be used in public service financing.*" and "*PPP leads the national resources to be used more productive and effective.*" with 2.88 and 2.69 means. These results can be interpreted as the society do not have sufficient information about PPP applications. Acartürk and Keskin (2011:106) in their studies remark this point. In the related study information level of the society about PPP applications was tried to be measured with the statement "*I'm sufficiently informed about Public Private Partnership Model.*". According to the result, it was found that society do not have sufficient information about Public Private Sector Partnership and it is pointed out that society can be informed by ministries and other public units through academic studies.

Generally a lack of confidence about Public Private Sector Partnership is observed. In accordance with this observation using the supervisory and regulatory functions of the state effectively will reduce the hesitant approach to PPP. It is thought that the regulations and supervisions have to be performed to arouse the dynamism of private sector and to refrain the profit maximization effort of private sector independent from the cost.

5. CONCLUSION AND DISCUSSIONS

While the approach of producing the public services and some private goods and services by the public is traditionally dominant, participation of private sector in public production areas has been accelerating recently. Private sector can participate in these activities in different forms. With the change in state's approach, meanings attributed to

public sector have also been changing and PPP is regarded as an important component in this sense. PPPs are called as the applications that private sector has a role in production of public nature goods and services. PPP is defined as long term concracts of central or local government institutions with private sector services providers in the provision of some services. In this contract, private sector takes the responsibility of establishing infrastructure investments, providing financing of the investment and the maintenance and management of the facilities.

In one aspect health is a private and in another one a public service area and the fact that health is a private goods derives from the ability to individualize the provision and financing of the health service. On the other hand, negative externalities of health care services cause this service to have public quality. The fact that effective and sustainable provision of semi-public goods that have a management gap can be realized by PPP structures has been observed as a generally accepted approach recently. In this context, provision and financing of health care services is also foreseen to be effectively provided with a good planning and coordination in PPP.

It is observed that theoretical and practical reasons meet at three points in terms of expected potential benefits of PPP applications. These are;

i. The expectation that supervision efficiency of public will increase,
ii. The expectation that regulatory and supervisory role of the state will stand out,
iii. The expectation that resource use efficiency will increase by utilizing private sector business experience.

Presenting the expectations of the society about the expected benefits from PPP is determined as the main purpose of the study. In the context of this main purpose how PPP is percepted by the people living in Uşak city was researched by presenting the operating principles of PPP model special to health sector. Besides this main purpose, the determination of the perception of the people living in Uşak concerning health care services quality and identifying public-private sector preference of the society in the provision of health care services are defined as the other purposes of the study.

Survey method was used in determining the perception about PPP applications. The results from the surveys conducted with health sector employees and health service beneficiaries were evaluated by analyzing on SPSS 18 programme.

Analysis and evaluations were conducted according to the main and secondary purposes and with answers to the statements. Within the analysis, first of all, the perception of the participants to the survey in terms of the expectations from public and private sector applications is determined. In the analyses it was observed that the participants to the survey were hesitant whether PPP aplications would be useful or not.

When the distribution of hospital types that the participants work in is taken into consideration, it is observed that distribution rates of general health sector employees in Turkey are close. When the private sector employees were observed that they do not agree with the statements about health service quality in Turkey, but public sector employees agree. However, the statements about by whom the health care services have to be provided were thought by both sector employees stated that they should not be left to private sector. When

the answers of the participants to the statements are analyzed about measuring the benefits that PPP applications provide, private sector employees state that PPP applications will increase supervisory and regulatory role of the state and resource use efficiency will be increased by utilizing private sector business experience. However, public sector employees present an attitude that these expected benefits will not be provided as a result of PPP applications.

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APPENDIX

Table 6. t Test Results

	Statement	Health Care Employee or not	Mean	Sig.(2-tailed)
1	Quality of health care service in Turkey is sufficient.	Yes	3.00	0.000
		No	2.48	
2	Sufficient fund is allocated by the state for health expenses in Turkey.	Yes	3.01	0.001
		No	2.59	
3	Health care service demands of the public in Turkey are rapidly catered.	Yes	3.11	0.000
		No	2.35	
4	Public is satisfied with health care services in Turkey.	Yes	3.28	0.000
		No	2.54	
5	Management and supervision of health care services are efficient in Turkey.	Yes	2.98	0.927
		No	2.44	
6	Family medicine practice has increased the quality in health.	Yes	2.80	0.000
		No	2.79	
7	Health care services in Turkey must be completely provided by the state.	Yes	3.57	0.000
		No	2.98	
8	Provision of health care services can be left to private sector.	Yes	2.01	0.345
		No	2.14	
9	While preventive health care services are provided by the state, treatment services should be provided by private sector.	Yes	2.07	0.085
		No	2.29	
10	If health care services in Turkey are provided by private sector, quality increases.	Yes	2.28	0.155
		No	2.48	
11	System may have new facilities as soon as possible by completing the investments in PPP.	Yes	2.88	0.785
		No	2.92	
12	PPP may increase the employment.	Yes	2.80	0.570
		No	2.87	
13	PPP provides the public to benefit from business experience of private sector.	Yes	2.85	0.925
		No	2.84	
14	Since provision of service will be rapid and productive by PPP, satisfaction of the public from health care services can be increased.	Yes	2.80	0.887
		No	2.78	
15	PPP is one of the solution ways of public financing problem.	Yes	2.74	0.548
		No	2.82	
16	PPPwill increase the productivity of the employees.	Yes	2.58	0.044
		No	2.85	
17	PPPmust be performed only by domestic private sector.	Yes	2.95	0.666
		No	2.88	
18	PPP provides the inactive accumulated funds to be used in public service financing	Yes	2.91	0.651
		No	2.85	
19	PPPleads national resources to be used more productive and efficient.	Yes	2.63	0.371
		No	2.75	
20	I believe public supervision efficiency will increase with PPP application.	Yes	2.81	0.774
		No	2.85	
21	PPP application will feature the regulatory and supervisory role of the state.	Yes	2.89	0.607
		No	2.81	
22	Mangement and business experience of private sector will increase resource use efficiency.	Yes	2.79	0.463
		No	2.89	
23	PPP application will increase the provision quality of health care services which are actually private goods.	Yes	2.66	0.131
		No	2.88	

Table7. Descriptive Statistics

	Statement	Health Sector Employees Mean	HealthService Beneficiaries Mean	OVERALL						
				Mean		1	2	3	4	5
1	Quality of health care service in Turkey is sufficient.	3.00	2.48	2.71	n	56	97	92	80	15
					%	16.5	28.5	27.1	23.5	9.4
2	Sufficient fund is allocated by the state for health expenses in Turkey.	3.00	2.59	2.77	n	57	92	84	85	22
					%	16.8	27.1	29.7	25.0	6.5
3	Health service demands of the public in Turkey are rapidly catered.	3.11	2.35	2.69	n	65	96	83	73	23
					%	19.1	28.2	29.4	21.5	6.8
4	Public is satisfied with health care services in Turkey.	3.25	2.54	2.87	n	53	80	92	88	27
					%	15.6	23.5	27.1	25.9	7.9
5	Management and supervision of health care services are efficient in Turkey.	2.98	2.44	2.68	n	62	91	104	60	23
					%	18.2	26.8	30.6	17.6	6.8
6	Family medicine practice has increased the quality in health.	2.80	2.79	2.79	n	72	76	72	90	30
					%	21.2	22.4	21.2	26.5	8.8
7	Health care services in Turkey must be completely provided by the state.	3.57	2.98	3.24	n	52	68	59	68	93
					%	15.3	20.0	17.4	20.0	27.4
8	Provision of health care services can be left to private sector.	2.01	2.14	2.08	n	144	91	60	23	22
					%	42.4	26.8	17.6	6.8	6.5
9	While preventive health care services are provided by the state, treatment services should be provided by private sector.	2.07	2.29	2.19		124	93	74	33	16
						36.5	27.4	21.8	9.7	9.7
10	If health care services in Turkey are provided by private sector, quality increases.	2.28	2.48	2.39	n	116	80	68	47	29
					%	39.1	23.5	20.0	13.8	8.5
11	System may have new facilities as soon as possible by completing the investments in PPP.	2.88	2.92	2.90	n	50	74	97	98	21
					%	19.7	21.8	28.5	28.8	6.2
12	PPP may increase the employment.	2.80	2.87	2.84	n	57	69	102	95	17
					%	16.8	20.3	30.0	27.9	5.0
13	PPP provides the public to benefit from business experience of pri	2.85	2.84	2.84	n	51	78	105	86	20
					%	15.0	22.9	30.9	25.3	5.9
14	Since provision of service will be rapid and productive by PPP, satisfaction of the public from health care services can be increased.	2.80	2.78	2.79	n	58	80	98	83	21
					%	17.1	23.5	28.8	29.4	6.2
15	PPP is one of the solution ways of public financing problem.	2.74	2.82	2.79	n	64	72	99	83	22
					%	18.8	21.2	29.1	29.4	6.5
16	PPP will increase the productivity of the employees.	2.58	2.85	2.73	n	71	81	75	94	19
					%	20.9	23.8	22.1	27.6	5.6
17	PPP must be performed only by domestic private sector.	2.95	2.88	2.91	n	66	72	81	68	53
					%	19.4	21.2	23.8	20.0	15.6
18	PPP provides the inactive accumulated funds to be used in public service financing	2.91	2.85	2.88	n	47	71	123	75	24
					%	13.8	20.9	36.2	22.1	7.1
19	PPP leads national resources to be used more productive and efficient.	2.63	2.75	2.69	n	67	89	85	79	20
					%	19.7	26.2	25.0	23.2	5.9
20	I believe public supervision efficiency will increase with PPP application.	2.81	2.85	2.83	n	63	70	99	78	30
					%	18.5	20.6	29.1	22.9	8.8
21	PPP application will feature the regulatory and supervisory role of the state.	2.89	2.81	2.85	n	66	73	89	71	41
					%	19.4	21.5	26.2	20.9	12.1
22	Mangement and business experience of private sector will increase resource use efficiency.	2.79	2.89	2.84	n	64	71	94	76	35
					%	18.8	20.9	27.6	22.4	10.3
23	PPP application will increase the provision quality of health care services which are actually private goods.	2.66	2.88	2.78	n	79	66	78	84	33
					%	23.2	19.4	22.9	29.7	9.7