HEALTH REFORM AND PPP HOSPITALS IN AKP'S TURKEY

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ABSTRACT

This dissertation examines Turkey's AKP-associated transformation in health policies, both in its global and national context, with a particular focus on the controversial PPP (Public-Private Partnership) hospital projects as the latest phase. The study draws a picture of the Turkish health care transformation with a political-economic approach, strengthened by contextualizing the impact of global changes in health policy formation in the country and analyzing country-specific political and economic developments simultaneously. A comprehensive framework to capture the developments after the 1980s emerges when the Washington Consensus, private sector involvement, and state-capital relationships are considered together as components of a dominant paradigm. Turkey's AKP-associated health reform fits into this transnational policy paradigm, where post-1980 economic liberalization, the impact of international organizations, legislative changes towards privatization, and changing role of the state in healthcare are the implications. While some steps were taken in Turkey to implement these changes before AKP came to power, we see that AKP saw health reform as a populist tool and invested in it in a sustained manner, using the advantage of governing as a single party. Thus, for AKP, health reform became an important tool to garner popular support. Structural changes were needed and implemented along with more private sector involvement. In the first years of the reform, the capitalist class was optimistic, and expansion in health expenditures was promising. Yet, both developments started to slacken at the beginning

of the 2010s and the PPP hospital projects came out of the party's search for a strategy to extend the popularity of health-sector reform and its promises to the private sector. Yet, as the results unfolded, neither the government nor capitalist actors significantly benefited from the projects. Instead, they became concrete reminders of AKP's decreasing power to reproduce its legitimacy.

To the hundreds of health care workers who lost their lives due to COVID-19 in Turkey

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LIST OF ABBREVIATIONS

AKP: Justice and Development Party *(Adalet ve Kalkınma Partisi)*

BLT: Build-lease-transfer

CCT: Conditional cash transfer

EPEC: European PPP Expertise Center

HTP: Health Transformation Program

MCOs: Managed Care Organizations

MoH: Ministry of Health

MÜSİAD: Independent Industrialists and Businessmen Association *(Müstakil Sanayiciler ve İşadamları Derneği)*

NHS: National Health System

OHSAD: Private Hospitals and Health Institutions Associations (Özel Hastaneler ve Sağlık Kuruluşları Derneği)

PPP: Public Private Partnership

PRD: Party of the Democratic Revolution *(Partido de la Revolucion Democratica)*

PRI: Institutional Revolutionary Party *(Partido Revolucionario Institucional)*

PRONASOL: National Solidarity Program *(el Programa Nacional de Solidaridad)*

PRSP: Poverty reduction strategies papers

PWC: PricewaterhouseCoopers

SAP: Structural adjustment program

SGK: Social Security Institution *(Sosyal Güvenlik Kurumu)*

SMEs: Small and medium-sized enterprises

SPO: State Planning Organization

TİSK: Turkish Confederation of Employer Associations *(Türkiye İşveren Sendikaları Konfederasyonu)*

TOBB: Union of Chambers and Commodity Exchanges of Turkey *(Türkiye Odalar ve Borsalar Birliği)*

TRIPS: Trade-Related Aspects of Intellectual Property Rights

TTB: Turkish Medical Association (Türk Tabipler Birliği)

TURKSTAT: Turkish Statistical Institution

TÜSİAD: Turkish Industry and Business Association *(Türk Sanayicileri ve İş İnsanları Derneği)*

CHAPTER 1 INTRODUCTION

1.1. Drawing the framework of the study

The development process of this study on health policies and public-private hospitals in Turkey, known as city hospitals, has coincided with the controversial consequences of the COVID-19 pandemic across the world. The pandemic has stimulated a long-running debate on the privatization of health care. The inability of the health care systems worldwide to fight against the novel coronavirus of 2020 has revealed itself. The pandemic marked the practical collapse of health systems in some countries, such as Italy, where the system experienced a deadlock in treating new cases. The US, the wealthiest country in the world, is now remembered for its hospitals not accepting uninsured, poor people and not protecting health care workers. In Turkey, as in many other capitalist countries, the measures taken against the pandemic aimed to prevent a scandalous deadlock in the health system rather than protecting the country's people as a whole.

At the same time, the state was almost spontaneously accepted as the first addressee, which has to search for and implement solutions. Political powers were not in a position to deny this legitimate expectation in such a health crisis. They had to directly assume the

obligation to act or to explain their attitude towards this crisis. It is plausible to say that this situation reinstates the state's responsibility on health policy. Even in countries with liberal health systems, states accepted that the organization of the health care system in times of crisis, taking the necessary social measures for public health, lock-down decisions, and supplying the essential medical supplies, drugs and vaccines are their responsibility. The March 4th, 2021 issue of *The Economist* recommended that states return to affordable welfare policies. As it was clear how inadequate capitalist economies, in general, are in a public health crisis that emerged during the pandemic, the protective welfare policies of the state started to be discussed again. The world's influential sources began to refer to the importance of the state's intervention in social security emerged anew during the epidemic.

Nevertheless, during all these discussions, the states have made controversial decisions in reality. Instead of total lock-downs at the beginning to prevent the spread of the virus, the capitalist states of 2020, no matter how advanced their health systems are, tried to manage the crisis with minimum interruption and halt in the production sector. The "stay home" calls of the governments in Turkey and others only applied to a limited percentage of the working population since a significant part had to continue working to "turn the wheels" with no adequate precautions in workplaces. Risking the health and lives of millions by "turning the wheels" in various non-vital sectors was accompanied by the deepening inequalities in accessing health care services, surfacing more than ever during the pandemic.

Yet, the inadequate and controversial responses to the pandemic are, obviously, a result of the health care system's current organization rather than a reason for the surfacing crisis. Direct and indirect privatization, pro-market inclination, the changing role of the state in health care, the decline in investments in preventative care have characterized the last 40 years of health care policy paradigm across the world. Although the development of health care systems is not limited to the health care schemes after 1980, contemporary discussions evaluate the worldwide policies and changes in health care under the broad umbrella of neoliberal health systems. When considering the various developments in different country cases, the post-1980 policy paradigm has proved to be an economically and politically inconsistent scheme. The world has faced the COVID-19 pandemic with the dominance of this complex and ill-planned scheme.

The paradigmatic change affecting health policies worldwide has ended well-known welfare state systems and the beginning of neoliberal reform packages. Lengthy and sophisticated discussions on the welfare systems' retrenchment (or transformation) in different contexts have been central to the social policy literature. The major restructuring of the state has been almost global, although existing structures differ. The WB's (World Bank) summary of the reform agenda may exemplify the shift in the states' changing mode of intervention in health policies: The Bank suggested introducing user charges, expanding the participation of the private sector in health care, and decentralizing governmental health services. Despite some retreats from the global policymaking circles after the 2000s due to unexpected consequences of harsh neoliberal reforms, these main points still reflect the essential characteristics of intended changes in health care after the

1980s' state restructuring.

Related health transformation has been implemented mainly under structural adjustment programs in developing countries. Based on these programs, health care reforms after the 1980s have tended to include changes concerning financing and organization of health services. Most Latin American reforms and the Turkish health care reform share a politically secretive process, mostly excluding non-governmental actors and trade unions. Furthermore, along with the Latin American and Turkish cases, the developing state cases in Southern Europe and East Asia seem to be implementing passive or incremental privatization while increasing the role of the private sector in their health care systems. Exemplified mainly by the increasing numbers of PPPs (public/private partnerships), the incremental privatization process entails a shift in favor of the private sector within the public/private mix of service provision. It also favors private financing rather than a total sale of public health care facilities or entirely leaving the health insurance market to the private sector.

Turkey has not been an exception in implementing this paradigmatic change. However, the reform process in Turkey took longer than in other similar countries. The restructuring and the effect of the World Bank's policy paradigm started with the radical change after the military coup in 1980. Yet, the Turkish government could not fully activate the internationally orchestrated health care transformation until the AKP (Adalet ve Kalkınma Partisi/Justice and Development Party) government came to power in 2002. The period after 1980 until the large-scale transformation project witnessed no significant

policy response in line with changes experienced in the global economic and political arenas. The 1990s mainly remained passive, with few exceptions such as attempts to increase the private sector and the Green Card scheme, which made limited progress in expanding health care coverage for the poorest sections of the population. However, especially the organizational problems in provisioning health services were visible to all political actors. Neither left politics could put a dominant agenda forward against the pressure of implementing market-based reforms coming with the neoliberal wind, nor the other political actors in the meantime could design a durable market-based reform.

After 2002, a real opportunity emerged to put market-based reforms in practice actively. Successive AKP governments carried out the reform in Turkey from the beginning, and it was not blocked or delayed by any other political actor. The fact that the significant transformation started with AKP's first electoral success in 2002 and the thought that the government's health policies have played an important role in its 19 years in power has turned the transformation into an intriguing political and scholarly topic. This interest has remained popular since AKP used the reform policies as an essential factor in building a wide electoral base that has remained intact until today. The major health care transformation implemented by a conservative government has had a powerful impact on social and political spheres. The transformation has created visible changes such as better health facilities and broader coverage.

There has been a prominent ground for correlating the reform with AKP's political agenda in the Turkish case. Because of the steps taken to implement the reform and the

political discourse of conservative AKP governments, the initial project was widely seen as a successful populist move, consistently compared to the older health system that was problematic because of insufficient resources and limited access to services. Theorizing the process by reference to populism discussions and literature has dominated the Turkish health care reform debates. However, the privatization dimension of the reform has been apparent throughout, which casts doubt on initial intentions.

One of the most visible examples of this privatization dimension has been the PPP projects in the health sector, known as "city hospitals," presented by the government as a megaproject that will serve people's interests. The project has become a controversial topic regarding the public tender processes, the government's visible links to the benefiting contracting companies, and the doubts on the intentions to pursue public interest. Apart from these issues, the “mega” aspect has made the projects an internationally non-standard case. The PPP hospitals are too large compared to international standard scale and are built at far points from city centers. For example, hospitals with a bed capacity of less than 100 and more than 600 are considered inefficient by international standards, while the average bed capacity of PPP hospital projects in Turkey is 1417. Along with bed capacity, the closed area per bed is too large. The closed area per bed in these new hospitals in Turkey is 40 percent bigger than new hospitals in the USA and EU (Transparency International Turkey, 2019). The massive scale prevents the personnel and the patients to have easy access to different departments or places in the hospitals, sometimes requiring golf carts for transportation within the hospitals. Furthermore, while hospitals are expected to be as accessible to citizens as

possible, transportation to PPP hospitals requires a journey of up to 1 hour in big cities. These non-standard choices of the AKP government necessarily requires questioning the political and economic results of these projects in the Turkish case.

1.2. Main questions and outline of the study

Health is a multi-faceted policy area that concerns and affects society as a whole. We live in a period in which all the experiences, problems, and transformations of humanity in daily life cannot be understood without any connections to commodification and marketization. The field of health has never been outside of this process. However, this gradually deepening process is also progressing by getting more complex. It is inevitably necessary to look into the complexity with a clear theoretical lens. The AKP-associated health transformation program in Turkey that started in 2003 has become an important case in which restructuring of the health sector has been implemented without interruption. Changes in health service delivery, financing, and organization of the health system, the transformation of the Ministry of Health, and ultimately, PPP hospitals were incremental steps involving all kinds of complexities to open the health field to the market. The Turkish case both fits into the global policy paradigm change and exhibits particular developments and consequences.

This study will scrutinize the AKP-associated health transformation both in its global and national context. As an alternative to the focus only on the dominance of the political actor, this study will attempt to draw a comprehensive picture of the Turkish health care transformation with a particular focus on the PPP hospital projects as the latest

development. This picture will analyze the multidimensional contexts of the policy formation processes theoretically and practically. The literature review and the following discussions aim to lay out a base for a political-economic approach that will incorporate the complexity in the process. The study suggests that the capitalist class, both with the capitalist actors themselves and the organizations to represent them, also has an important role in the legislative and practical changes made within the context of AKP's health reform and the PPP hospitals projects.

Shaped by the above framework, this study aims to address the following research questions:

- How should we analyze global and national contexts to understand the transformation in health policies in developing countries such as Turkey?
- On what basis could Turkey's health reform, associated with the AKP governments, be implemented?
- How has the political and economic conjuncture progressed in Turkey's health transformation process? What was the attitude of the capitalist class along with the policy choices of the AKP government?
- Where do PPP hospital projects fit between the marketization of health care and AKP's political ambitions?
- What does the relationship between state and capital in PPP hospitals tell us about the particular context of the Turkish case?

The chapters will present discussions based on these questions. Chapter 2 draws the

study's theoretical framework by reviewing and evaluating the existing literature on social policy, policy transformations, and health policies. Studying Turkey's health policies transformation requires a thorough examination of the social policy literature, including the specificities characterizing the developing country cases and the global transformations in policy areas. Acknowledging that the debates, theoretical approaches, and explanations are vast in this area, I review the literature in two broad categories: One is the literature on the transformation of the welfare systems in general, and the other is the literature on the transformation of health care systems and policies. After looking at the statistics and trends in health policies in developing country contexts, the chapter will introduce the early theoretical approaches focusing on welfare states. A review of the post-1980 literature, which can be analyzed as structural and political explanations, will follow. Based on the existing literature, the chapter will also include a critical examination of the literature on social policies. In light of these discussions, the second part of the chapter will introduce the debates on health policies and healthcare systems transformation.

Chapter 3 aims to further the discussions in the previous chapter, attempting to draw a framework for a political economy analysis of health policies and transformations. The chapter will identify the Washington Consensus as a social policy paradigm incorporating the changes in the developing world. Next, a discussion on the impact of the organizations pushing the Washington Consensus (WB, IMF, and WTO) in social policy formation and their agenda towards health policies will complete the picture better. Since the agenda of these organizations and the practical changes they implied can be

characterized by the involvement of the private sector in health care, the increasing role of the private sector will also be examined. The related literature either focuses on the negative social impact of market-based reforms or emphasizes the benefits for the private sector and individual capitalist actors. One common observation is that developing country states need to intervene to facilitate the growth of the pro-market health system. At this juncture, I will try to rethink the critical state-capital relationship to propose a more comprehensive political economy approach to study health policies. Finally, the last section will combine these related discussions and offer a perspective to explore health policy (trans)formations.

Informed by the literature review, Chapter 4 will scrutinize Turkey's most recent health system transformation associated with the AKP governments by considering the transformation's historical political process. To better contextualize the latest policy formation processes in Turkey, the chapter will present a review of the health policy history of Turkey and the critical changes after the 1980s. Then, I will examine the AKP's Health Transformation Project (HTP), considering the related literature on the transformation. To see the trends and changes in the course of the most prominent transformation process, I will take a closer look at the official statistics, including public and private health expenditures as a proportion of GDP (gross domestic product), public and private expenditure per capita, and investment expenditure. On the side of the capitalist class, I will take a closer look at the public statements made and reports published about the HTP by the important capitalist organizations and actors, including TÜSİAD (Turkish Industry and Business Association), TOBB (Union of Chambers and

Commodity Exchanges of Turkey), and OHSAD (Private Hospitals and Health Institutions Association). The evaluations made after these examinations will allow me to contextualize the start of the PPP hospital projects as the second phase of the HTP in Turkey. Chapter 4 will present the PPP hospital projects in their context and introduce the related discussions in Turkey over the projects.

Chapter 5 will focus on a mapping that goes through the moves of the AKP government and the capitalist actors in the PPP hospitals projects. The first task of the chapter will be to summarize the theoretical underpinnings of the state-capital relationship in Turkey to contextualize the actors and developments. On the state side of the relationship, I will critically examine the particular decisions of the AKP governments regarding the introduction and the continuation of the projects. AKP's decisions and intervention during the legal and institutional base, the controversial steps taken against the opposition, and the details and complications in the tender processes are essential in examining the state side. One of the most important actors in this period has been the TTB (Turkish Medical Association). I will often refer to TTB to understand the legal processes and the AKP's determination to continue the projects despite opposition. For understanding the capital side of the relationship, the chapter will offer a general overview of the capitalist organizations and actors in health and their involvement with the PPP hospitals projects. The overview will be followed with a closer look at the contractors and construction companies that won the hospital construction tenders and mostly eliminated the other prominent capitalist actors in health. The reasons behind this final picture in Turkey's PPP hospital projects will be evaluated, considering the latest

developments shaping the political and economic policies of the government. Finally, Chapter 6 will present the concluding discussion based on the main underpinnings of the theoretical and case-specific conclusions of the study.

The sequence of chapters is intended to answer the main questions above. To summarize very briefly, I suggest that theoretical approaches should explain the expansion related to social policy and health policies in particular. A comprehensive framework to capture the developments after the 1980s emerges when the Washington Consensus, private sector involvement, and state-capital relationships are considered together, as components of a dominant paradigm. Turkey's AKP-associated health reform fits into this international policy paradigm, where post-1980 economic liberalization, the impact of international organizations, legislative changes towards privatization, and changing role of the state in healthcare are the implications. While some steps were taken in order to implement changes before AKP came to power, we see that AKP saw health reform as a populist tool and invested in it in sustained manner, using the advantage of governing as a single-party.

Thus, for AKP, health reform became an important tool to garner popular support. Structural changes were needed and implemented along with more private sector involvement. The capitalist class was optimistic in the first years of this involvement and expansion in health expenditures was promising. Yet, both developments started to slacken at the beginning of the 2010s and the PPP hospital projects came out of the party’s search for a strategy to extend the popularity of health-sector reform and its

promises to the private sector. Yet, as the results unfolded, neither the government nor capitalist actors gained a significant benefit from the projects. Instead, they became concrete reminders of AKP's decreasing power to reproduce its legitimacy.

1.3. Method

Almost all parts of this study except the in-depth interviews are outcomes of a desk study. While I was able to access the library shelves during the intense literature review process for Chapters 2 and 3, most of the research and writing process for the later chapters coincided with lockdowns and limitations due to the COVID-19 pandemic. This situation did not pose a serious constraint on this study—the design of the study anticipated from the very beginning that the desk study would be a significant part. However, there were times when it was inevitable to conduct some in-depth interviews face to face. Thus, I resort to online meetings with some of my interviewees. Although it is not the ideal method of communication, it also made it easier for some of my interviewees in terms of time management and allowed them to spend more time talking to me.

I used qualitative and quantitative analysis together in the study. My major sources for quantitative analysis were the official statistics and database of the Turkish Statistical Institution (TURKSTAT) and the statistics provided by OECD, WB, and EPEC (European PPP Expertise Center). I mostly interpreted the health spending data of Turkey myself, but the graphs and information provided by other institutions were sufficient for my analysis instead of using their raw data. Apart from quantitative resources, several reports of capitalist organizations and websites of the companies provided the basis to understand the capitalist class in health care. The Ministry of Health (MoH) website, the

online archive of the legislative decisions published in the Turkish Parliament's website, and newspaper archives helped me analyze the state side of the developments. The online resources provided by TTB, the internet archives of the oppositional newspapers and news portals, especially Cumhuriyet, Birgün, Sözcü, and soL, helped me understand the views of the opposition. Finally, I used the information I collected from the semi-structured, in-depth interviews. I conducted interviews with two TTB representatives (Bayezit İlhan, Özgür Erbaş), oppositional journalists and scholars who are especially interested in the PPP hospitals (Uğur Emek, Mustafa Sönmez, Çiğdem Toker) and two anonymous high-rank private sector representatives. One of the private sector representatives is from a major company in the health sector, and the other is from another major company in the construction sector. I conducted the first in-depth interview in September 2020 and the last one in April 2021.

CHAPTER 2 THEORIZING HEALTH POLICIES

2.1. Introduction

This chapter aims to draw the theoretical framework of this study by reviewing and evaluating the existing literature on social policy, policy transformations, and health policies. Studying Turkey's health policy transformation requires a thorough examination of the social policy literature, including the specificities characterizing developing country cases and global transformations in policy areas. Acknowledging that the debates, theoretical approaches, and explanations are vast in this area, I will review the literature in two broad categories: the literature on the transformation of welfare systems in general, and the literature on the transformation of health care systems and policies. To understand and contextualize health care reform and related changes in Turkey, grasping the general transformation in all social policy areas and health policies worldwide is of great importance to establish the global context.

Based on the mentioned theoretical aim, the chapter addresses this central question: "How should we understand and study the current health policies with all the complexities they incorporate?" The review of the theoretical answers given to this question and assessment of these answers will lay the ground for this study's main guidelines. The review of the concerned literature will be followed by an attempt to form

a political-economic approach to study the recent developments in Turkey, with a particular focus on the most recent but controversial phase of the reform: PPP hospitals.

In addition to providing the theoretical ground of this dissertation, the discussions in this chapter aim to contribute to existing theoretical debates. First, the big debate in the literature on the "crisis of the welfare state" is still alive. The sources and impacts of the crisis, or even the question of whether it should be considered a "crisis," still lead most of the scholarly discussions. The complexity of the penetrating processes of changing global politics, economic policies, and state-capital relationships has turned the subject into a multifaceted one. The social policy literature seems to reflect this complexity. Many faces of these transformations have been studied in different contexts, levels of analysis and policy areas, and from different theoretical perspectives. Policies and institutional changes implemented after the welfare state model, which has a historically unique place in terms of how the state plays a role in meeting people's economic and social needs, have been important topics in many ways. However, the "crisis of the welfare state" debate practically opened itself to the criticism of the neoliberal theory, which blamed the expansion of government social spending for the economic crisis in the 1970s. The victory of the neoliberal accounts is visible in historical trajectories and scholarly discussions, yet alternative approaches still have their strong sides that should be resurfaced.

Second and related to the first one, due to the hegemony of liberalism and its institutions, scholarly discussions on welfare systems after the neoliberal shift tend to focus on

specific policy ideas and how to design and implement these policies on global and national levels. Critical approaches have tended to view these transformations in various ways, such as neo-liberal political offensive that needs to be reversed, the imposition of international policymakers, or the policies of political actors with negative consequences. However, these academic discussions neglect a critical inquiry: Questioning the links between welfare systems, capital accumulation, and the capitalist state. Although this kind of questioning was central to the welfare state scholars of the earlier period, it seems to have lost its popularity after the transformation. However, trying to understand particular expenditures, policy programs, and their restructuring without linking them to the reproduction of capitalist relations, we are obliged to continue functioning in a "relative theoretical vacuum," as O'Connor (1973:255) puts it.

Third, despite the increasing interest in explaining the crisis of welfare regimes in neoliberalism, the literature is still being dominated by studies focusing on evaluating the changes within the Western world. However, a picture depicting the transformation of welfare systems cannot be drawn only by considering countries with mature welfare states. Given that public social spending ratios, contrary to expectations, have been increasing, particularly in developing countries, the task of re-emphasizing the link between capitalist accumulation and social policies has become even more crucial.

These points above are the primary reasons that underpin my inquiry in this chapter and upcoming chapters, based on the theoretical ground to be provided here. My initial questioning of the current policies in Turkey that led me to the literature on welfare

systems has opened a crucial need for theoretical clarity on how to understand the controversial and changing nature of social policies. For instance, the expansion of social spending and increasing universalization of access to major welfare programs such as health care and pensions in developing countries after the 1980s constitute a puzzling question. The puzzle arises because the expansion is, at first sight, in contrast with the neoliberal pattern and unexpected in the context of developing countries since these countries are expected to have fewer financial resources for such an expansion. The following sections will address the issue by evaluating welfare system transformations and reviewing related theoretical discussions, starting from the earlier literature on welfare systems.

2.2. Understanding welfare system transformations in developing countries

2.2.1. Welfare systems after the neoliberal turn

The restructuring period is assumed to begin with the world economic crisis in the 1970s. This period is characterized by the declining profitability of capitalist production, low investment rates, low growth, mass unemployment, and high inflation, and also saw the expansion of and dependence on international markets as governments started to borrow internationally. Trying to understand the relationship between welfare state practices and the crisis led to the questioning of the welfare state, and the most radical opposition to the welfare state came from the New Right. The discussions on the "death of the welfare state" complement the neoliberal agenda's expectations. The widely perceived crisis and its effects on dominant economic understanding put the New Right’s solution as the only agenda for recovering, resulting in the institutionalization and normalization of

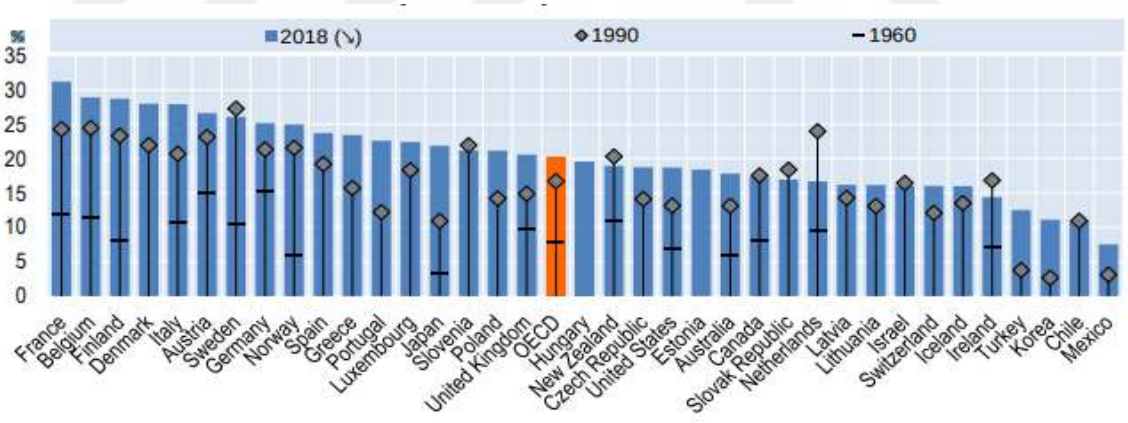
neoliberalism (Hay, 2004). The New Right criticized the welfare state and suggested economic liberalization with the argument that the welfare state is a system that blocks the functioning of the capitalist market. It also advanced the discussion to the political arena, stigmatizing the welfare state as a system limiting people's freedom.

The point that the world economy and politics have reached has proven that the neoliberal agenda has transformed state policies for its benefit worldwide. However, what kind of changes specifically occurred during this restructuring is still a critical scholarly question. The social policy/welfare state literature has rightfully emphasized qualitative changes in the discussion of the transformation of welfare systems. Recent studies have suggested that there has been restructuring instead of an overall retrenchment. This restructuring can be identified, for example, as a change from employment-based to income-based policies (Brooks and Manza, 2006a), from welfare state to social risk management strategies (Yalman, 2007), or from Keynesian welfare to Schumpeterian workfare state (Jessop, 2002). Moreover, the characteristics, economics, and politics of the changes, as well as their different impacts on different countries, are significant debates for contemporary academic projects within the scholarship of social policy (e.g., Eren-Vural, 2011; Esping-Andersen, 1996; Farnsworth and Irving, 2011; Glatzer and Rueschmeyer, 2005; Manning and Shaw, 2000; Pierson, 2001).

Without ignoring the centrality of the abovementioned theoretical explanations on the qualitative changes, I would like to evaluate the transformation based on public spending

rates in this section. One of the most critical arguments claimed by the neoliberal agenda for the welfare state system was that high public spending ratios due to rising unemployment and aging of the population put the state budget into crisis. State's retreat from the welfare area and the replacement of the free market were supposed to solve the problems. However, this retreat also needs to be questioned in terms of public social spending rates in advanced capitalist countries. Contrary to the expectations of the neoliberal agenda, public social spending as a percentage of GDP has decreased minimally or not at all in the majority of advanced capitalist countries since the crisis of the 1970s. Figure 1 below shows the change in public social spending to GDP ratios, comparing the data from 1960, 1980, and 2018.

Figure 1. Public social spending as a percentage of GDP, 1960, 1980, 2018



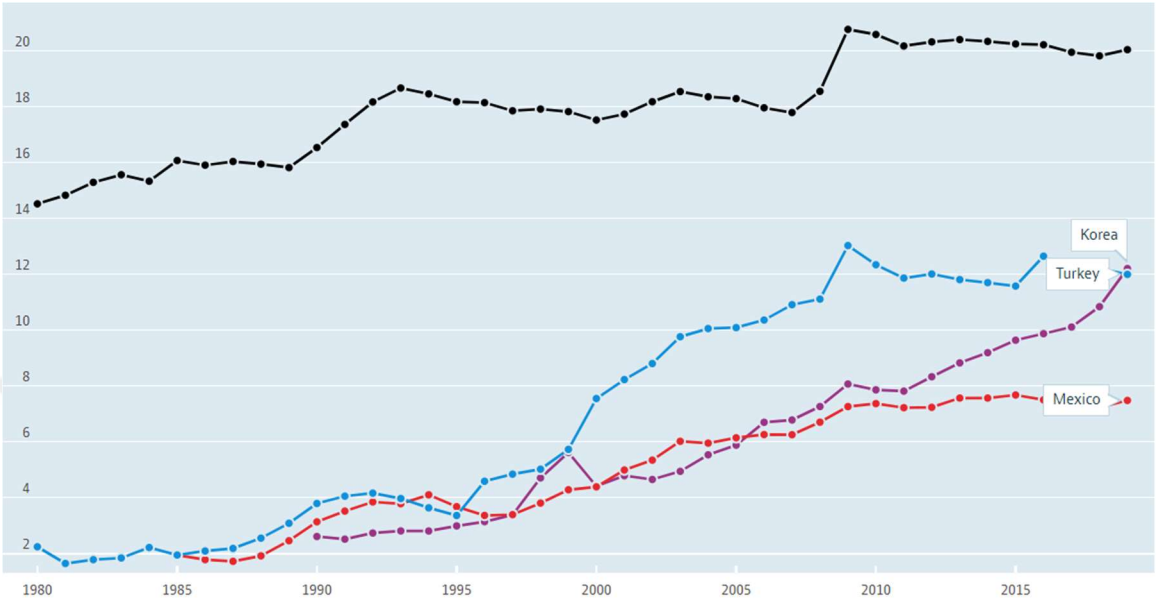
Source: OECD, Social expenditure update 2019, available at: https://www.oecd.org/social/soc/OECD2019-Social-Expenditure-Update.pdf

In countries known to have welfare state regimes in Western Europe, such as France, Finland, Sweden, Germany, and Norway, public social spending (as of GDP) has not shown a declining trend since 1960. Although the public social expenditure to GDP ratios have edged downwards starting in 2009 and fell in almost two-thirds of OECD countries

(OECD, 2019), it hardly indicates the expected decline that neoliberalism targeted and showed as a burden to the state. According to one of the recent OECD (2019) reports, for today, pensions and health remain the largest items of public social expenditures, with health being the second-largest. The most recent ratios are still above 20 percent, suggesting that states in capitalist economies still invest or have to invest in social policies. The cost-cutting plan of the neoliberal shift has to be re-evaluated and questioned in that sense.

While public social spending is still high on average, there is an interesting expansion trend in particular countries. In some middle-income and even low-income countries, public social expenditure is on the rise. As Figure 1 also shows, since 1990, public social spending to GDP ratios have more than tripled in Korea and Turkey (ibid:2). This increasing interest of particular governments in expanding their welfare systems has been studied by some scholars and included in international organizations' reports. Noting that the indicators of how well a welfare system performs can be many and complex, we can still see this trend of expansion by looking at specific welfare system characteristics, particularly in the countries where the numbers suggest an upward trend. The figure below shows the changes in the three countries, Turkey, Mexico, and South Korea, and the OECD average with the top line.

Figure 2. Public social spending as % of GDP for selected countries: Turkey, Mexico, South Korea, OECD total, 1980-2019



Source: OECD (2021), Social spending (indicator).

Aggregate social spending ratios in middle-income economies, including Turkey, Mexico, South Korea and Brazil, India, China, and South Africa, have undergone significant changes since the 1980s. According to OECD statistics, public social spending as a percentage of GDP in Turkey rose from 2.25% to 12% from 1980 to 2019. Similarly, the Mexican state increased its public social spending from 1.95% to 7.4% between 1985 and 2019. South Korea increased from 2.68% to 12.2% between 1990 and 2019.[1]

Some influential studies focusing on social expenditures in middle-income countries questioned the determinants of the changes in spending (Haggard and Kaufman, 2008; Huber et al., 2008; Segura-Ubiergo and Kaufman, 2001; Seekings, 2005). As political

[1] OECD (2021), Social spending (indicator). doi: 10.1787/7497563b-en (Accessed on 16 April 2021).

scientists, these scholars are primarily interested in short-term or long-term political power distributions. They depart from a point that the countries might be classified according to their regime forms as democratic, authoritarian, and some intermediate forms based on their strategies (Huber et al., 2008). According to other studies, some lower-income countries in Sub-Saharan Africa and Latin America also expanded their commitments to social protection programs, especially after the 1990s (Barrientos and Nino-Zarazua, 2010; Carnes and Mares, 2015). This commitment, in most cases, has been a result of the poverty reduction-based programs of international organizations such as the IMF, UN, and WB.

In terms of overall social protection policies, conditional cash transfer (CCT) programs have played a crucial role in the transformation. The poverty-based programs were not limited to the lowest-income countries. Starting with the programs *Bolsa Escola* in Brazil and *Progresa* in Mexico, cash transfers have become very important in the global strategy of international financial organizations in terms of poverty reduction policies, spreading to many Asian and sub-Saharan African countries later. CCT programs had visible short-term effects on the labor market and health and educational programs. The long-term impact of the so-called "poverty reduction" strategy after the 1990s and its motivations are rightfully questioned by critical scholars (Craig and Porter, 2006). However, the widely adapted CCT and other social assistance programs provide evidence of the increasing interest of both national governments and international actors in welfare policies after neoliberal restructuring.

Regarding social security, South Korea, Mexico, and Turkey have more than doubled their low rates of public spending on pensions starting in the 1990s (OECD, 2015a). Turkey reached the OECD average as a percentage of GDP in 2017.[2] Pension reforms, especially after the 1990s, were introduced and expanded in many other developing countries, including India (Buğra and Adar, 2008). It is not possible to talk about universal coverage regarding old-age pensions; however, as a poverty reduction strategy in developing countries, basic pensions started to be discussed widely, especially after the World Bank's 1994 report. Although most pension reforms are based on means-tested programs, some national- and local-level governments, such as New Zealand, Mauritius, Bolivia, Mexico City, provide a basic old-age pension without any testing (Willmore, 2007).

Although the rates are still much lower than the OECD average, government spending on health care tended to increase in most of the countries mentioned above, such as Chile, South Korea, Colombia, Mexico, Turkey, Brazil, China, and South Africa, since the 1990s.[3] Among them, Korea, Mexico, Colombia, and Turkey have achieved universal or near-universal coverage of health care costs, similar to most OECD member countries

[2] OECD Pension spending (indicator). doi: 10.1787/a041f4ef-en (Accessed on 05 August 2021)

[3] The increase in government spending on health will rise more with 2020 due to COVID-19. The data for the following years will reflect this rise in the pandemic period, which will complicate the analysis. According to OECD (2021:188), “preliminary estimates for 2020 for a number of OECD countries all point to a significant increase in the ratio of health spending to GDP. This reflects both the extra health spending needed to combat COVID-19 and reductions in GDP caused by restrictions on economic activity. Based on the initial data, the average share of GDP allocated to health is estimated to have jumped from 8.8% in 2019 to 9.7% in 2020.”

except for the United States, Greece, and Poland (OECD, 2015b:121). However, we cannot say that the subcategories of health expenditures show similar characteristics with the increase in public health expenditures in the mentioned countries. For instance, increasing government spending has been accompanied by countertrends in terms of out-of-pocket spending. While Korea still has high rates of out-of-pocket medical spending as a share of health spending, Turkey and Colombia had rates lower than the OECD average, according to the latest data available.[4] The expansion, therefore, has specific characteristics for different country cases.

The statistics and the identified changes in various social policy areas show us that welfare policies continue to be an interesting research agenda, especially for nonadvanced welfare regimes after the 1980s. Depending on the available literature and statistical data, Turkey, South Korea, Mexico, Colombia, Brazil, Chile, India, China, and South Africa seem to show similar trends in increasing governmental expenditures and expanding welfare provisions. There are, indeed, structural and consequential variances between the social policy programs within these countries. As statistics clearly show, the proportion to the national income of the amounts invested in different policy areas differs. Even when the proportions seem to converge, the consequences of the policy decisions may vary widely. However, states continue to be the actors shaping the welfare

[4] OECD Health spending (indicator). (Accessed on 05 August 2021). It is also important to note here that the increases in governmental spending may not necessarily reflect a healthier society. In Korea, for example, where the coverage is universal (100%), the proportion of the people who consider themselves in good health is 35%, the lowest percentage in the OECD statistics (OECD, 2015b).

system, particularly in the countries mentioned above, which might allow us to conclude that welfare systems have been transforming with puzzling trajectories after the neoliberal shift.

Therefore, the observation we made on this group of countries reserves a puzzle that makes us question why these governments have been significantly increasing their budgets for social spending and are interested in expanding welfare services and people's access to services. The agenda of expanding the free market has been implemented; however, this process has also been realized by increasing public social expenditures. The economic crisis in developed countries and the restructuring of the welfare regime were followed by structural adjustment programs in developing and underdeveloped countries. As I will discuss in the next chapter, the Washington Consensus of 1991, in particular, embodied a policy transformation for the world. The studies focusing on expenditure changes in the developing world have primarily been informed by the policy set created by this consensus. However, the effort to understand and analyze social policies goes further back than these relatively recent discussions. As the literature will point out, although there are significant structural differences between the two periods, the expansion of welfare services and the increase in public social expenditure in both periods may reserve some common explanations. Therefore, to understand developing countries, it is necessary to benefit from the earlier literature that tries to explain the expansion in their period. Before moving on to approaches to post-1980 restructuring, I will review pre-1980 theoretical approaches, which mainly include the welfare state discussion. The following sections will attempt to review the concerned literature on

welfare systems and social policies, keeping in mind that the neoliberal scheme did not undermine capitalist governments' and international actors' interests or needs to keep public social expenditures at a certain level.

2.2.2. Early literature on welfare systems

Although the worldwide welfare expansion after World War 2 had not been taken as an intellectual puzzle because of the rapid economic growth in the Western world, the comprehensiveness of the social programs and universal benefits denoted a major transformation. Modernization theory assumes that "only a matter of time before less developed nations would modernize sufficiently to develop the economic surplus and bureaucratic capacity that would allow them to initiate similar [welfare] programs" (Quadagno, 1987:110). As a result, the earlier theoretical accounts on social policies primarily focused on explaining the welfare state's emergence and role, mostly assuming continuous economic expansion. The mid-1970s crisis changed this assumption, but the major discussion had been around the welfare expansion until this crisis. Tracing theoretical developments before the crisis will, therefore, provide us with helpful theoretical insights about welfare expansion trends in general

A basic functionalist approach, known as the logic of industrialism thesis, stated that the emergence of the welfare state as a new institution was an automatic response to industrial development. The dissolution of traditional welfare (family, churches, etc.) resulting from the transition from agrarian to industrial production necessitated new welfare institutions, mainly because traditional institutions cannot meet the needs of new

vulnerable groups in industrialized societies. This perspective, which establishes a direct relationship between industrial development and welfare expansion, has explanatory power to a certain extent. For developing countries, industrial production might have required new institutions of welfare. However, this thesis was intensely criticized in later discussions because there is no sufficient evidence to assume a direct relationship. Such a need will uncertainly be met by political and economic elites or any others. Moreover, according to its main assumptions, heterogeneity in economic development and welfare regimes was not an issue (ibid: 112). The economic expansion, which the logic of industrialism thesis saw as solid before the crisis of the 1970s and thinks it will continue, is valid for neither the post-1970 capitalist economy nor the economy of developing countries.

On the other hand, rather than attributing the expansion of welfare to industrialization only, neo-Marxist theorists proposed more comprehensive explanations considering different forces. Accordingly, it is true that the transition to capitalism led to the dissolution of other societal insurances and necessitated a welfare system by the intervention of the state, but the welfare state should be examined within the capitalist state discussion, and the social policy interventions of the states should be considered as the requirements of the capitalist market. O'Connor (1973) was the first to emphasize the need to understand social expenditures within the power relations of the capitalist economy. According to him, the capitalist state organizes capitalist production while trying to balance two different social relationships. One of them is between and within the economic classes. The other is between economic classes and state power. The state is

under bilateral pressure to increase welfare expenditures on the grounds of both accumulation and legitimacy. Any state power that ignores the necessity of saving the process of capitalist accumulation would risk "drying up the source of its own power" (O'Connor, 1973:5), and any state power that ignores its legitimacy would jeopardize its own existence. Gough (1979) also offered a Marxist explanation, opposing the idea that social policies' role is to improve individuals' life conditions.[5] According to him, the development of the welfare state is inherently contradictory because it has to work toward controlling the workers while trying to increase social welfare. According to Gough (1979:44-45), "we shall characterize the welfare state as the use of state power to modify the reproduction of labor power and to maintain the nonworking population." At the same time, in his work on state expenditures in advanced capitalism, Gough puts that the increase in spending contributes to profit and surplus value production. In this sense, the increase does not contradict capital accumulation, and it is an increasing necessity of accumulation (Gough, 1975: 83).

Another neo-Marxist scholar, Claus Offe, emphasized late-capitalist societies' tendencies while making similar emphases in explaining the state's role in capitalist accumulation and legitimacy. Offe emphasizes that the capitalist state must intervene in the economy and society to create and protect the market, and these interventions are social policies.

[5] I should note that although he seems not to abandon his emphasis on the explanatory power of the political-economic approach in social policies, Ian Gough has changed his anti-capitalist inclination with anti-neoliberal capitalism. Therefore, the difference in the ideological inclinations between the earlier and later works of Gough should be kept in mind for following references. For an exemplary discussion, see: Gough, (2012).

Offe's (1984:153) influential study on the contradictions of the welfare state is dedicated to showing that "while capitalism cannot coexist with, neither can it exist without, the welfare state." The welfare state functions to make class conflict less visible by compromising with both classes. Workers accept the legitimacy of the capitalist system because welfare benefits depend on economic surplus, and capitalists do not oppose welfare state expenditures to ensure a healthy working class. Regarding this second argument, critical accounts said that it is not possible to find a straightforward relationship between health expenditures and the population's health (Parkin et al. 1989). Nevertheless, Offe's account makes it possible to see the development of social policies as dynamic. Accordingly, any explanation of social policy "must take into account as causal factors both 'demands' and 'systemic requirements' that are problems of 'social integration' and 'system integration,' the political processing of both class conflict and the crises of the accumulation process" (Offe, 1984:104).

It is plausible that the contribution of neo-Marxists to the welfare state debate has primarily remained an explanation for the welfare state itself and assumes some insufficiently evidenced direct relationships. However, it does provide an essential framework to understand the relationship between the capitalist state and social policies that can also be considered beyond the advanced welfare regimes. One of the most critical points evolving from the neo-Marxist approach is that social policy is constitutive of the market economy and exists to secure the market. This argument does not necessarily mean that the state responds to the ruling class only. In contrast, Marxist explanations consider the welfare state's contradictory nature a simultaneous response to

capitalists' and working classes' interests. It is possible to evaluate the theoretical contribution of neo-Marxist explanations for nonadvanced capitalist systems. Although the policies of the welfare state practices and the current welfare regimes are very different, it is still possible to think that social policies and public expenditures contribute to the legitimacy of the economic and political systems. The mentioned contradiction is a valuable contribution to theoretically explaining the complicated nature of social policies. However, theories that say this nature is more complex than neo-Marxist explanations, especially in explaining different welfare regimes, also have significant contributions.

Approaches such as the social-democratic approach, power resources theory, and institutional approaches criticized the previous approaches. They suggested filling the gaps, arguing that the logic of industrialism and Marxist approaches share an economically "crude" and structurally determined analysis, especially when the differences and complexity in welfare systems are considered. Moreover, the conceptualization of the state is mainly considered not comprehensive enough by many nonMarxists. The contributions from scholars such as Korpi (1983), Esping-Andersen (1990), and Skocpol (1995) put the discussion of "politics matters" forward. The social-democratic view conceptualizes the state and social policy as positive forces that lead to a socialist society. Thus, the functions of welfare policies are considered favorable to the extent that they help reduce inequality, meet social needs, and extend liberties. In this context, industrialization is the base that created the social conditions for a collective response to emerge through state activity. As a derivative of the social democratic view, power resources theory focuses on the strength of organized labor (Korpi, 1983) and with

whom the working class aligns (Esping-Andersen, 1990).

On the other hand, institutional approaches shift the focus from labor politics to the influence of the state in social policy formation. Accordingly, the state is not considered a set of different activities shaping social policies. According to institutional approaches, policies are affected by various other factors, such as bureaucrats' role, the capacity of welfare programs, party systems, and the influence of past policies (Heclo, 1974; Skocpol, 1995; Skocpol and Amenta, 1986). These models took advanced capitalist economies as their case studies in the mentioned seminal studies; however, especially after 1980, they formed a fundamental basis for understanding and classifying welfare regimes outside of developed capitalist countries.

Esping-Anderson's classification has become a classic classification for comparative studies and has been extended to cover those other than Esping-Anderson's original three regimes.[6] His suggestion of an interactive approach for comparing welfare states by considering the principles for which historical actors have willingly united and struggled (Esping-Anderson, 1990: 32) allows scholars of social policy to analyze other cases with their differences in class coalitions. As I will mention in the next section, although these classification studies have now turned into a futile effort in the literature for developing country cases, they maintain their pioneering role in understanding the impact of different

[6] Esping-Anderson (1990) identifies three main welfare-regimes in his seminal work, *The Three Worlds of Welfare Capitalism*. Based on the different arrangements between state, market, and family, the three regimes are named as the liberal welfare state, corporatist welfare states, and social democratic welfare states.

actors on social policy formations and conducting an interactive analysis.

After all these debates, the neoliberal approach rejected the idea of social or welfare rights totally, advocating that any criteria other than market distribution would lead to unjust outcomes. Methods advocated for getting out of the crisis led to neoliberal restructuring, and Washington Consensus was a crucial point of departure in the restructuring process. As I will try to address in Chapter 3, it is not possible to say that the radical rejection of the neoliberal approach to welfare has been fully implemented either practically or theoretically. However, at a general theoretical level, neoliberal restructuring has changed the nature of the mainstream political debate and the way to think about the state's responsibilities, thus dominating policy discussions. It can be regarded as a paradigm shift, after which the theoretical debates on social policy focused on explaining the transformations led by the restructuring and different policy outcomes in different parts of the world.

2.2.3. The literature on the transformation of welfare systems

Social policy scholarship experienced a kind of rupture after the economic crisis of the 1970s with the dominance of neoliberal economics and politics. Furthermore, historical trajectories of welfare systems varied widely as the welfare issue in the neoliberal era became more complex and puzzling. The common assumption of welfare state scholarship, the positive relationship between economic growth and welfare expansion, was questioned in the context of advanced capitalist states. Thus, the concern of explaining the role of the welfare state and its structure has been replaced by what is

happening to welfare systems. This section will identify the common features and assumptions underpinning the post-1980 welfare state or social policy debates. While ideologies and theoretical inclinations differentiate themselves from each other, they also have a common tendency toward explaining transformation as a response to structural change (primarily referring to advanced capitalist states) and as a matter of failure or success in responding to these changes (primarily referring to developing countries). This common tendency largely expanded, ignoring class politics and political struggles (see Yörük, 2012b) and the role of social policies in the accumulation and reproduction of capital at both the social and economic levels. The existing post-1980 literature on welfare systems needs to be outlined critically considering the mentioned gaps.

It is important to note that the post-1980 literature cannot be considered separate from the earlier major accounts that shaped the basis for contemporary studies. There is no doubt that much has been added to earlier debates. However, the literature concerning the welfare systems after the neoliberal turn mainly proceeds without much political and ideological conversation that the preneoliberal literature had (i.e., the dialogue between the social-democratic, institutional, Marxist and liberal approaches). While Marxist explanations have lost their influence on the overall literature, different approaches have started to converge with some of the assumptions of liberal accounts.

In a general sense, classifying the post-1980 literature as prioritizing structural and political-institutional factors is possible. While the first focuses on the structural consequences of restructuring, such as the rise of poverty, unemployment, and labor

informalization, and aging in developed countries, the second prioritizes the factors imposed by domestic politics and institutions and international political institutions. Although the earlier accounts had considered many political factors in terms of advanced welfare systems, it is possible to say that structural factors have dominated the explanations for welfare system transformations in the neoliberal era. As I will elaborate on, political-institutional explanations analyze various factors, such as institutional cultures, voter influences, and the influence of governments and international organizations. In many theoretical explanations, structural and political-institutional factors have been considered together. Most of the influential studies have suggested that many structural transitions work together. Social policies are defined as the responses of governments to social and economic problems led by neoliberal restructuring. These studies insist on focusing on the effects of technological and economic factors related to the particular development of capitalism while acknowledging certain political factors. However, contrary to the analysis of advanced welfare systems, political-institutional aspects are emphasized more in the analysis of developing states' welfare regimes.

In his influential work, Pierson's (2001) main focus was structural factors, suggesting four main "postindustrial transitions" that put pressure on welfare systems: the rise of service sector resulted in slower growth; the welfare state expansion has gone thus far that the growth is no longer sustainable; population aging requires expanding contributions (in terms of both pensions and health provisions); and finally, the transformation of household structures, such as the increase in women's labor force participation and rise in single-parent households, putting pressure on traditional welfare

systems that were based on male breadwinners. From a similar point of view, Iversen (2001) has put deindustrialization as the main factor challenging traditional welfare systems. According to him, the most crucial source of the risks in the labor market, which the states are expected to compensate by expanding social security, can be studied under the concept of deindustrialization. For these explanations, the rise of income-based welfare policies replacing employment-based policies can rightly be defined as the "logic of deindustrialization thesis," referring to the "logic of industrialization thesis" that explained the shift after World War 2 (Yörük, 2012a:30). Although the general structural transformations were studied as the effect of the postcrisis in advanced welfare regimes, it also became inevitable to examine the developing country cases in terms of these transformations in the new international order.

From a different point of view, Jessop's (2002) significant contribution aiming to identify the social policy regime emerging from the 1980s is also mainly based on structural changes. He extended his analysis to many different country cases in the following literature. As a Marxist, Jessop attempts to explain the transformation by evaluating the changes in the accumulation regime. Like the Marxist theorists of the welfare state, Jessop emphasizes the function of accumulation in the continuation of capitalism. However, he still argues that the form and functions of the state in capitalist society differ historically and nationally, thus emphasizing, in addition to Offe in particular, that state power can be more or less capitalist depending on specific situations (Küçük, 2018a:49). This argument leads him to define a new regime that emerged according to the different accumulation regimes after the crisis of Keynesian policies. Accordingly, the post-Fordist

accumulation regime, characterized by small-batch production, economies of scope, flexible production, and flexible labor force, has brought in a different labor process. The new labor process has necessitated a different mode of governance. Jessop identifies the old regime as the Keynesian Welfare Nation State (KWNS) and the new mode of governance as the Schumpeterian Workfare Postnational Regime (SWPR). In the Schumpeterian state, state activity focuses on the supply side and supports innovation and production. The implications of this accumulation regime for social policy are that social policy becomes subordinate to the demands of economic competitiveness to sustain the market economy and reproduce labor power. The reorganization of UK's NHS in the 1980s and 1991, for example, can be seen as a fit with the SWPR framework with the start of contracting out of ancillary services, tendering processes for nonessential services, the competition required for hospitals, and the rise of prescription charges (Greener, 2004: 665, 666).

Jessop's supply side-oriented theory has been criticized by some scholars working on the politics of health care. Some said that, unlike earlier neo-Marxist approaches, Jessop's emphasis on accumulation left the legitimation function behind. Harrison and McDonald (2004) argue that there is not enough evidence that health policies, in particular, contribute to Schumpeterian economic policy in the NHS. They show that despite the financial crisis and the transformation in policy areas such as education and social security, the NHS remains a highly legitimate institution. Major political parties still aim to reproduce their legitimation through the NHS. It is also possible to consider social policies as state legitimation tools by exemplifying how states can utilize different social

policy areas to contain social unrest to ensure capitalist accumulation. Following the Marxist perspective on welfare systems, Fox-Piven and Cloward (1993) argued that state intervention in relieving poverty is an issue of reproducing necessary labor and containing the possible social unrest triggered by capitalist conditions. Their seminal study showed that the capitalist system also uses social services to contain public disorder, jeopardizing capital accumulation. According to them, relief systems help capital regulate labor, and this kind of analysis of social services focuses on the functions of welfare in relation to both the economy and polity. Therefore, as it is understood from the important studies on how health policies are used as a populist tool, it is necessary to consider the characteristics of state legitimation reproduction, especially in addition to supporting the accumulation process of health policies.

In line with the mentioned critical accounts, many contemporary studies have touched upon political-institutional factors such as public opinion, institutional cultures, partisan politics, voter influence, and the stance of governments in the political spectrum. These factors are mostly considered determinants to explain the persistence of the importance of public expenditures. For example, in their study, Erikson et el. (2002:319) concluded that "national institutions reflect public opinion" in policymaking, and they do so "with considerable urgency" in the US setting. Wleizen (1995) argues that public opinion works like a “thermostat,” sending signs to policymakers about their preference for more or less spending. Although Wleizen’s study focused on defense spending, he argued that the public response was significant in the changes in expenditures for other social policy domains such as education, health and welfare. Others have drawn similar conclusions,

arguing that social spending decisions are affected by aggregate policy preferences in the US (Brooks and Manza, 2006a) and in various OECD countries (Brooks and Manza, 2006b; Hobolt and Klemmensen, 2005; Korpi, 2003; Soroka and Wlezien, 2005). These empirical studies build themselves upon a theoretical mix of social policy scholarship, from power resources to Esping-Anderson's modeling, making theoretical clarity of secondary importance. Moreover, it should be noted that public expectations are questionably independent of manipulation (Brooks, 1985).

Seeing dominant political parties' or government coalitions' stances as the primary determinant is another but popular explanation for the difficulty of rolling back in advanced welfare states. Navarro et al. (2004) argue that welfare states of the developed world after globalization did not change their characteristics established in the preglobalization period. According to their study, the welfare states measured by social expenditures and by public employment have, for the most part, continued to expand primarily due to the social democratic parties that had continued to be influential in advanced capitalist countries even after globalization. They suggest that the exceptional times when social spending did not increase in a certain period in a particular country can be attributed to political changes in that country rather than the effects of globalization. Brooks and Manza (2006a) also conclude that mass policy preferences significantly affect policy outcomes, particularly in European Social (Norway and Sweden) and Christian democracies (Austria, France, Germany, Italy, the Netherlands, and Switzerland). While citizens have a significantly effective preference for public provision in European social and Christian democracies, these countries have higher levels of

spending effort than liberal democracies (Australia, Canada, Ireland, New Zealand, the United Kingdom, and the United States). Following these studies' conclusions, we may infer that since governments have to respond to their citizens' policy preferences and social democratic parties occupy a powerful place, the task of retrenching welfare systems is considered not easy. In other words, an already established welfare structure can hardly be moved backward, mostly because policy or social spending expectations of the masses are high.

Searching for political explanations rather than focusing on economic factors is certainly not new to analyzing welfare systems. As I examined in the previous section, some perspectives also highlighted class politics together with explanations of economic structure. However, regarding the analysis of welfare system transformations, politics is also mostly bound to a theoretical complexity. Moreover, in these studies, public opinion was generally limited to voter behavior instead of considering grassroots movements or organized groups as pushers for more public provision. Different from their theoretical references, these kinds of contemporary analyses tend to pull economics away from politics. Marxist attempts, especially Jessop's intervention, attempted to fill this gap for critical social policy scholarship students. However, we must acknowledge that all the mentioned studies, including the Marxist studies, focus on the transition in advanced capitalist states. In addition to channeling the analysis toward voter behavior for empirical evidence, the contemporary literature also faces a challenge in understanding the changes in developing economies. Although some of the structural factors may well apply to neoliberalized developing economies, it is considered rather challenging to base

welfare system transformations in these countries on the same structural factors, mainly because the historical trajectories of welfare system developments are different. As a result, politics seem to be a more popular explanatory factor for developing economies.

The studies on developing economies rightly start with the truth that there is no history of an established welfare system to compare with the present welfare regime. This truth understandably creates a more complex picture for scholars interested in the transformation in less advanced capitalist countries of the world. Many studies focusing on social policies in less developed countries are informed by Esping-Andersen's (1990) concern of comparing and categorizing different systems. Esping-Andersen's original typology concentrates on the developed world. Still, his approach suggests that we can also identify some common characteristics of the welfare systems found in the developing context. A significant contribution was made by Ferrera (1996), who suggested a "Southern Model." The idea is based on the fact that the southern part of Europe and the world does not fit into Esping-Andersen's categorization. Ferrera includes Southern European countries, Spain, Portugal, Greece, and Italy in his model by mainly focusing on these countries' political and institutional structures. [7]

The Southern Model, according to Ferrera, still relies on traditional welfare systems and cannot establish a modern state in a Weberian sense, primarily due to their different styles of state administration. Therefore, particularly with neoliberal restructuring, public-

[7] Turkey is suggested to be discussed in this category (Buğra and Keyder, 2006; Grütjen, 2008). Another category was also suggested for East Asian countries (Lee and Ku, 2007).

private relationships have not been well established, which resulted in a clientelist welfare model. To illustrate the Southern Model, Ferrera uses the term clientelist welfare model, based on the notion of "stateness" that refers to state penetration in the welfare sphere. According to Ferrera, Mediterranean welfare states have a "low degree of state penetration of welfare institutions" and "high vulnerability to partisan pressures and manipulations" (1996: 25). He defines the difference of these countries as follows:

> (T)he south European welfare state is characterized by a peculiar mode of political functioning which distinguishes it not only from the highly homogeneous, standardized and universalistic welfare states of northern Europe but also from the more fragmented continental systems. The social policy institutions of Italy, Spain, Portugal and Greece may formally resemble those of other, 'corporatist' (and Catholic) countries; however, the 'sociopolitical etiquette' which inspire their functioning is hugely different. Welfare rights … rest on a closed, particularistic culture and on a 'soft' state apparatus, both still highly imbued with the logic of patron-client relationships which has been a historical constant in this area of Europe (Ferrera, 1996: 29).

Wood and Gough (2006) follow similar thinking and conclude that the primary problem in the Global South is the lower capacity of poorer states in terms of pursuing better welfare rights. According to them, "states in poor countries have problems of legitimacy and that well-functioning labor and financial markets are not pervasive" and "that these problematic conditions limit the capacity of the state to act in a compensatory way for the inequitable outcomes of the market in highly unequal societies."[8] Similarly, by building

[8] Wood and Gough (2006) diagnose these welfare systems as clientelist and propose using the concept of declientelization for the developing countries because Esping-Andersen's decommodification concept can only be applicable for advanced capitalist countries. In their own words, the term "is deliberately etymologically constructed as a

upon different comparative work cases, Glatzer and Rueschemeyer (2005:207) conclude that in middle-income countries, "[domestic] politics make a decisive difference for the consequences of economic globalization for social policy in a given country." According to them, some of the major political factors affecting welfare systems can be summarized as the degree of democratization, the state's (in)capacity for policy innovation, less powerful labor, and an unsustainable pattern of previous welfare mechanisms. Therefore, the expansion of welfare systems among developing countries can be explained to the extent of their democratization, labor strength, and state capacity to implement necessary welfare mechanisms.

There is no doubt that studies explaining the differences and commonalities have enlightened particular aspects of newly emerging and transforming welfare system groups. However, including the transition of welfare systems that have not been considered advanced welfare systems into a global categorization resulted in focusing on the state incapacity of the nonadvanced systems. Moreover, as Abrahamson (2000) argues, the "welfare modeling business" has turned into unfruitful clustering work since much effort has been put into explaining the outliers and trying to identify new clusters. Powell and Barrientos (2011), referring to Esping-Anderson's work, find it ironic "that a

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conceptual alternative to decommodification. It refers to the process of delinking client dependents from their personalized, arbitrary and discretionary entrapment to persons with intimate power over them." Although the terminology they offer may seem to be a unique suggestion, the scholars' proposition to overcome the problems in welfare rights in poorer countries are extremely generic to have any practical results. They argue, for example, "a social policy agenda in poor countries has to include converting the elite's objective interest in, and frequent desire for, public goods into the corresponding public action to deliver them. In other words, it needs to pursue a regime change, in which the elite's correlative duties are expanded in response to the rights claimed by others."

work aiming to lay bare the theoretical substance of welfare states has led to a largely atheoretical debate." I should also add this focus to national "capacities" results in ignoring global political and economic changes and enforcements in the developing world.

Contrary to the national focus, another angle within the literature has been international politics rather than domestic politics. This perspective is partly able to move the discussion to global political-economic issues. The starting point of these studies is that international economic and political organizations have increasingly addressed social policy issues, especially after the post-Washington Consensus. One of the most cited scholars studying the globalization of social policy in the developing country context, Deacon (Deacon *et al.,* 1997), argues that international organizations need to be given more attention to explaining the transformation of welfare systems or changing social policies. Accordingly, "because social policy's analytical frameworks have derived from work on economically privileged North and West welfare states they have tended to downplay the importance of background institutions like the IMF and the World Bank" (ibid:2).

Putting forward the need to understand the impact of international politics is convincing. This kind of need arises more explicitly when the developing world is considered since international organizations, and developing countries are so connected that no study about the political economy of a developing nation can ignore the relationship. Many studies informed by this perspective have examined different international institutions

and different country settings. For instance, focusing on international actors, particularly the EU and OECD, Ervik *et al.* (2009) attempt to examine how important international actors are in national policy-shaping in the context of EU and OECD member countries. Deacon (2007) conducted another study in which he reviewed the social policies of organizations. He examines the World Bank, IMF, WTO, OECD, and UN agencies individually. In other studies, the focus has been directed to international interventions in different regions, such as southeast Europe (Deacon and Stubbs, 2007), Africa, Asia, and Latin America (Deacon, et al., 2010). When similarities and differences are considered in each case, it seems that at least two important conclusions would be possible. First, different international actors are "competing to shape the social policy of the region." Second, "where the economy and the state have been weaker (even taken over as a protectorate) and where 'civil society' or the 'public sphere' appears less active, then the role of international actors has been that much stronger" (Deacon and Stubbs, 2007:226). As we shall see, policy transfer from the IMF and the WB also characterized the policy changes in Turkish history, especially when a neoliberal structural agenda was secured after the 2001 crisis (Dorlach and Savaşkan, 2018; Şener, 2015).

2.2.4. A critical assessment

Both the literature focusing on structural transformations and the literature focusing on political-institutional factors explaining the post-1980 transition have significant contributions. However, in terms of structural factors, mature welfare state cases tend to dominate the literature. On the other hand, the scholars who contribute to the literature on middle-income countries mainly limit themselves to determining different welfare regime

categories based on the idea that comparative studies should include other parts of the world. It is difficult to see the clarity of the theoretical approaches before the transformation in the approaches after the transformation. In general, it seems that theoretical perspectives are blended. The fact that complex processes have been experienced in all countries of the world and the economic restructuring experienced after 1980 may have also invited a theoretical mix. However, for middle-income countries, the approaches mostly tend to emphasize political-institutional factors. Studies that connect the fact that a strong welfare regime has not developed to the cause of state incapacity and that examine the impact of the global social policy agenda set on middle-income economies constitute two crucial parts of the literature dealing with political-institutional factors.

An important conclusion emerges, I suggest, after critically examining the studies on social policy transformations after 1980: Neo-Marxist theories that try to explain the connection between social policy and the transformation of capitalist production relations, which seem to disappear from the theoretical debates, need to be revived. By acknowledging that the increase in public expenditures is structurally different from the welfare state regimes, social policy needs to be evaluated together with the capital accumulation processes and the changes in these processes to understand the policy transformation as a common result of both economic restructuring, the response of the state and political-institutional factors changing with this restructuring.

When considering the neo-Marxist explanations of welfare systems, it becomes clear that

one of the most critical aspects of Marxist social policy studies is to contextualize the complex social policy-making processes within the capitalist mode of production. Lavalette (1997:97) suggests that earlier Marxist explanations have mainly talked about four pressures through which social policies are shaped: a) the structural needs of the system; b) capitalism and the bourgeoisie's need to obtain legitimation; c) the demands of the working classes; and d) intraclass conflict. By looking at this basis created by Marxist theory, it is possible to make more comprehensive interpretations of the social policy formation process, especially in late capitalist countries after 1980. As I mentioned above, one of the most focused points of the literature examining social policy formation processes in these countries is the active role played or expected to be played by the capitalist state in policy formation and the impact of international social policy conjuncture. In addition to the four pressures that Lavalette counts, I suggest adding the following two pressures for middle-income countries: (1) the specific development of the less advanced capitalist state and (2) the international policy framework.

The first of these additional pressures would help consider the complicated development of less advanced capitalist states and accumulation strategies, whether we engage in a welfare regime modeling business or not. These complex developments are very dependent on structural needs, as Jessop suggests. However, we should also acknowledge that legitimacy issues for the capitalist state, different power dynamics, and weaker labor power differentiate the policy formation processes for these countries compared to less advanced countries. Putting forth and evaluating these differences can form a whole together with the country-specific analysis that each study will make. The second is also

a strong pressure that should be analyzed for every less advanced capitalist country. The relations of states with international economic and political organizations and how they position or have to position themselves according to the transnational social policy paradigm are essential parameters. In short, there are many intertwined processes that we need to consider when examining today's policy formation processes, which can be relatively complicated for less advanced capitalist countries.

As I will try to elaborate in Chapter 3, acknowledging the above complexities for less advanced capitalist countries is of great importance. This acknowledgment, I argue, will provide explanatory power as long as we bring back the fundamental underpinnings of the Marxist theory on welfare regimes into our questioning and consider the recent transformations based on this critical perspective. Considering that there is no academic integrity regarding the studies on late-capitalist countries' state of articulation with the world economic system and the dynamics that shape this process, the example of Turkey, which we will examine in this study, will serve to understand the process better. However, we should also complete the picture by looking specifically at health policies and reforms, in line with the particular purpose of this study.

2.3. Understanding health policies in developing countries

2.3.1. The history of health policies

As one of the major social policy areas, health care comprises several different production and labor processes. Although it is mainly considered a service industry, it is also linked to various production industries, such as pharmaceuticals, medical

technology, and even construction. Lister (2007:12) defines the health care industry as probably the world's largest single industry, equivalent to a tenth of global GDP. However, in addition to being an ever-expanding industry, health care has always constituted a field where state-society relations have been shaped. In other words, it is one of the most regulated sectors in all developed countries despite different types of health systems.

The earliest example of the governments' systematic and planned involvement in public health is seen as Bismarckian social reforms of the 1880s started by Bismarck in Germany. Establishing a series of compulsory insurance programs for workers in Germany, Bismarck started a policy debate, which disseminated across Europe and the Americas. It was about helping workers by creating state-run and state-subsidized schemes[9] "when market incomes were interrupted by old age, ill health, or unemployment" (Skocpol, 1995:160). Only 40 years before these discussions, in England, at the epicenter of industrialization, the physical health of most of the population was very poor, infectious diseases were prevalent, and people ate contaminated food. This situation worsened when the masses migrated from the countryside to the cities. In fact, in Liverpool in 1840, the average life expectancy of

[9] Briggs (1961: 249) warns that Bismarck's this decisive policy was actually a move to prevent the further strengthening of the economically and socially stronger working class. Accordingly, "Bismarck was anxious to make German social democracy less attractive to working-men. He feared "class war" and wanted to postpone it as long as possible." He also quotes Bismarck who argued that that “if the state would only show a little more Christian solicitude for the working-man, then the social democrats would sound their siren song in vain”.

working-class children was 15 years, while it was 35 years for upper-class families (Leys, 2009).

Rapid industrialization and urbanization were considered the most important factors that pushed governments to intervene in public health issues. The physical and social reproduction of working classes started to be a concern for governments. Most epidemic diseases led to tragic increases in mortality in industrial cities in the mid-1800s. According to Fraser (2009), only a sudden cholera epidemic could mobilize state action. It was, of course, not only the working classes that were affected by cholera. As a water-borne disease, cholera "attacked all, notably the middle classes with their water supplies and struck fear into the hearts of the governors" (ibid:73). In this period, developments concerning public health were mainly related to preventing the spread of epidemic diseases (Fraser, 2009; Panitch and Leys, 2009). Due to various preventive measures, life expectancy and general public health experienced a significant improvement that was unprecedented in human history. By 1950, the average life expectancy in England had risen to approximately 70 (Leys, 2009). As Leys (2009) puts it, this improvement resulted from the sanitation movement beginning in the 1870s. The governments' role had been to improve the economic and environmental factors that had serious impacts on public health.

In the first half of the nineteenth century, countries throughout Europe witnessed similar epidemic diseases, poverty, and urbanism, pushing many European governments to take measures. However, it is essential to note that the impacts of these problems on societies

and their influence on governments vary greatly. For example, while in United Germany after 1871, the state program for health reform was already extensive, French governments enforced little systematic or comprehensive state action until later decades (Porter, 1999). After the sanitation movement, the second phase of social policy in health was the welfare state movement after World War II. Coinciding with advances in medical science, health policies in welfare states evolved into "health care systems." The welfare state era in advanced capitalist countries was characterized by the more direct intervention of the state and public spending on health, eventually constituting approximately 20 percent of state budgets.

The expansion of health care systems within welfare states throughout Europe, however, has never been uniform. Although each country's case can be regarded to have a different form of a health system, it is generally accepted in the related literature that these systems have two roots that differ in their resource generating models for health funds. One is the model of Bismarck, who introduced social insurance in the nineteenth century. Bismarck’s compulsory health care system includes contributions that are deducted automatically from salaries along with contributions of employers and the state. The other model, named after Beveridge, who reorganized the British welfare system after 1945, depends on funds from the state's tax revenues.

While the Bismarckian model primarily expanded in continental Europe, the Beveridge system was adopted in Britain and Nordic countries. It is again important to remember that each country has had its own version of these systems. However, for each case, it is

possible to say that there was, in addition to securing the wellbeing of citizens, a redistribution concern to some extent, as higher income means higher taxes and higher social insurance contributions. The state's role has been critical in terms of taking responsibility and expanding access to health care. European states expanded their commitment by introducing supply plans, research funding, education for medical professionals, control of medical standards, and, more importantly, by extending health care funding (Hermann, 2009:126).

On the other hand, the development of health care does not follow a historical trajectory on which a systematic picture can be drawn for so-called developing states. However, many of them shared the tendency to cover urban, active, and predominantly public and formal sectors. The shares of government expenditures have also been much lower than in European countries (Sen and Koivusalo, 1998). There were also other structural differences. For instance, since the preventative mechanisms had not been developed as they did in European countries, diseases that spread in developing countries evolved differently and generally more seriously (Ağartan, 2015).

Moreover, access to health care has been problematic; infrastructures for health services have been insufficient; the most critical health institutions were limited to large cities (Belek, 2014). In fact, public spending on health was concentrated in cities, although the population was still concentrated in rural regions until the recent mass urbanization processes started in the 1960s and 1970s. This situation also led to the fact that majority of rural populations had no access to health coverage (Buğra and Keyder, 2006). An

exceptional trend of the 1970s should be acknowledged here by reminding that some governments in Asian and African countries had to respond to universal health coverage demands from anti-colonial and revolutionary movements. This demand could be met only by the rapid creation of a government health service (Bloom et al., 2008). However, for developing countries in general, the state has never reached the Keynesian state's dominant role in advanced capitalisms.

2.3.2. Health reforms after the 1980s

The second paradigmatic change affecting health policies was the ending of well-known welfare state systems and the beginning of neoliberal reform packages, starting with the 1980s. The major restructuring of the state has been almost global, although the existing structures were different. The shift from Keynesian to Schumpeterian aims and modes of intervention, as Jessop (2002) identifies, characterizes the neoliberal change in developing countries as well. An early report of the World Bank suggesting a reform plan can be considered a summary of transformations. The 1996 report proposes four main policy reforms for developing countries: 1) charging users of government health facilities, 2) providing insurance or other risk coverage, 3) using nongovernment resources, and 4) decentralizing governmental health services (Mehrotra and Delamonica, 2005). Despite some retreats from the global policymaking circles after the 2000s due to unexpectedly harsh consequences of neoliberal reforms, these four main points still reflect the major characteristics of the intended changes in health care after the 1980s' state restructuring.

Unlike advanced capitalist states, health reforms in developing countries have been implemented chiefly under the rubric of structural adjustment programs (SAPs). Based on these programs, health care reforms after the 1980s have tended to include changes concerning the financing and organization of health services. Although economic restructuring and state reorganization have shown differences in implementation in different country contexts, the central tendency has been to establish a pro-market character in the reform processes. However, it is not the case that the reforms have turned health care systems into totally private systems where states have no regulatory power. However, despite the differences, the most characteristic feature of health care reforms in developing countries is their pro-market inclination. The dominant policy paradigm promoted by international institutions, especially the World Bank, established this common tendency. Merging social insurance funds originally established for different occupational groups (by claiming to overcome inequality problems), introducing a purchaser-provider split, which means separating the payer and provider of health care services (by claiming to achieve cost-effectiveness), introducing user charges, and increasing the role of the private sector can be counted among the most common elements of the mentioned policy paradigm.

Two important trends concerning the content of health care reforms in developing country cases, as Yılmaz (2014) points out, are worth mentioning. Most of the Latin American reforms and Turkish reform share a politically secretive process while implementing the reforms. It means that nongovernmental organizations and trade unions have not been included, at least formally, in the policy-making processes. Second, along

with the Latin American cases, the developing country cases in Southern Europe and East Asia also seem to be implementing passive (or incremental) privatization while increasing the private sector's role in their health care systems (ibid:113-114). Exemplified mainly by the increasing numbers of public/private partnerships (PPPs), the incremental privatization process entails a shift in favor of the private sector. It incorporates a public/private mix of service provision and financing, different than the total sale of public health care facilities or leaving the health insurance market entirely to the private sector.

As mentioned before, compared to early capitalist countries, developing country governments have not reached high levels of government spending on health care. In sub-Saharan Africa, the share of the government budget allocated to the health sector fell during the adjustment period in many countries (Sen and Koivusalo, 1998:203). There have also been several studies documenting that the overall improvement in health status slowed down since the early 1980s due to rising inequalities in the distribution of income and resources (ibid:205). However, certain developing countries have shown a tendency to increase public healthcare expenditures and have achieved universal coverage. Although they are still much lower than the OECD average, the total government spending on health care as a percentage of GDP tends to increase in countries such as Chile, South Korea, Colombia, Mexico, Turkey, and South Africa, as shown in Figure 3.

Figure 3. Health spending (government, compulsory, % of GDP), in Chile, South Korea, Mexico, Turkey, 1980-2018

Source: OECD (2020), Health spending (indicator). doi: 10.1787/8643de7e-en (Accessed on 06 July 2020).

Among them, Korea, Mexico, Colombia, and Turkey have achieved universal or near-universal coverage of health care costs, similar to the majority of OECD member countries except for the United States, Greece, and Poland.

This kind of expansion in public health spending may be considered similar to the state's earliest responses to public health problems. Buğra and Keyder (2006:216) argue for Turkey's case, for example, "with deruralization and urbanization … the prevailing reality became that of the informal and sporadically employed urban worker, for whom employment status could not be counted upon to lead to stable social security coverage". Accordingly, the informal sector's enlargement due to post-1980 state reorientation in

Turkey toward a development strategy with less state intervention left the urban poor with no health coverage, which only those employed in formal sectors received. Governmental attempts to put universal coverage on the policy agendas, in that sense, can be read as an inevitable step toward answering the needs of "new poor" who were never employed in stable jobs with social security or had lost these. The number of people who had no health security before and were covered after the transformation in Turkey was 5.5 million (Soyer, 2009).

However, although this kind of expansion may signal a structural need, it also comes with certain political decisions toward transforming traditional health care policies and protection. We should note that, as many scholars identify, government policies do not necessarily reflect a general concern about public health to reduce the social causes of ill health (Leys, 2009; Belek, 2014; Mackintosh and Koivusalo, 2005; Hermann, 2009). For instance, although it might be expected that an epidemic such as HIV would force developing country governments to increase their spending on health, there is no evidence to suggest this, according to a study analyzing the databases of WHO and IMF (Lu et al., 2010). Additionally, according to a very recent IMF database, the percentage of additional spending (as % of GDP) due to the COVID-19 pandemic in the health care sector and related areas in middle-income countries is relatively low. While this additional expenditure is approximately 15 percent of GDP in advanced capitalist countries, it is roughly 4 percent in middle-income countries. Moreover, interestingly, the countries with the lowest additional health expenditures among middle-income countries

are Mexico, Argentina, and Turkey.[10] The public health spending analysis suggests that any health crisis does not trigger a trend of increase in health care spending.

Moreover, it is not possible to say that since the 1980s, responding directly to contemporary capitalism's changing social relations and their impact on public health has been on states' political agenda. As Leys (2009:9) argues, "even such modest measures as making taxation less acutely regressive, reducing class size in schools, or reducing the precariousness of work – all such state-dependent measures which could improve the health of the least healthy sectors of the population have had low priority, whatever the political rhetoric, while inequality has inexorably grown." Working conditions that are considered among the most important determinants of public health do not show considerable improvement. The ILO reports that global unemployment rates are expected to increase mainly due to deteriorating labor market conditions in emerging countries. "Significantly, almost half of all workers in emerging countries are still in vulnerable forms of employment, [i.e., own-account work and contributing family employment], and almost four out of five workers in developing countries are in this employment category" (ILO, 2017).

2.3.3. Health policies and populist politics

[10] IMF, Fiscal Monitor Database of Country Fiscal Measures in Response to the COVID-19 Pandemic. Available at: https://www.imf.org/en/Topics/imf-and-covid19/Fiscal-Policies-Database-in-Response-to-COVID-19

After the 1980s restructuring in developing countries, one major discussion on health policies has focused on emerging populism debate as a more refined follow-up of the "politics matter" approach in social policy literature. This debate has been hugely influential in contemporary policy discussions, including the literature on Turkish reform. Thus, I would like to refer to this populism discussion briefly before concluding this chapter and attempting to detail a political economy approach based on the conclusions of the literature review.

The Mexican poverty alleviation program associated with the Salinas governments and the Turkish welfare policy transformation, including the Health Transformation Program associated with Erdoğan's government and later his presidency, constitute good examples of populist politics. First, the National Solidarity Program, known as PRONASOL, is considered a response by Mexican President Carlos Salinas de Gortari to the threat of leftist votes merged under Cuauhtémoc Cárdenas Solórzano's PRD (Party of the Democratic Revolution). A strong advocate of the neoliberal approach, Salinas confronted opposition in the shape of leftist candidate Cardenas, and his solution to undermine the left's votes was to implement the market-friendly program PRONASOL (Bruhn: 1996:152). The program was considered "valuable" by international financial institutions such as the World Bank and IMF and designed to promote "competitiveness and productivity by improving the ability of the poorest to participate economically." Moreover, PRONASOL specifically targeted public policy areas that are the most visible to the public, such as school repair, clean water, and improving health clinics (ibid:155). The health program of PRONASOL increased the number of health clinics by 33 percent

in 3 years (1988-1991) and incorporated 1.4 million people under its coverage (Dresser, 1991:7).

This populist social program is known to have political objectives rather than idealist objectives. As Morris (1992:33) explains, the program "emerged as a powerful electoral device by which social expenditures can be made to wax or wane depending upon the rise and fall of support for the PRI [Institutional Revolutionary Party] and/or its election forecasts." One of the first moves of the program, for example, was to invest in Salinas' opposition in Cardenas' home state, where Cardenas' votes were far more than Salinas'. A 93 percent increase in public investment was documented in this state within one year (ibid:33). Similarly, Bruhn (1996:157) argues that the main motive of PRONASOL was "to consolidate political support by buying off a section of the electorate." Bruhn supports this argument with his statistical analysis, finding no significant correlation between the government's spending for a specific region and the economic conditions of the region. It means that the government does not necessarily allocate its social funds according to people's welfare needs.

The other case exemplifying that neoliberal social policies are used as populist tools is the transformation in the Turkish health system. This transformation is highly associated with AKP governments and particularly with Erdoğan. Erdoğan's emergence as a populist political leader was facilitated by the 2001 financial crisis that had severe social consequences and the political turmoil that included a problem in political representation and the legitimation of previous governments. Similar to the Mexican case, targeted and

neoliberal social policies expanded during the AKP era. Erdoğan's policies and populist hegemony targeted the population whose fortunes had been worsened by neoliberal policies, 'the long-neglected groups.'

For the Turkish case, the health sector is the most visible social policy area to observe populist politics, and this case will be discussed in more detail in the next chapter. The increase in health spending in the state budget and the health benefits that have visibly targeted the 'long-neglected poor sectors of the population are all associated with AKP governments, more specifically Erdoğan himself. One of the main reasons for the real increase in health spending is the increase in the budget allocated for "green cards" provided for those who have no social security to cover basic health coverage (TEPAV, 2008). Moreover, the fact that green cards also cover medicine expenses is an important criterion for the poor to "appreciate" the benefit (Buğra, 2008:234). Since universal health insurance began in 2003, the proportion of the population covered rose from 70 percent in 2002 to 83 percent in 2010 (WHO, 2012:118). Coverage among the poorest segments has also expanded. In 2003, only 24% of the poorest deciles had health insurance, whereas, by 2008, 82% of the poorest deciles had coverage (Ağartan, 2012:464).

One of the most cited scholars for his studies of the relationship between neoliberalism and populism, Weyland suggests that strong popular support for neoliberal reforms, especially in Latin American countries, is a big surprise. The reason is that the earlier theories of populism associated the concept with "nationalist, inward-looking economic

policies" (Weyland, 1999:379).[11] The prominent cases challenging the already established views for many scholars were Carlos Menem's (1989-1999) Argentina and Alberto Fujimori's (1990-2000) Peru. Contrary to the expectation that poor sections of the population would not support neoliberal market reformers since neoliberal policies hit them the most, Menem and Fujimori showed "stunning political success" by supporting the poorest sections of their populations (Weyland, 2003). This trend showed itself to different degrees and at other times in various cases, such as Bolivia, Brazil, Venezuela, Chile, Ecuador, Mexico, Israel, Indonesia, and Turkey (Aytaç and Öniş, 2014; Bruhn, 1996; Demmers et al., 2001; Dresser, 1991; Filc, 2011; Moffitt and Torney, 2014; Phongpaichit and Baker, 2008; Weyland, 1998).

Therefore, given the "unexpected" developments in political arenas, the alliance of populism and neoliberalism called for a new definition or a new approach for populism. Weyland's definition has been one of the most popular definitions among scholars who study contemporary forms of populist movements and leaders/parties in various developing countries. For Weyland (1999:381), populism is a "political strategy" with

[11] Early analyses of populism mostly deal with the classical populist era in Latin American countries, characterized by Peron in Argentina, Cardenas in Mexico. Kenneth M. Roberts (1995) identifies four different approaches to populism: 1) historical/sociological perspective associating the emergence of populist tendencies to the import substitution industrialization era, 2) economic perspective that relates populism with economic policies of states, mostly in the stage of import substitution industrialization when the economic growth allowed for redistributional policies, 3) populism as an ideology that associates populism with an ideological discourse that specifically builds upon a contradiction between "the people" and "the power bloc," 4) political perspective that focuses on the mostly paternalistic relationship between the populist leaders and the masses through and as a result of deinstitutionalization of political authority and that is mostly used to define neopopulism.

three characteristics: "A personal leader appeals to a heterogeneous mass of followers who feel left out and are available for mobilization; the leader reaches the followers in a direct, quasi-personal manner that bypasses established intermediary organizations; if the leader builds a new or revives an old populist party, it remains a personal vehicle with low level of institutionalization." Weyland also links populism and neoliberalism in terms of their common characteristics and dependence on each other. He suggests, "neopopulism and neoliberalism share an anti-status-quo orientation, and anti-elite discourse and a transformatory stance." Moreover, "to effect such a transformation, neoliberalism needs to rely on concentrated political power," namely, neopopulism (Weyland, 2003:1098).

One of the interests of scholars of populism is the factors leading to neopopulists' subsequent electoral successes. Weyland talks about, albeit not systematically, an observation that can help us understand contemporary populism in developing countries: the mass support for neopopulist politics comes mainly from the poorest sections of the population. Neoliberal reformers use neoliberal benefit schemes, prescribed mainly by international financial institutions, to strengthen their mass support. The neoliberal strategy allows populist leaders to institute targeted social programs such as targeted anti-poverty programs to extend social benefits to the long-neglected segments of the population.

Accordingly, a general populism definition in health care can be based on the presentation of health reforms by populist governments as reforms that will benefit the

most neglected segments of society who had been excluded from the social security system. According to this explanation, populist governments utilize ill-developed health care systems and gain popular support by reforming the exclusionary health system. In fact, the most critical and underlined argument of the literature interested in linking current populist policies in developing countries and healthcare reforms is that the governments in question have mostly succeeded in implementing policy reforms targeting the excluded.

Before the reform initiatives, the Turkish health system was mainly defined as a fragmented and hierarchical system in which the hierarchy was based on employment status (Ağartan, 2008). Thus, a considerable portion of the labor force in the informal sector and agricultural workers were excluded from the system. Moreover, because of the hierarchical system, benefits varied considerably for those included in the system. While civil servants were privileged within the system, workers and self-employed (those paying into the insurance program) had to live with lower health care benefits. Similarly, the urban labor force and civil servants benefited from better health care protection in the Mexican welfare system. The dual health care system did not exclude the poor and those in the informal labor force but included the formal labor force by a well-funded social security system, while others were included in the poorly funded public system. Along with the problems brought by the hierarchical system, it was mostly the Mexican economic crisis that started in the 1980s and left the most impoverished sections in deprivation, which led the populist government to respond (Brachet-Marquez and Sherraden, 1994; Laurell, 2007).

How successful populist policies have achieved their objectives is undoubtedly challenging to measure, considering that the policies implemented and political purposes become complex and varied over time. However, the literature arguing that these health reforms are tools of populist politics shares the idea that they are at least one essential element that provides or increases widespread support for populist governments. The fact that the AKP government in Turkey is still in power and the PRI in Mexico secured most of the previously lost votes from the targeted population can be given as evidence of the electoral success of the populist health reforms. Furthermore, according to the Turkish Statistical Institute's data on health service users, while user satisfaction was 39.5 percent in 2003, before the transformation, the rate increased to 75 percent in 2013 (Erol and Özdemir, 2014).[12] These facts, in brief, suggest to us that the expansionist tendencies in developing countries may be attributed to the rise of populist politics, which has a considerable impact on the political scene and political relations within the countries.

However, populism explanations necessarily draw on a form of randomness about the emergence of a leader who has populist characteristics. Although later attempts in the literature tend to emphasize populist politics as a method to come to and stay in power, most of the core questions of the approach remain within the limits of understanding the specific political actors and their personal and political characteristics. Finding common characteristic features in different political actors may help define who a populist

[12] However, some critical studies suggest that satisfaction surveys carried out by the Ministry of Health are not based on a conceptual framework, cannot be generalized to the society, and therefore are potentially manipulated (Öcek, 2014).

politician is or what (neoliberal) political populism is. However, it has limited power in explaining the emergence of populist politics with changing international political schemes. Analysis of contemporary individual cases of political populism could turn into a solid "trend" argument only by interpreting these cases within the global policy paradigm. The influence of international actors and institutions on developing governments' decision-making process may vary from economic sanctions applied for policy reforms (structural adjustment programs) to policy learning or transfer (policy recommendations of international organizations). This influence is one of the core questions of another vast literature dealing with the degree of autonomy of the decision-making processes in developing nations (see Arrighi, 1990; Barnett and Duvall, 2005; Mann, 1997; Robinson, 2004; for health policies, see also Price et al., 1999; Ruger, 2005).

Moreover, the neopopulist tools of obtaining and maintaining political power also need to be addressed in relation to their role in sustaining the neoliberal economic structure. In fact, techniques of populist politics appear as the health system reforms that "included" and satisfied the long-neglected sections of the developing country populations on the one hand and as increasing privatization and capitalist investment in private health institutions and pharmaceutical companies on the other. Considering the limitations of the populist politics approach to explain the interest in health reforms, I will try to turn the discussion to the political economy of health system reforms in the next chapter, which may provide us with the ground to question the relationship between capitalist needs and reform initiatives.

2.4. Conclusion

The discussions on understanding social policies in general and health policies in particular throughout this chapter involved two major subdiscussions: explaining welfare system transformations after the 1980s and contextualizing these transformations in developing countries. This chapter showed that public social spending after the 1980s did not decline as expected, and a trend of increase is visible, especially for some middle-income economies. Therefore, a closer look at the statistics shows that the states tended to invest in health policies in some developing country contexts, including Turkey. This trend calls for some possible explanations.

Around these major points, this chapter dealt with reviewing the literature on social policies and health policies. To have a broader look at the literature, I started with early theoretical approaches, including neo-Marxist, institutionalist, power resources, and social-democratic approaches, understandably focusing on welfare states. However, these scholarly discussions experienced a turning point with neoliberal transformation. The discussions were no longer about the role of the welfare state but what is happening to the welfare state we know. This rupture brought two major inclinations different from the earlier approaches to the post-1980 literature. Structural explanations include significant contributions analyzing the structural changes in economies that necessitated different welfare regimes. However, they are usually inclined to study developed economies. On the other hand, political-institutional explanations are tempted to make categorizations informed by Esping-Anderson's approach. This tendency results in a welfare-modeling or comparison exercise in which analyses focus on ambiguous determinants such as

democratization and state capacity. A more global perspective in political explanations focuses on the role of international institutions in determining national policies. Although this perspective is a must for analyzing developing economies, the related scholarships have limited space to incorporate the specific structural changes brought by capital accumulation strategies.

After reviewing the mentioned discussions, this chapter offered to revisit the earlier Marxist explanations for the role of the welfare state and attempted to draw a more comprehensive framework for developing economies. This framework could also be applied to health care policies, specifically. Marxian inspired analysis would focus on the production of health through the formation of a capitalist healthcare industry and recognize the way these have been produced through struggle and conflict (Collyer, 2015:10). Based on the fundamental underpinning of the Marxist explanations, which contextualize the complex social policy-making processes within the capitalist mode of production, to understand the post-1980 social policy transformations in late capitalist countries, we should consider several and intertwined pressures through which social policies are shaped: the structural needs of the system; capitalism and the bourgeoisie's need to obtain legitimation; the demands of the working classes; intraclass conflict; the specific development of the less advanced capitalist state; and international policy framework.

In terms of health policies, it can be said that they denote a vital arena in state-society relations since the systematic intervention of the state in public health issues started in the

late 1800s. This intervention became more direct with welfare states, and the literature became interested in defining "health care systems." The restructuring after 1980 was also a turning point for this arena, mostly because of the trend toward market-oriented health policies. However, despite the neoliberal agenda, the expansion of public expenditures and universal coverage aims are worth discussing. The post-1980 political explanations in the social policy literature showed themselves as neo-populism discussions when health policies are considered, especially for certain country cases, including Turkey. However, populist politics discussions fall short of explaining structural factors, why local actors are that important, and how populism finds its way in some societies but not in others.

At the end of this literature review, it became clear that a more detailed perspective should be developed on health policies and the transformation in health policies, which will be the focus of this study. Understanding the post-1980 health care system and its organization must start with understanding the context in which the transformation occurs. Therefore, health policies should be defined and analyzed together with the holistic relationship of society's political and economic system. The following chapters will focus on a single country case. Still, it is necessary to develop an inclusive perspective, dealing with the complicated political and economic contexts, especially for developing country cases. The next chapter will evaluate these contexts more closely and try to create a political economy framework for health policies and health transformation in developing countries.

CHAPTER 3 TOWARDS A POLITICAL ECONOMY OF HEALTH POLICIES

3.1. Introduction

An attempt to develop an inclusive perspective to study health policies and recent health reforms necessarily calls for many economic, political, and historical dimensions to be considered together. The previous chapter concluded that there is a need to understand health policy formation and changes by incorporating several different forces shaping policy outcomes. The influence of the earlier accounts explaining the mature welfare systems in the pre-1980s literature has understandably been significant for later social policy studies. However, the neoliberal political and economic turn after the 1980s shifted the discussions at a greater pace. As the influence of the neoliberal agenda in the scholarly debates and the policymaking circles propagated through international institutions has upsurged, the major theoretical approaches before the 1980s questioning the role of welfare systems, in general, have lost their influence.

The complexity after the 1980 turn in policymaking and the actors in the scene in developing countries deserves a macro view. As I tried to focus on in the previous chapter, adding the international policy framework, which played a very influential role in policy formation after 1980, and the development processes specific to late capitalist states to the analysis will bring us closer to an inclusive perspective. Aiming to develop

such a perspective to contextualize the transformations, this chapter will first identify the Washington Consensus as a social policy paradigm affecting social policy formation in nearly the whole world after the 1980 turn. In order to complete the picture of health policies specifically, the chapter will also critically examine the relationship between the most important international organizations and health policies. Additionally, in terms of understanding capitalist development, considering marketization processes and the state-capital relationship after the 1980s and the changing role of the state in the health sector will open a significantly comprehensive perspective. After reviewing related discussions, this chapter will conclude by suggesting a framework for approaching and studying health reforms from a political economy perspective. The need for such a perspective will become more apparent when returning to concrete analysis. A careful examination of theoretical understanding, historical context, contingency, and specificity of circumstances is required to explain dominant situations, processes, events, actors, and finally, outcomes. I will also apply this framework in the following chapters to examine the Turkish health care transformation critically.

3.2. Washington Consensus as a social policy paradigm

A discussion on social policies and the policy formation process in developing countries should consider the economic and political dependency of the developing world on the developed world and its institutions. Thus, understanding the nature and characteristics of social policy transformations in late-industrialized countries should start with understanding the articulation of these countries into the global neoliberal economy. I would argue that a political economy approach should attempt to understand economic

incentives shaping the current international and domestic trends in social policies. The Washington Consensus and its successor, the post-Washington Consensus, have critical importance for developing countries.

By its name, the Washington Consensus refers to the ten "policy instruments" that Williamson (1990) identified to deal with the debt crisis in Latin America. His aim was "to set out what would be regarded in Washington as constituting a desirable set of economic policy reforms." These reforms that Washington seems to agree on what developing countries need can be summarized as follows: fiscal discipline to overcome budget deficits, reductions in public expenditures (especially in subsidies, education and health, and public investment), increasing tax revenues, market-determined interest rates, market-determined exchange rates, import liberalization, liberalization of foreign financial flows, privatization, deregulation, and securing property rights. The "Washington" of this term, as described by Williamson, includes the top managers of international financial institutions, "the economic agencies of the US government, the Federal Reserve Board, and the think tanks" (Williamson, 1990:1).

It should also be noted that suggestions over social policy areas have usually been correlated with the post-Washington Consensus rather than the Washington Consensus, which focused on economic policy reforms (Saad-Filho, 2007; Stiglitz, 2008; Abrahamson, 2010). Even by the earlier proponents of the Consensus, it was broadly agreed that the reforms implemented after the Washington Consensus failed to reach the

initial aims as the poverty rates continued to increase in developing countries (see Narcis and Stiglitz, 2008). The Consensus imposed neoliberal market reforms on developing countries in the form of "structural adjustment programs." Bello (2012) writes that the World Bank research unit attempted to systematically manipulate its published data to show that neoliberal reforms promoted growth and reduced poverty in developing countries. However, economic failures came to the point that the consensus could no longer sustain the initial program. Thus, the post-Washington Consensus was introduced as a "more democratic" alternative to the Washington Consensus (Stiglitz, 2008). It is possible to say that the difference in this "democracy" is that it is seemingly more socially concerned. World Bank's acknowledgment of the failures of the neoliberal orthodoxy rendered the need to address the discontent by complementing market orientation with a focus on the social dimension (Güven, 2018). With the post-Washington Consensus agenda starting in the 1990s, critical actors such as IMF and World Bank began to focus on the importance of subsidies, education, health, and public investment. The new interests of these institutions became poverty and governance issues in developing countries.

Although the post-Washington Consensus adopted a slightly different discourse, it would be an incomplete analysis to consider these two consensuses separately. Most of the critical accounts on the Washington Consensus tend to agree that the post-Washington Consensus is not yet another policy paradigm and does not represent a shift but has the same logic with some minor differences (Bello, 2012; Babb, 2012; Fine, 1999; Porter and Craig, 2004; Öniş and Şenses, 2005; Yalman, 2011). The core elements, fiscal

enforcements, and liberalization of markets are common in both consensuses. As Güven (2018) defines, the PWC agenda was not a new paradigm but a paradigm expansion, aiming not to replace but to complement the main plan. This paradigm as a whole comprises not only economic policies but also social policies. The global framework with the Washington Consensus aligned every economy within a liberal economic paradigm to secure market relations. The agenda of PWC as an expansion with its boundless capacity to incorporate policy novelties and refinements rescued the credibility of the Washington Consensus. The agenda became the hegemonic player for international institutions, academia, and many aid agencies.

The literature on social policies seems to be primarily influenced by the hegemonic pro-poor discourses of international organizations. The political-institutional explanations of the transformation of welfare systems that I reviewed earlier mainly adopt these discourses, even if they question the "sincerity" of these conceptions from time to time. The reflections of this hegemony on scholarly discussion reveal themselves by more dialog suggestions for better and fair capitalist global governance. Therefore, it is clear that the discourse on poverty alleviation has to coexist with neoliberal policies. The discourse has been creating an increasingly hegemonic compromise both in academia and the policymaking arena. For instance, Craig and Porter's (2003) study on the poverty reduction strategies papers (PRSP) approach of the WB and IMF reveal that these organizations have been references to "favor the technical and juridical over the political-economic": "Very quickly, the PRSP process has become an imprimatur of policy orthodoxy, an access requirement for institutional development assistance, and the entry

point for a bewildering range of disciplinary 'good governance' innovations" (Porter and Craig, 2004:389).

The (trans)formation of welfare systems in developing countries must first be explained in such a transnational context directly influencing the policy formation processes in country cases. "The absence of an integrated theory of the economics and politics of public finance," as O'Connor (1973:5) writes, "has compelled economists to adopt an almost metaphysical attitude toward government spending." His observation is still valid not only for economists but also for sociologists and political scientists. Considering the importance of the Washington Consensus for developing countries' policy regimes, using the term Washington Consensus as a transnational policy paradigm instead of using broader and perplexing concepts such as globalization and neoliberalization seems adequate.

The idea of considering the Washington Consensus as a transnational policy paradigm was suggested by Babb (2012), who was inspired by Hall's (1993) theory of policy paradigms. According to her, the Washington Consensus has been treated by academics (like Stiglitz (2002) and Rodrik (1997)) as an intellectual product by neoliberals; however, it "was a transnational policy paradigm produced by both intellectual and political forces. It was legitimated through economics scholarship but was also embedded in the practices of two types of bureaucratic organizations: the national governments that adopted the policy reforms and the international financial institutions that encouraged

their adoption" (Babb, 2012:269). Babb suggests that considering the Washington Consensus as a transnational paradigm would fill the insufficient attention given to developing countries' policy (trans)formation. She writes:

> "(…) The Washington Consensus was neither an economic theory nor a particular list of reforms, but a transnational policy paradigm that was institutionalized at two levels – within the governments that adopted the reforms and the IFIs that encouraged them. The Washington Consensus was soon weakened by its own internal vulnerabilities and changing intellectual and political circumstances. However, it has not yet been overthrown by a competing paradigm, either at the national or transnational level" (ibid:289).

Babb also argues that no transnational policy paradigm seems ready to replace the Washington Consensus in the near future, but "a more heterogeneous international regime that is less uniformly structured by transnational policy paradigms" (ibid: 291). Accordingly, powerful emerging-market governments may sometimes have the means to bargain with this transnational paradigm and financial institutions, which will require a closer analysis of each case in terms of these bargaining processes.

Inspired by Babb's intervention, I also argue that we should think of the Washington Consensus as a policy paradigm, which denotes a whole in terms of economic, political, and social policy processes in developing countries. The term also acknowledges different actors, such as transnational and national capital, powerful governments, and international organizations, in international relations. The less uniform structure

emerging in middle-income countries is also of great importance in case analysis. The changed paradigm aimed to change the state-business relationship, suggesting or sometimes forcing developing countries to adopt more pro-market but socially expanded policies. Thus, the increasing role of the private sector in health and the expansionist tendencies of the states operate together under the concerned global social policy paradigm. Situating the health reforms in developing countries into this global political-economic approach would allow us to continue analyzing the specificities of the country cases. Each case has experienced a specific adaptation process shaped by specific political and economic processes.

3.3. Washington Consensus organizations and health policies

Although the World Health Organization (WHO) comes first in mind for health care, as this study referred to many times, WB and IMF have been prominent global actors. WB's interest and strategic plans in health started to widen with the 1993 World Development Report titled Investing in Health (Mooney, 2013). The report voiced a threefold approach to health policy for developing countries; it envisaged the following:

(1) to foster an economic environment that will enable households to improve their own health; (2) to redirect government spending away from specialized care and toward such low-cost and highly effective activities such as immunization, programs to combat micronutrient deficiencies, and control and treatment of infectious diseases; (3) to encourage greater diversity and competition in the provision of health services by decentralizing government services, promoting competitive procurement practices, fostering greater involvement by nongovernmental and other private organizations, and

regulating insurance markets (World Bank, 1993).

The policy suggestions of this voluminous report summarize the most important strategies WB would take in global health. It was declared that the role of the WB would be to support and promote the marketization and privatization process in health. The approach also ensures that governments control poverty and related health crises so that the marketization process proceeds smoothly. Throughout the years, despite its leading position in policymaking, WB's policy advice has been confined to how to strengthen regulatory frameworks, especially for public-private collaboration, financial sustainability, basic infrastructure and "human resources," and how to control governments using loans in these areas. Moreover, the political agenda behind the social assistance programs and policy reccommendations of WB show that the Bank also targets containing social unrest in developing countries (Gils and Yörük, 2015).

Another important organization is the IMF. Similar to the WB, and perhaps more impact on financial regulations, it became the most critical post-1980 organization to control structural adjustment or economic reform packages, "inappropriate" government policies, to develop the liberal economy. The IMF has been criticized for its direct and indirect effects, especially on health expenditures, because of its programs' severe conditionalities and fiscal tightening measures. According to critical studies, financial restrictions, which are the standard policy of the IMF, have meant that the budgets allocated to the health sector for developing economies are restricted and that long-term health investments

cannot be made in developing countries. Rowden (2013) shows how these financial restrictions prevented the activist steps from improving public health systems. IMF-borrowing countries also ended up spending much less on health, and therefore IMF operations have been more likely to have a negative impact on government spending on health.

Although the studies conducted by the IMF's staff or supporters say that IMF has positively promoted health expenditure (Clements et al., 2012), Moona (2017:45) suggests that the results seem to be engineered for the purpose of self-preservation. Stuckler et al. (2011) showed that "as found in existing studies, for each $1 of development assistance for health, approximately $0.37 is added to the health system. However, evaluating IMF-borrowing versus nonIMF-borrowing countries reveals that nonborrowers add approximately $0.45, whereas borrowers add less than $0.01 to the health system. On average, health system spending grew at about half the speed when countries were exposed to the IMF than when they were not." In addition, the IMF, like other international organizations, put conditions for changes in health in the agreements it made with countries. For example, while the AKP government in Turkey presented a letter of intent to the IMF in 2005, it promised to pass the laws regarding General Health Insurance through the parliament. The government fulfilled this commitment in 2008, if not in 2005 (Koray, 2020: 182).

Mooney (2013) adds the World Trade Organization (WTO) to the list while evaluating

the impact of international organizations on health policies. TRIPS and other trade agreements and relationships have significant links with powerful pharmaceutical, insurance, and service corporations in health. As Price et al. (1999) put it, "multinational and transnational corporations, including the pharmaceutical, insurance, and service sectors, are lining up to capture the chunks of gross domestic product that governments currently spend on public services such as education and health." This competition environment bolstered by WTO has had negative implications on access to drugs and vaccines globally. For instance, "75 percent of the world's population who live in developing countries consumes only 14 percent of the world's drug supply" (Ranson et al., 2002:29).

The most recent problem has been experienced with the emergence of international inequality in access to vaccines in the COVID-19 pandemic. By late October 2021, while 62.79 percent of the population had been vaccinated with at least one dose in high-income countries, the proportion was only 4.51 percent for low-income countries. This inequality has been a result of the high financial burden of purchasing vaccines, for which low-income countries have to increase their health care spending by more than 50 percent.[13] Despite the crisis, intellectual property rights have become a significant barrier to affordability and accessibility (Kumar Chattu et al., 2021). Attempts were made to provide equity with demands such as temporary waivers or suspension of intellectual property. Although in October 2020, India and South Africa's proposal for a temporary

[13] Available at: https://data.undp.org/vaccine-equity/

waiver of IP rights to COVID-19 technologies for the duration of the pandemic was backed by 100 countries, it was blocked at WTO meetings by the UK, Japan, and EU countries (Harman et al., 2021). The imbalance in the production of and access to health needs is clearly worsened by the multilateral agreements and intellectual property rights for corporate profits and financial incentives.

3.4. Increasing role of the private sector in health

The post-1980 turn and the global policy regime with international institutions promoted health care marketization and privatization processes. The implications of these globally promoted policies on different country cases constitute another vast body of literature in policy analysis. Although the difficulty of measuring the consequences of health reforms due to complexity is usually agreed upon, it is possible to discuss some common trends according to the critiques of market-based reforms. In their study, Mackintosh and Koivusalo (2005) conclude that commercialized health care has been a significant outcome of reforms more in the middle- and low-income countries than in affluent countries. They found that private health spending is higher in countries with lower average incomes per head. In fact, "among rich countries, only the United States and Singapore have private expenditure shares over 50 percent, while all but one of the countries with private health expenditure shares over 70 percent have national incomes per head under $1000 per year" (Mackintosh and Koivusalo, 2005:8). India, among developing countries, is the most privatized, with 82 percent private health spending (Lister, 2007:17).

Among Latin American countries, Chile, Colombia, and Brazil partially privatized health care services. In contrast, many others have made relatively more minor changes supporting the private sector's involvement in the industry. For example, Colombia's 1993 reform closely followed what had been suggested by the World Bank and IMF and ranked as the best health system in Latin America by the WHO. Colombia's reform came after the catastrophic results in the Chilean reform[14] and tried to avoid similar results, yet it failed, as Homedes and Ugalde (2005) clearly show.

The reform attempted to universalize health care access by collecting funds according to individuals' income levels and increasing total health expenditures. The social security system was divided into two types of affiliation, one for those who could pay their insurance premiums and one for the poor, for whom the government would pay the premiums. However, it was not possible to achieve universalization with the obstacles posed by privatization itself. Companies called Health Promotion Enterprises have been given the right to collect insurance premiums, and in theory, these enterprises would offer care for low-income households. However, in practice, these private companies found loopholes to bypass the law and not serve these groups (Homedes and Ugalde, 2005). The result remained to be a large uncovered population, and the poor had difficulties accessing health care.

[14] Before the 1973 military coup, Chilean health system was considered the most comprehensive system with universal coverage provided by the central government. Being the first country to implement the neoliberal economic reform, Chile faced the unadjusted neoliberal policies ending in extreme inequities in health care (Homedes and Ugalde, 2005).

In Turkey, although the dominant policy paradigm had already started changing the health care system, it was after 2002 and through the Health Transformation Project (HTP) that an actual window was opened to put the market-based reforms in practice actively. The Ministry of Health was restructured to finance and regulate the reforms, leaving its role in providing services aside. For example, the authority to contract with private and public providers was assigned to a single institution (Social Security Institution, or SGK) to encourage competition between health care providers. However, since private health care providers can charge higher fees, only high-income households benefit from this competition. Studying the impact of the health care reform on access inequalities in Turkey, some scholars argue that access inequality has only been shifted among different segments of the population (Balta, 2013; Yılmaz, 2019). For instance, while disparities were based on occupational status (providing government workers with a good coverage plan, excluding people outside the labor market) in the pre-reform era, the inequalities are now income-based. With the new financing mechanism introduced by the HTP, user fees for public health care services and medications and contributory payments for private health care services were added to the system that perpetuated income-based inequalities. Furthermore, the higher quality of health care in private health care provision, for which HTP provided incentives, started to increase the gap between those who can make extra out-of-pocket payments and those who are not (Yılmaz, 2019: 107).

Examples of critical studies on the negative social impacts of marketization and commodification of health care services can be widened with different country cases,

including both developed and developing countries (see Navarro, 2007; Mackintosh and Koivusalo, 2005). On the other hand, another trend in this critical literature focuses on showing how private capital in health was promoted by middle-income governments' health policies, including policies expanding public spending in health. Corporate expansion, especially US-based corporations' expansion into international markets, has been intensely studied by many critical scholars. As the Latin American health care market presented a lucrative opportunity for corporations, the global expansion of these corporations has primarily been under review in the Latin American context (Armada *et al.*, 2001; Jasso-Aguilar *et al.*, 2005; Iriart, 2005; Stocker *et al.*, 1999). Accordingly, the strategic steps for corporations have been engaging in joint ventures with local companies, promoting corporatization principles, and using governments to influence international organizations' agendas. Analyzing the Mexican health care reform, Jasso-Aguliar *et al*. (2005) argue that the reform moved public resources into the private sector. The 'uninsurable' population in rural or urban areas, for example, was given a free package, which was said to provide universal coverage. However, "the package in reality contained fewer services than those traditionally provided to the poor by the Ministry of Health. In concrete terms, this gap in coverage meant that all services not included in the package would be charged directly to the patient or financed by state governments…" (ibid: 48).

This fact was also reported by several international agencies and the US government itself. For instance, a report from the US Embassy in Caracas stated that a "significant part of government's health care modernization project would be funded by IDB [Inter-

American Development Bank] and the World Bank. In this regard, there is up to 120 million USD in potential business to US companies" (Armada *et al.,* 2001:750). Stocker *et al.* (1999) documented the largest multinational companies (Aetna, CIGNA, Principal Financial Group, The American International Group, and EXXEL Group) involved in and profited from managed care in Latin American countries the very first years of the reforms. These multinational companies have used several strategies, such as organizing conventions for health care leaders in Latin America who received financial assistance from WB and investing in joint ventures with national companies. The executives responsible for the exportation of managed care have emphasized its financial rewards, mainly referring to "the importance of access to the social security funds of these countries." For North American executives, social security funds in Latin America were a new primary source of financial capital (ibid: 1132).

In line with the executives' motivations, one of the recent studies reports that "in Chile and Colombia and to a lesser extent in Mexico, public spending has increasingly been used to finance privately provided health services either through contracting out with private insurers as in Chile or directly with MCOs [Managed Care Organizations] and providers as in Colombia" (Bustamente and Mendez, 2014:862). Despite the increase in public spending and health coverage, users of public health facilities are often forced to seek care in the private sector due to limitations encountered with public providers such as supply problems (drugs, testing, equipment). In fact, in Colombia, for example, while the insured population has almost doubled from 49.7 percent to 94.3 percent between 1995 and 2010, the share of the population applying to private sector health services has

also followed an increasing trajectory from 40.3 percent to 51.2 percent for the same years (ibid).

A very similar situation is also reported for Turkey. The data from the Ministry of Health revealed that between 2002 and 2011, the total number of patients, per capita applications, the total number of inpatients, and the total number of surgeries had increased for all health units, while the rate was the highest for private sector facilities, with a 937 percent increase. Like Latin American cases, private hospitals increased their shares within public health spending at twice the rate of public and university hospitals (Elbek, 2015: 28). This shift in favor of the private sector can also be seen in the pharmaceutical sector. According to Eren-Vural (2015), the most critical impact of health reform in Turkey on the pharmaceutical industry has been the increase in public spending on drugs. This increase has resulted in an expansion in the drug market in terms of its size and revenues by stimulating international pharmaceutical companies to enter the Turkish health market. The prescription drugs market in Turkey had a 14 percent compound annual growth rate, from 4 billion US dollars in 2003 to 10 billion US dollars in 2009 (ibid: 141).

The critical literature mentioned in this section mainly focuses on country cases, analyzing the negative social impact of market-based reforms. In these studies, the most emphasized issue for developing country cases is the international policy paradigm mentioned in the previous sections and its effects on the policy formation of institutions. However, almost all studies embody the active role of governments in developing

countries in the policy transfer and marketization of health care processes. One of the most emphasized points is that state intervention in the health sector in these developing countries tends to facilitate the growth and expansion of health care markets. It is usually agreed upon for developing country cases that the state's active role in health care is needed. Governments search for ways to implement the international policy agenda and facilitate corporate investment while carrying out a regulating role. In other words, we see that capitalist states, along with the steps to reorganize the health system to comply with the reform agenda, also have to enter into a complex relationship with private capital. The increasing share of private capital in health care cannot be expected to result in smooth state-capital relations. While the pressure of private capital on state institutions is a well-known fact, in many examples, including Turkey, governments also have efforts to regulate privatization and marketization processes over specific bargaining points between state and capital. Therefore, another issue that needs to be examined closely, especially for late developed capitalist countries, is to describe the state-capital relationship with all its complexity.

3.5. Health system transformations and state-capital relationship

We should start by accepting that the lines between private accumulation and public activity are unclear, neither theoretically nor practically. However, there is an extensive literature, from the classical state-capital debate mostly on advanced capitalist states to various case studies depicting the multifaceted relationship between the two. We have touched on this broad debate occasionally in the previous chapter. Theoretical accounts about the role of the capitalist state in forming social policy and the role of social policy

in the capitalist economy form the basis of all these discussions. In this section, without going into these classical debates, I will try to focus on the accounts that will help us understand the health policies in Turkey, which will be the specific focus of the following chapters. It is possible to talk about two ways to look at the state-capital relationship in health policy studies. First, by taking a closer look at the capital side, detailed analyses can be made on how the state and, in particular, governments in different cases are influenced by capitalist actors, especially in policymaking processes. These analyses tend to show the direct relationship between state actors and private sector actors and focus on how dominant private actors are in the policy decisions of governments. Second, by looking from the other angle, an examination can be made by focusing on the state side to see how state power interacts with the private sector while fulfilling the requirements of the international policy paradigm and implementing the marketization process. Governments in power have a balance to consider in protecting their power and the state's legitimacy.

An excellent example for the first way would be Colin Leys' influential studies mainly focusing on the transformation of NHS in England. Leys (2009) starts his analysis with the term "market-driven politics" and reveals how the capitalist class has worked hard to penetrate relevant elements in the state to secure a place in the capitalist accumulation process opened by the transformation. His analysis mainly focuses on capital as taking an active role in these changes by pressuring governments to benefit from opportunities for capitalist accumulation. He argues that in England, the private health sector has achieved:

> "A text-book case of state capture: In mid-2006, the 32-strong leadership team in the Department of Health contained only one career civil servant. Six came from the private sector, and eighteen came from clinical or management jobs in the NHS. Only five had been in the post for more than five years. Their collective memory of the original structure and philosophy of the NHS was heavily outweighed by their collective involvement in marketizing it. In 2007, the Commercial Directorate of the Department, which was the dominant driver of the marketization process, had a staff of 190, of whom 182 were recruited on short-term contracts from the private sector" (Leys, 2009:20).

Moreover, the health lobbying industry has increasingly become more influential within the state by using tactics such as "financing of political parties, think tanks and very many lobby groups; the manipulation of public debate through the press; the "revolving door" and the capture of whole government institutions by pro-market players; and the old-fashioned, behind-closed-doors schmoozing" (Cave, 2015: 244). A US company, United Health Group, has secured several NHS contracts through its lobbying efforts. The vice president of United Health from 2004 to 2013, Simon Stevens, was appointed the CEO of the NHS in 2013. While serving as the CEO, he became a founder member of a US lobby group working on state-run health systems to employ private firms from the US under the Transatlantic Trade and Investment Partnership (TTIP).[15] The company also ran for what was thought to be the biggest outsourcing deal in NHS history, the £1.2bn contract to deliver cancer care, but after widespread criticism, the tenders were dropped.[16]

[15] Available at: https://www.nhsforsale.info/private-providers/optum-united-health-new

[16] Available at: https://www.kingsfund.org.uk/publications/articles/big-election-

Leys (2009) also puts that the drug industry's pressure on governments is enormous, especially in countries with universal public health care systems. While companies press for the highest possible prices to governments with the argument that research and development cost too much, it is estimated that their spending on promotion is twice or three times more than their spending on research and development. Revenues and the concentration of capital in the pharmaceutical and biotechnology industry reveal how profitable the health sector is. "In 2008", for instance, "world sales of pharmaceuticals were estimated at more than $600 billion, two-thirds of which came from the twenty largest companies, most of them American or West European. Biotechnology companies estimated revenues of $51 billion in 2005 but were expected eventually to overtake pharmaceuticals in value" (Leys, 2009:12).

Although Leys' notion of "market-driven politics" is a useful analytical construct for examining the recent changes in health care, we should also acknowledge that the market forces influencing state policy are not novelties of contemporary restructuring. Leys' notion, in this context, rests on "an uneasy assumption that deep connections between state and markets have only recently been forged," as Whiteside (2015) points out. Therefore, the changing form of the relationship depending on the specific development of the capitalist state and economy has to be analyzed closely to understand the contemporary situation. For example, after controversial discussions of private sector

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questions-nhs-privatised

involvement in the NHS, in 2018, Health Secretary Matt Hancock stated that the government would no longer hand integrated care contracts to big private health care companies.[17] Although critical circles say that the money paid to private providers is increasing every year, Hancock's statement shows that the UK government needs to signal to roll back outsourcing patient care. [18]

Assuming that the nature of the relationship should be understood by starting from the private sector may fall short in explaining the seemingly contradictory policies. Governments' policy choices are affected by individual capitalist actors and factors such as international actors, the results of competition between capitalist actors, and the government's need to protect its legitimacy. The tension created by these factors at the same time is significant in terms of policy choice. It should not be forgotten that the policy changes in a particular area in a period reflect an effort to respond to these different tensions. In Turkey, for example, according to Eren-Vural (2007), the state's policy changed to a more robust intellectual property regime for pharmaceuticals after the reform and aimed to prioritize international capital. Although it was necessary to remain a member of WTO due to having signed the TRIPS (trade-related aspects of intellectual property rights) treaty, Eren-Vural argues that the particular form of the policy outcome regarding the pharmaceutical patents was also shaped by the local pharmaceutical

[17] Available at: https://www.healthinvestor.co.uk/big-private-health-companies-wont-run-integrated-care-hancock-tells-hsj/

[18] Available at: https://www.theguardian.com/society/2019/jul/21/private-firms-nhs-budget-matt-hancock-promise

capital's limited political capacity and Turkish conglomerates' aim to reintegrate with transnational capital. What health transformation in Turkey meant for the pharmaceutical industry was the increase in public spending on drugs. This increase created an expansion in the pharmaceutical market in terms of market size and revenues. However, it is also evident that, especially after 2009, the intra-businesspeople conflict reshaped the Turkish government's policies. The patent protections were then reduced in compliance with the demands of national capital (Eren-Vural, 2015).

Although these tensions would be found everywhere, it is plausible to assume that they would be more significant in late capitalist countries. According to Buğra (1994), problems arise regarding the legitimacy of both the state and the private sector, as the economic dominance of the private sector in late industrialized cases is not integrated into society with the necessary institutions and ideologies. In addition, because industrialization took place with the birth of the nation-state, the functioning of institutions expected to balance state and capital is closely related to the attitudes of political figures (ibid: 36-37). In this context, as a second way of examining the state-capital relationship, it is essential to discuss the form of government intervention in the economy. As a result of changing economic strategies by governments, it can also be seen that the government influences the interest mechanisms among capitalist actors by their political preferences (Buğra and Savaşkan, 2014:122). Capital accumulation opportunities that arise in a market economy can be shaped by a series of political factors and actors who determine how these opportunities will be used. For example, in contrast to Eren-Vural's approach for the case of Turkey's pharmaceutical price policy, Dorlach

(2016) argues that the stricter government regulation of prices and profits in the sector after 2009 was mostly a result of government technocrats' macroeconomic stability concern and Erdoğan's political concern over electoral support.

The previous chapter mentioned the literature showing that health policies can provide a critical case study for analyzing populist policies. Evaluations limited to populism theories risk pushing aside the implications of the global policy paradigm, which is not directly connected to political actors, and the use of theoretical analyses on the relationship between state capital. However, as is evident in Turkey's case, it is not possible to ignore the direct effects of the government's populist concerns on the policy outcome in some cases. In this sense, as Buğra (1994) suggests, legitimacy concerns appear to be an essential phenomenon to understand state intervention and the effect of the capitalist class, especially in developing countries. This suggestion reminds us once again of the legitimacy concern of the capitalist state, which neo-Marxist scholars had emphasized long ago. In their analysis of the welfare state, neo-Marxists said that the state had a unique function to legitimate itself in the eyes of the population while at the same time guaranteeing and promoting accumulation for owners of capital.

It may not be possible to make the same evaluation for today's capitalist countries, as this concealment refers to the welfare states. However, a comprehensive analysis would necessarily accept that the legitimacy concerns of the governments shape social policies. For example, one of the most discussed issues with the COVID-19 pandemic was the

ability of states to respond to this public health crisis. State power and legitimacy have come into question again, as it is known that the epidemic/pandemic or other crises seen in world history have a high potential to bring political and socio-economic changes. It is not possible to say that the COVID-19 pandemic had a more dramatic impact in terms of death toll than the earlier deadly pandemics such as Black Death or Spanish flu did.[19] However, it is still possible to argue that the states have been expected to be the first respondents. The COVID-19 pandemic has strengthened "the power of the state in its traditional role as protector of society from outside threats" (Herbert and Marquette, 2021: 33). Declaring a state of emergency and curfew, restricting mobility, increasing state surveillance were the applications that provided power consolidation for the states. In addition, the necessary medical treatments and, recently, the provision of vaccines by the state reinstate that the state is the greatest power to protect public health (ibid.). Therefore, it is clear that no matter how market-determined the health care systems are, the obligation of all states to respond to the crisis is evident as their legitimacy is at risk of weakening. Therefore, one of the most crucial elements in current health policies will be simultaneously analyzing the intricate relationship of legitimacy concerns with the general policy paradigm and economic pressures.

The transformations in the current health policy need to be examined through the multifaceted changes and levels of political and capitalist class actors, partnerships, and

[19] See: https://www.businessinsider.com/coronavirus-deaths-how-pandemic-compares-to-other-deadly-outbreaks-2020-4

conflicts of interest. The aim of increasing the role of the private sector among the social policies that we encounter as a paradigm shift in the international arena and advocated by international organizations finds its application in many different ways. To quote Jessop, as we observe the "destatization of the political system," we are trying to understand health policy outcomes when the public-private distinction was redrawn and became blurry compared to the past. Some states' technical-economic, ideological, and political functions are now shared with parastatal, nongovernmental, private, or commercial actors (Jessop, 2002:199). In this case, it may be the most accurate approach to understand the formation of health policy in developing economies with the different forms it takes in different societies and with the specific mix of pressures and the diversification of actors.

3.6. Conclusion

This chapter aimed to propose perspectives to fill the gaps mentioned in Chapter 2 and prepare a base for a political economy analysis for Turkish health transformation associated with the AKP government. To this end, the chapter started with defining a social policy paradigm by which we can understand and interpret the developing country cases after the 1980s. As complementary flows, the Washington Consensus and the post-Washington Consensus dictated together a framework for economic policies first and social policies later for developing countries. The Washington Consensus framework, which was carried out to ensure that the neoliberal economic agenda was implemented worldwide, tried to respond to the problems this economic agenda created after a while by increasing public social expenditure without changing the basic logic. In this respect, it is not possible to evaluate the two separately. The social policy paradigm I mentioned

is a whole together with the economic policy recommendations of the Washington Consensus that came before social policy recommendations. The Washington Consensus as a social policy paradigm proposal enables us to handle economic, political, and social policy transformations with many national and international developments and actors.

Washington Consensus organizations have been the implementers of this policy paradigm. This chapter also summarized WB, IMF, and WTO interventions and indirect impacts concerning health policy outcomes. For example, WB's intervention in health care started at the beginning of the 1990s by directly proposing a policy approach for developing countries. The focus of WB has been the effectiveness of financing schemes, implementation of public-private partnerships, and controlling the results in the countries taking WB loans. On the other hand, the IMF's intervention has adverse effects on governments' health spending because of its fiscal restrictions. Critical studies in the literature have shown that IMF-borrowing countries are worse in developing their health outcomes. The WTO also directed negative consequences for developing countries by initiating trade agreements and patents to benefit transnational pharmaceutical, insurance, and service companies.

In compliance with the overall change in the capitalist accumulation process after the 1980s, the paradigm shift in social policy changed the state's role in health care services to a more regulatory role. It made social policy formation a market-based process. As a result of economic liberalization reforms, the private sector has become a more prominent actor in health systems. Public-private partnerships have become an alternative

way to provide health care services. The results of this policy paradigm and the hegemonic impact of its organizations gave rise to critical literature analyzing health policy transformations in different country cases. The related literature either focuses on the negative social implications of market-based reforms initiated with the policy paradigm or emphasizes the benefits of the private sector and individual capitalist actors. One common observation is that developing country states have been active actors in reform processes to facilitate the growth of the pro-market health system. At this juncture, one needs to rethink the state-capital relationship to propose a more comprehensive political economy approach to study health policies.

The complexity of the state-capital relationship was acknowledged in critical studies referring to the blurring of the division between public and private. When looking at such a picture, it becomes difficult to translate the relationships between different actors and organizations into a single model. What impacts capitalist actors have implications on policy outcomes, and the basis of this impact provides important data when considering individual country cases. A good example is that scholars working on the NHS example reveal how capitalist actors are positioned within the state mechanism. However, there are limitations to understanding state policies only through actors. Integrating the legitimacy concerns of governments with the impacts of organized political, economic, and civil society actors in the policy formation scene will also be important in terms of political economy analysis. In this case, case studies should inevitably focus on case-specific developments after examining the effects of policy paradigm and marketization trends.

While trying to understand health policies and reforms, grasping the history and overall economic system shaped by health policies is a critical starting point. From a political economy perspective, one should analyze the mutual impact of health regulations on the capital accumulation process and the effect of the accumulation process on the change in the organization of health services. Such theoretical abstraction allows us to distinguish the characteristics of health policies in different country contexts while grasping their general function in capitalism. Accordingly, while turning to concrete analysis, theoretical understanding must always be combined with a careful and detailed analysis of the historical context, contingency, and conditions to explain the dominant situations, processes, events, and consequences (Jones, 2012).

The following chapters will focus on understanding the Turkish health system transformation and the public-private partnership projects in health as a complicated process with this theoretical base in mind. The need for reform in health services in Turkey has been a matter of debate since the 1990s due to fundamental problems such as the low coverage of health insurance in Turkey and the quantitative and qualitative inadequacy of health services. These discussions and the neoliberal transformation were followed by a transformation in Turkey, as in many countries, that necessarily overlaps with the international social policy paradigm. Within this transformation, one of Turkey's most prominent actors of change in recent years has been the AKP government. In the following discussions, I will look at transformation and see how the complex relationships in the Turkish case have developed. In addition to the studies on the first

years of health transformation in Turkey, I will also attempt to understand the nature of the transformation in later years.

CHAPTER 4 CHANGES IN HEALTH POLICIES AND POLITICAL ECONOMY OF THE RECENT TRANSFORMATION IN TURKEY

4.1. Introduction

This chapter aims to scrutinize the most recent health system transformation in Turkey associated with AKP governments, throughout their 20-year time in power, by considering the historical and political process leading to the transformation. As mentioned in the previous chapter, Turkey's health reform has been in line with global reform policies and the related post-1980 transnational policy paradigm. Turkey's role in adhering to these international policies will be shown and detailed in the following sections of this chapter. The path that led to the much-debated, controversial health policies of AKP appeared after the post-1980 reform attempts, which remained small scale and largely scattered. The expanded reform in the health care system organization, which is called the Health Transformation Program (HTP), was announced in 2003. In addition to examining the overall transformations in the organization of health care, this chapter also aims to explore the Public-Private Partnership (PPP) method for building and operating public hospitals. This method, which emerged as AKP's newest policy, will be detailed in the next chapter.

The form and content of the overall transformation program, PPPs, and implementation processes are not unprecedented. What distinguishes the Turkish case from others is that the transformation and the hospital projects which followed were carried out under the rule of a one-party government, which has existed from 2002 until now. The significant changes in the organization and delivery of health care have been presented as one of the most important political projects of the conservative AKP governments. The discourse used by the party leader and current president of the Turkish Republic, Recep Tayyip Erdoğan, to define the PPP hospitals (known as City Hospitals) as "his dream" has strengthened the projects' affiliation with political power. Erdoğan has described the hospital projects on many occasions as his project and a dream that he had been waiting to realize for a long time. Erdoğan's insistent rhetoric and the public controversy over the projects led the critical media and circles to describe the projects as unwise and unsustainable, projects which they argue that Erdoğan had tried to achieve only out of populist interests. One of the most significant characteristics of the hospitals has been their large size, making them one of the "mega-projects" of the AKP government. Along with other large-scale investments such as highways, tunnels, bridges, and airports, the oversized PPP hospitals played a pivotal role in AKP's electoral campaigns and PR activities. This direct connection between PPP hospitals and politics leads to criticisms targeting the projects and their adverse economic consequences, with some of the criticisms also being aimed at the then political power as well as Erdoğan himself, the prominent actor behind the projects.

The legal and political considerations of the project and the related economic

consequences are indeed reflections of a more extensive process involving global changes in health care policies. In this context, before going into the details of the latest health policies in Turkey, this chapter will establish a basis for evaluating and observing the Turkish case. In order to better contextualize the latest policy formation processes in Turkey, a more comprehensive examination is needed of the health policy history of Turkey, the crucial changes which appeared after the 1980s, and finally the AKP government. Considering that all of the reform items had been introduced as part of the larger Health Transformation Project (HTP), this chapter will continue to examine the HTP. I will explore the PPP hospital projects in a separate section as part of the second phase of the HTP. PPP projects continued amid the overall transformation but include specific political and economic dynamics that marked the changing dynamics that are part of the AKP leadership.

4.2. Health care policies and reform attempts in Turkey before the AKP governments

4.2.1. A general overview of the changes

Two critical historical developments can be noted concerning the global changes in health systems. First, while strong welfare states arise in European countries, weaker welfare regimes in middle-income countries emerged. Second, the post-1980 so-called neoliberal shift led to the transformation of welfare states and authorities. The rapid industrialization and urbanization which started in Europe were considered the most important factor that first pushed governments to intervene in public health issues. Although each country has a different form of a health system, it is generally accepted

that these systems have two roots that differentiate them in their models for generating resources for health funds: the Bismarckian and the Beveridge models. For each case, it is possible to say that there was a resources redistribution concern. In addition, the state's role has been critical in taking responsibility for the health system and expanding access to health care.

The attempts to draw a systematic picture of the historical trajectory of advanced capitalist states have constituted the basis of the literature on social policies and health policies. On the other hand, the development of health care does not follow a historical trajectory for which a systematic picture can be drawn for the so-called developing states. However, many of them, including Turkey, have shared the tendency to cover the active population in urban, predominantly public, and formal sectors, resulting in excluding the unemployed and rural populations. The shares of government expenditures allocated towards health expenditures have also been much lower when compared to European countries. There were also other structural differences. For instance, since the preventative mechanisms had not been developed as in European countries, diseases that spread in developing countries evolved differently and spread in a generally more serious way (Ağartan, 2015). Moreover, access to health care has been problematic: The infrastructures for health services have been insufficient, and the most critical health institutions were limited to big cities (Belek, 2014). Public spending on health was mainly focused on cities, although the population was still concentrated in rural regions until the recent mass urbanization processes primarily started in the 1960s and 1970s. This situation also led to an outcome in which the majority of rural populations had been

deprived of health coverage (Buğra and Keyder, 2006). An exceptional trend of the 1970s that should be acknowledged here is that some governments in Asian and African countries had to respond to the universal health coverage demands coming from anti-colonial and revolutionary movements. This demand could be achieved only by the rapid creation of a government health service (Bloom et al., 2008). However, for developing countries in general and Turkey, the state has never reached a dominant role within the welfare state like those seen in advanced capitalisms.

The most recent paradigmatic change affecting health policies has been the changes in well-known welfare state systems and the beginning of reform packages, which started in the 1990s. These health reforms in developing countries have been implemented chiefly under the structural adjustment programs (SAPs), also known as the Washington Consensus. As mentioned in the previous chapter of this study, the programs were designed by the World Bank and IMF. Reforms were based on the assessments of the international organizations of the Washington Consensus, pronouncing a future "health crisis" in developing countries due to "insufficient spending on cost-effective health programs," "wasteful public programs" and, "inequitable distribution of the benefits" (WB, 1987). Before evaluating the internationally orchestrated IMF and WB-shaped reforms packages in Turkey, it would be helpful to look at the earlier health policies briefly.

4.2.2. From the beginning to the 1990s

The history of and the changes within the Turkish health care system before the recent reform have been analyzed by various scholars of social policy and history (Buğra, 2008; Özbek, 2006; Talas, 1992). While the periodization can differ in these analyses primarily because of the challenge of how to include the Ottoman period within the analyses, the social policy history of the Turkish Republic, founded in 1923, has generally been periodized similarly. Accordingly, from the first attempts of the newly established republic in 1923 until the end of World War II, the state's involvement in public health was significant. This role has been mainly focused on preventative care. In terms of curative health care services, state capacity was insufficient to meet the public's needs in human resources and institutional capacities (Buğra, 2008:120).

The second period, covering the years after World War II until 1980, is mostly identified with the state's attempts to invest in its capacity for providing health care services, especially with the enactment of the Law of 1961 on Socialization of Health Care Services (Pala, 2018:34). However, healthcare services were defined by "labor market attachment," which means covering the active population in urban, predominantly public, and formal sectors and mostly excluding the informal, unemployed, and rural populations, resulting in a limited expansion of services. Turkey's Social Insurance Organization (SSK) and the Retirement Fund (Emekli Sandığı) created hierarchical protection systems for the privileged sections of the population, the industrial working class, and retired state employees. They differed in terms of benefit packages, premium

rates, and the quality of services (Ağartan, 2012: 460).

The third period has usually been defined as the post-1980 period and is based on several structural changes. The new social policy paradigm that appeared after the 1980s was first signaled by a constitutional change in Turkey. While Article 49 of the Turkish Constitution of 1961 writes that "It is the responsibility of the state to ensure that everyone leads a healthy life both physically and mentally, and receives medical attention" (Constitution of the Turkish Republic, 1961), Article 56 of the 1982 Constitution says that "The state shall regulate the central planning and functioning of the health services to ensure that everyone leads a healthy life both physically and mentally, and provide cooperation by generating and increasing productivity in human and material resources. The state shall fulfill this task by utilizing and supervising the health and social assistance institutions, in both the public and private sectors" (Constitution of the Republic of Turkey, 1982). While the state was defined as the party solely responsible for administering and providing health care in 1961, its obligation was narrowed to the coordination of public and private institutions in 1982. This constitutional change brought specific pro-market developments such as increasing private sector presence and means-tested programs to expand health care coverage for the poorest segments of the population.

The 1982 Constitution followed the military coup, which occurred on September 12, 1980, against rising leftist and worker movements. Turkish Armed Forces ruled the

country through the National Security Council until 1983. With a 1981 decision of the cabinet, health investments were included in the scope of incentives, the powers of professional organizations were narrowed, physicians working in the public sector were given permission to open private clinics, and user fees were introduced for medicines (BSB, 2008:223). The civilian right-wing Motherland Party (ANAP) formed a one-party government after the National Security Council, further implementing economic liberalization policies.

With the passage of the 1987 Basic Law on Health care Services, public hospitals were allowed to be converted into public enterprises. This change allowed for significant transformations in hospitals' financial management models, which led to the establishment of revolving funds based on user payments[20]. It also introduced flexible contracts and a performance-based payment model for health professionals, and a contribution-based general health insurance system. Despite these attempts, which were in line with the changed social policy paradigm, the Constitutional Court in 1988 annulled some law articles in response to the appeals of the center-left party SHP (Social Democratic People's Party) request. The objectives of the law had been impossible to put in effect until the arrival of the HTP. However, the Court did not rule that the transformation of public hospitals into individual enterprises was unconstitutional.

[20] Regarded as an alternative source of revenue, revolving funds suggest that the public hospitals would charge citizens for health care services and pay the hospital staff from the fund. The share of revolving funds in the MoH budget increased from 13.7 percent to 81.4 percent from 1993 to 2003. While a few hospitals were implementing the revolving funds resource generation method, all hospitals under the MoH in Turkey had revolving funds by 2006 (Kartal, 2009).

Yılmaz (2019) concludes that the Constitutional Court "saw no contradiction between charging for access to services in public hospitals and people's right to health care," The introduction of revolving funds can be seen as the first step of the marketization process within the Turkish health care system.

The law also made it possible to "purchase services when necessary" on the grounds of preventing a waste of resources in the establishment and operation of public and private health care facilities. As a continuation of this, with an amendment made in the civil servants' law in 1988, the basis was created for the provision of support services, partially or wholly, services that would come from the private sector. It was also known that some large hospitals had started to contract with private companies for cleaning services, even before the amendment had appeared. In the same period, state incentives were announced for health investments. Thus, incentives such as discounts for private hospital investments, customs exemptions, and interest refunds on medium-term loans were announced. However, these incentives did not lead to the expected increase in private hospital investments. Between 1982 and 1990, the proportion of private hospitals to the total number of hospitals fell from 16 percent to 13 percent (Küçük, 2018a: 164-169).

4.2.3. The start of internationally orchestrated reforms

The financial crisis of the 1980s in Turkey ushered in the structuring of the financial institutions in the late 1980s. With the decree adopted in 1989, capital movements were

liberalized, and Turkey was integrated into the world financial system. What was expected from this regulation was that the flow of international funds would serve to both finance growth and facilitate the financing of public deficits. In addition, the transition from the Ministry of Health and Social Aid to the Ministry of Health in 1989 in Turkey stands out as a historical moment that occurred as the related transformation and reforms were beginning (Küçük, 2018: 170). Related to this restructuring, in the 1990s there was also the beginning of health projects with WB loans and various consecutive projects designed according to the assessments of the international organizations. This start marks the beginning of a set of actions that would continue for several years before leading to the more comprehensive and large-scale transformation realized by the AKP governments. In fact, as Ağartan (2008:221) notes, in the 1990s, civil society actors in health policymaking started to become mainly the "political elite who initiated reform attempts with the growing support of international policy actors."

One of the earliest moves was a report by PricewaterhouseCoopers (PWC) on Turkish health policies. The report was prepared to evaluate the existing situation of the Turkish State Planning Organization (SPO)[21], a state institution existing within the health sector.

[21] The SPO was established in 1960 as the most important institution of the planned development period. The historical transformation of the organization clearly shows how government planning transformed over time in Turkish history and especially during the AKP governments. In order to realize the goals determined by the government, the SPO was responsible for preparing development plans as well as annual plans. After 1980, with the structural adaptation policies, development planning was replaced by "strategic planning", which is also called private sector-based strategic planning (Ekiz and Somel, 2005). With the Seventh Five-Year Plan (1996-2000), SPO's only task was turned into allocating a budget to investor organizations. As the AKP government strengthened its political power, it reorganized the SPO as the Ministry of Development in 2011 and

The *Health Sector Master Plan for Turkey* was finalized in December 1990, outlining "the strategy for public hospitals to be operated by the Ministry of Health (MoH) until they become autonomous health care enterprises, with a long-term plan for decentralization" (Küçük, 2018b:3). In August 1990, Turkey signed a loan agreement with the WB, starting the First Health Project, which covered 1991 and 1998. To realize the First Health Project, the Health Project General Coordination Unit was established under the Ministry of Health following the Project Evaluation Report of the World Bank and the provisions of the Loan Agreement. The Unit was defined as responsible for preparing and implementing health projects designed by WB experts and the coordination unit (Turkish Ministry of Health, 2020).

The high-ranking and highly-paid staff in charge of preparing reports for the WB reappeared later in high-level positions within the Public Hospital Association, which was established in 2011 to assign a board of directors and a general secretary for the management of public hospitals. It was later suspended, however, due to financial deficits (Atalay, 2015). The First Health Project, covering eight provinces, had 147.7 million USD, with 75 million USD coming from the WB and 71.6 million USD from various government sources (Belek, 2012: 15). The highest budget items were construction and equipment. The government funded 82.3 percent of the total construction costs, while 80 percent of the investment in equipment came from the WB loan (ibid:17).

abolished the Ministry in 2018, placing the responsibilities for the planning under the Presidency under the Strategy and Budget Department.

Soyer (2003:311) argues that the "Economic Package" of 1992 showed in general that the government had no money to allocate to health, that the budget and public investment gap would be filled with incentives to be given to the private health sector, and further, that the health sector would be opened to foreign capital. After the First Health Project, another loan agreement was signed in September 1994 for the Second Health Project covering 1995-2001. The project's total budget was 200 million USD, three-quarters of which came from WB loans. The second project can be seen as a continuation of the first one, expanding the project to another 23 provinces in the country (Belek, 2012: 19). The projects' defined main objectives were very similar and can be summarized as improving the infrastructure for health services and strengthening the state's management capacity. However, one of the ultimate objectives of these projects was to provide the necessary financial, political, and legislative base for a significant transformation in the "health sector." The process that started with PwC's report proceeded with national health congresses, the preparation of legal drafts, and talks on these drafts with various state and private organizations.

In terms of the legal base, the first drafts were prepared in 1993 and presented to the National Assembly in 1994. The reform package was included in the 7th Five-Year Development Plans in 1995. The drafts were discussed with other state ministries, such as the Finance, Justice, Labor and Social Security, Treasury, and SPO and Social Security Institution (SSI) in the following years. The new financing model designed under the

reform drafts was also introduced to the private insurance companies in 1996. It is also worth noting that the Ministry of Health organized two national health congresses and, in the first congress, included one of the most important parties in the discussion, the Turkish Medical Association (TTB), along with other labor and professional organizations, to discuss the planned reforms. Following the direct critical evaluations in the first congress directed towards the reform process, especially towards privatization and changes in the hospitals' management, the Ministry eliminated these organizations in the second congress (Belek, 2012).

Despite the preparations to establish a legal foundation for implementation in the 1990s, the major transformation of the health system would wait until AKP's electoral success in 2002 as a one-party government. The coalition government between 1999 and 2002 was politically unsuccessful in terms of managing the consequences of the large earthquake of 1999 and the resultant economic crisis. The government made a historically controversial move by calling a high-ranking WB staff, Kemal Dervis, to Turkey and appointing him as the Minister of State for Economic Affairs. He was the architect of a so-called economic recovery program, a typical IMF-led prescription for one of Turkey's biggest financial crises in 2001. As Boratav (2003:183-184) notes, "The management of the crisis was transferred to the IMF. As a result, the economy and the social structure were reshaped in line with the program and demands of the IMF and WB. Among the well-known 15 laws that were passed at surprising speed in this period, social insurance and general health insurance laws paved the way for the significant transformation for the coming AKP government.

4.3. The major change in health policies: The Health Transformation Program (HTP)

4.3.1. A general overview of the HTP

Considering that the reform process had started with the agreement signed with the WB in 1990, the period leading up to the transformation program in 2003 had remained scattered and unstable, as the winds of global reform had not been able to generate wide-reaching and lasting changes. The WB declared the First Health Project "partially successful" because, in the end, the reform attempts had not been able to fulfill the projected objectives (WB, 2009:27). The main reason was the interruptions in the process of policy making. As mentioned before, consecutive governments in the 1990s attempted to pass the necessary laws for the reforms that the WB had suggested. However, they were unable to finalize them due to legal challenges from other parties, civil society actors, as well as changing political actors. Another smaller-budget project, the Primary Health care Services Project, was deemed unsatisfactory because the state could not develop the primary health care services in this period (ibid:27). Moreover, the 1990s were marked by the worsening of health provisions, as the problems of limited coverage and significant regional disparities of access to health care as well as poor health care outcomes (infant and maternal mortality were high) continued to persist (Ağartan, 2015). In 2002, 67.2 percent of the population was covered by the public system, excluding the segments of the population who were poor and living in less developed regions of the country (Ağartan, 2012: 461). An even lower share of 58 percent had access to pharmaceutical reimbursement (Dorlach, 2016: 62).

In the 2000s, a more substantial commitment to the Washington Consensus organizations prevailed, especially given the crisis. The Second Health Project that closed at the end of 2004 was deemed satisfactory by the WB. A 2004 report assessing the first project application for the transformation program states that "While [the] Bank's past involvement in the health sector in Turkey has not been very effective in bringing about systemic reform, the timing and scope of this new partnership is very opportune, as the current government is strongly committed to extensive reforms in the health sector." The report also adds, "Both the Urgent Action Plan and the Program for Transformation in Health have set tight deadlines for the necessary legislative and institutional reforms" (WB, 2004: 1,2).

The government mentioned by the WB was formed as a one-party government of the AKP (Justice and Development Party) in the 2002 elections. Founded in 2001 by members of some old and new religious conservative parties, the AKP won a sweeping victory in the 2002 general elections, securing two-thirds of the seats in the Turkish Parliament. This victory of the AKP with its renowned leader, Recep Tayyip Erdoğan, brought in an era that would mark the next 20 years of the country. It is clear from the history of the politics of health care in Turkey that the AKP government was fortunate to find the legislative base for the WB and IMF-led reforms already in existence. The legal and institutional amendments that appeared with the WB loan agreements and the quick actions of Kemal Dervis, who implemented the IMF-led economic recovery program

during the 2001 crisis—all of which occurred before the AKP came on the scene—established the vital ground for further liberalization in health care. The AKP launched an Urgent Action Plan, which included policy actions in health care immediately following its electoral success. The government announced its major program as the Health Transformation Program in 2003 and signed a loan agreement with the WB in 2004.

A 2003 WB report titled *Turkey: Reforming the Health Sector for Improved Access and Efficiency* suggests a two-phase implementation carried out by the AKP government. According to the report, the objectives that should be adopted in the program included universal social health insurance, hospital autonomy and reorganization, institutional consolidation and redefining institutional responsibilities, empowering the Ministry of Health to carry out regulation, and strengthening primary care (WB, 2003: 73-77). The report also suggested two phases for implementing the program to be carried out by the government. The first phase was defined as the preparatory phase to implement the necessary legal and institutional requirements, while the second phase was defined as the period of actual implementations (ibid:73).

The HTP announced by the MoH in 2003 had eight main components:

1. The Ministry of Health as a planner and controller

2. General Health Insurance gathering everybody under a single umbrella

3- Widespread, easily accessible, and friendly health service system

a- Strengthened primary health care services and family medicine

b- Effective and staged referral chain

c- Health enterprises having financial and administrative autonomy

4- Health manpower equipped with knowledge and competence and working with high motivation

5- Education and science institutions supporting the system

6- Quality and accreditation for qualified and effective health services

7- Institutional structure in the management of rational medicine and equipment

8- Access to effective information at decision making process: Health Information System (Ministry of Health, 2003).

The similarity between the WB prescriptions and the agenda of the AKP was obvious. One of the first articles on health care states, "The health sector will be coordinated from a single center by the Ministry of Health. The Ministry will only assume an organizational, coordination, guiding, supervisory, follow-up, policy-making role" (AKP, 2002: 80). The new role of the Ministry in Turkey was in line with the examples seen in other countries, in which governments took steps to primarily oversee the insurance services (Leys, 2007: 96). At the same time, AKP had also declared that the government's policies would be formed in coordination with the private sector and that the rules of market competition would be determined (BSB, 2008:226).

The AKP government signed a loan agreement in 2004 for a two-step transformation project following the WB's recipe. The first step was called the Health Transition Project, covering the years between 2004 and 2009 with a release of a loan of approximately 49.4 million USD. While most of the funds with the earlier projects with WB loan agreements had been spent on construction and equipment, this project's budget was mainly used to invest in training and consultancy services (Yilmaz, 2019: 127-128). For the second step of the transformation, called the Restructuring of Health Sector Support Porject, a 75.12 million USD loan agreement was signed with the WB, covering 2009 to 2015. The budget of this loan was primarily dedicated to supporting the MoH's strategic plan and helping the MoH and SSI become effective health sector steward. A third loan agreement also started in 2005 to improve prevention of selected non-communicable diseases, increase the efficiency of public hospital management and enhance the capacity of the MoH with a commitment amount of 134.4 million USD.[22] The Turkish government also signed other agreements with the WB in addition to the three agreements directly related to the transformation in health care. Two loans for Programmatic Public Sector Development Policy and two more loans for Restoring Equitable Growth and Development Policy had significantly associated components with the health sector (ibid: 128). Additionally, in the 2007 program of the WB's Development Marketplace Program, a loan valued at 4 million USD was released for Turkey to develop PPP projects (Belek, 2012: 28). The WB assessed the transformation projects as satisfactory, noting that the

[22] The closing date for the last project is December 31, 2021. The Bank's completion and results reports for the first two and the project appraisal report for the last agreement are available at: https://www.worldbank.org/en/results/2018/04/02/turkish-health-transformation-program-and-beyond

government had successfully prioritized implementing the projects in line with WB suggestions (WB, 2009).

In line with the steps and institutional transformations that took place with this global social policy paradigm and implementations by various international organizations, the HTP brought in fundamental changes specifically tailored to Turkey's health care system. The previous insurance system, composed of different insurance schemes and stratified according to various occupational groups, was transformed into the general health insurance model. It became a model for universal public health insurance coverage, largely erasing the earlier disparity between occupational groups. The General Health Insurance Law (GSS) aimed to cover the entire population under the umbrella of health insurance and provide justice in financing. The segment of the population covered had increased with the Law, and according to the latest available statistics, in 2020, 98.5 percent of the population was covered by public health insurance.[23] Although scholars have also mentioned that the means-testing methods have sometimes made it difficult for the segment of the population living below the poverty threshold to access health care (Yoltar, 2009; Yılmaz, 2013), the level of satisfaction with the health care system among the citizens, in general, had increased. Polls especially related to the election performance of AKP (KONDA, 2018) and TURKSTAT's Life Satisfaction Surveys (Uğur and Tirgil, 2018) reflected this increase. The major change was presented as the change in the level of responsiveness of the health system, which was associated with the waiting time for

[23] Social Security Institution, 2020 Statistical Yearbook. Available at: http://www.sgk.gov.tr/wps/portal/sgk/tr/kurumsal/istatistik/sgk_istatistik_yilliklari

patients in both health centers and hospitals. The policymakers mainly emphasized the shorter waiting time after the appearance of the HTP as one of the primary reasons behind the increase in satisfaction (OECD, 2008). Yet, the other main reasons for this positive view that emerged among the majority of the population can be attributed to the fact that people could apply to every hospital with the merging of social security institutions. This family medicine system also had increased the level of responsiveness of the system, the cheaper medicines, and the implementation of general health insurance (Atalay, 2015). Thus, these positive effects on the users of the health system translated as a positive attitude towards the transformation and the AKP governments.

The HTP also brought essential changes that complied with the rules of market competition as it had promised to do. Contributory payments for public health care delivery and medications are required to access outpatient health care services. The amount varies according to the type of hospital that is ranking the quality of services. The Program also introduced additional payments for private hospital visits, even if the patient is publicly insured. Private hospitals, therefore, were integrated into the public health insurance scheme (Yılmaz, 2013). The reform also formed the necessary basis for the introduction of supplementary private health insurance in the system. However, it is not possible to say whether the private insurance sector has achieved a promising opportunity with the HTP. As I will mention later, the AKP government did not give positive signals regarding policy changes that would benefit the private insurance sector in terms of accumulation opportunities. Lastly, the most visible step of the reform in integrating the private sector was public-private partnership (PPP) hospitals. A close

examination of these hospitals, which were introduced as the continuation of the reform, both economically and politically, will be critical in examining the course of the reform. I will devote the next section entirely to this purpose. Still, first I will look at the literature that assesses the HTP from the very beginning and what the statistical information offers to evaluate the evolution of the reform.

4.3.2. Evaluating the HTP and the related literature

The makeup, economic and social background, and the outcomes of the market-based reforms implemented within the Health Transformation Project in Turkey were not unprecedented. The Washington Consensus policy paradigm has brought similar consequences in developing countries. In his detailed comparative analysis on the similarities and differences between the reform in Turkey and the reforms in selected Latin American, Southern European and East Asian countries, Yılmaz (2017) points out that, in the end, it is possible to talk about a general trend in these economies in terms of marketization and passive privatization. The global policy paradigm led by the World Bank has by and large resulted in similar changes in the restructuring process of various health care systems.

However, the implementation processes varied due to different domestic factors. Considering these differences, according to Yılmaz (2017:109), the Turkish case differs from other cases on two major issues. First, the Turkish state has been continually

dominant in health care financing. The Turkish reform has not allowed for opting out of general health insurance. In contrast, in their Popular Health Insurance (Laurell, 2007), Argentina and Mexico have included a voluntary element in the reform, the option of opting out, which allows the private health insurance sector to expand within the domestic market. In Turkey, since universal health insurance began in 2003, the proportion of the population covered rose from 70 percent in 2002 to 83 percent in 2010, and finally 98.5 in 2020 (WHO, 2012:118). The increase was significant among the poorest segments, especially in the first years of the HTP. In 2003 only 24% of the poorest deciles had health insurance, whereas, by 2008, 82% of the poorest deciles had coverage (Ağartan, 2012:464). The ratio of green card expenditures (i.e., health care premiums of the poor paid by SGK) to GDP increased by 254% between 1999 and 2007 (TEPAV, 2008:28).

Second, the reform in Turkey has been carried out by successive AKP governments from the beginning, and the process has not been blocked or delayed by any other political actor. The first Minister of Health of the AKP government, Recep Akdağ, was appointed for four consecutive periods, from 2002-2013, and then for one more year in 2016. However, in similar reform cases, political parties implementing reforms faced various interventions from different national and global actors. For instance, after the 1997 financial crisis, the developmental state had increased the coverage in South Korea to reinstate the legitimacy of the state. However, after the single-party government from the center-left launched its plan to unite health insurance, the government was opposed by the Federation of Korean Trade Unions. The country's largest business organization and

the main opposition party worked against the plan and succeeded in delaying its implementation (Yılmaz, 2017:106). In Greece, reformers were opposed by strong trade unions in the country, on the one hand, and restricted by the EU's Maastricht criteria that undermined the government's control on the public budget due to the financial crisis the country had experienced, on the other hand (ibid:102). In the Mexican case, the *Seguro Popular* health insurance program, which was adopted in 2004, changed party presidents and federal governments and the state government, which was a totally different experience than the path of the one-party AKP government existed during the Turkish reform.

The two points mentioned above make the Turkish case different from others regarding the state's visibility as an actor in health care transformation. This dominance of the AKP as the prominent political actor has usually been more significant in the literature as the AKP has reconsolidated its political power based on its successes in elections. Although health care transformations are unquestionably in line with global economic changes, examining the political actors of the reforms in each case and analyzing the role of these specific actors in the implementation processes remain essential. For the literature on the Turkish case, a simple grouping of factors would help explain the general tendencies in analyzing the reform. Emphasizing the role of the AKP as the central actor, the reform has been studied from the angle of at least three valid points: (1) as a state response to structural needs, (2) as a set of populist policies of the government, and (3) as a sector to implement pro-market policies of the government. They can be seen as the main arguments that attempt to explain why the AKP has invested in health care.

According to the first one, the transformation in the Turkish social welfare regime and especially the reform tendency towards a universalist system in health care had been in the agenda of "more reformist wings of the governing party", who proposed that neither the older welfare system nor a total inclination towards privatization would be a proper response to the structural need that had emerged from the increasing population in the urban and informal sectors (Buğra and Keyder, 2006; see also Buğra and Keyder, 2003; Buğra and Adar, 2008). On the other hand, some studies focus on the argument that the AKP's interest in health can be explained as a tool for the party to gain and retain popular support. Accordingly, it can be said that the AKP has invested in health care reforms as a political strategy and designed its political propaganda to influence its voters. In the context of this argument, scholars tend to examine how neoliberal policies and populism come together in theory and practice (Aytaç and Öniş, 2014; Koray, 2015; Yıldırım, 2009). Moreover, it has also been suggested that the welfare mix created by the AKP with neoliberal policies and institutions can be considered the creation of "political patronage" (Eder, 2010).

The third group consists of critical studies on how well the AKP government has implemented the policies and reforms concerning the free market. According to these, the primary motivation of the AKP is to implement the rules of the market and open up the health sector further to capitalist accumulation (Atalay, 2015; Elbek, 2015; Ercan, 2013; Hamzaoğlu and Yavuz, 2006; Sönmez, 2011). The government integrated private

hospitals into the general health insurance plan in 2005 and introduced legislation for public-private partnerships in the construction of public hospitals. A health care industry has emerged with private clinics, private hospital chains, private insurance companies, and other profit-seeking product and service providers. The 2011 decree constitutes a turning point, especially for the realization of the PPP hospitals and, relatedly, for the public controversy that accompanied the PPP hospital projects. In this context, the PPP hospital projects, for example, have been one of the major components of accumulation possibilities in the market (Pala 2018; Tükel, 2018).

One of the most important inferences from the debates on the introduction and consequences of the HTP is that the transformation was successfully utilized as a political strategy by the AKP governments. There is no doubt that the AKP has been a prominent actor in realizing and expanding the transformation by implementing the global policy paradigm and securing the advancement of the reforms with its unique political strategies. That is why there is a growing tendency of the literature focusing on the health system transformation in Turkey to emphasize the role of AKP as it remains to be seen as a prominent actor. Yet, the marketization process in the third group of literature needs to be better outlined and expanded. First, as most critical scholars do, I will look closer at the official statistics showing the public and private health expenditures. I will include the latest data available, enabling us to see possible trends in expenditures and evaluate them. After assessing the official statistics, I will also take a closer look at the evaluations of the capitalist circles of the HTP to develop a more comprehensive picture of the HTP.

4.3.3. A closer look at official statistics

To assess the role of government and the marketization trend in health care, scholars tend to look at health expenditure statistics. The related information for Turkey is composed of the Health Expenditure Statistics produced following the OECD Health Accounts System (SHS) for the years 1999-2000 and National Health Accounts statistics calculated by TURKSTAT using the same method for the following years until today. While public health expenditures include the expenditures made by public institutions, private health expenditures are the sum of out-of-pocket payments, medicine and treatment expenditures covered by individuals and households, and the expenditures made by individuals and companies paying for private insurance systems. According to the information given by the institution, TURKSTAT uses the household budget surveys and Insurance Association of Turkey as sources of the private health expenditure data.

4.3.3.1. Current public and private health expenditures

The table below shows the total current public and private expenditures in million USD and the percentage of the private expenditure in total health expenditure between 1999 and 2019.

Table 1. Public and private sector expenditure, percentage of private expenditure in total expenditure and total health expenditure in Turkey, 1999-2019 (in million USD)

Year	Total public sector expenditure	total private sector expenditure	% of private expenditure in total expenditure	total health expenditure
1999	7,257.14	4,611.90	38.86%	11,869.05

2000	8,370.97	4,932.26	37.08%	13,303.23
2001	6,860.16	3,217.89	31.93%	10,078.05
2002	8,788.08	3,645.03	29.32%	12,433.11
2003	11,719.46	4,575.17	28.08%	16,294.63
2004	15,062.68	6,078.87	28.75%	21,141.55
2005	17,900.75	8,486.57	32.16%	26,387.31
2006	21,060.14	9,757.34	31.66%	30,817.48
2007	26,561.54	12,595.38	32.17%	39,156.92
2008	32,681.40	12,078.29	26.98%	44,759.69
2009	30,251.61	7,110.32	19.03%	37,361.94
2010	32,321.33	8,797.33	21.39%	41,118.67
2011	32,682.63	8,400.00	20.45%	41,082.04
2012	32,840.78	8,605.59	20.76%	41,446.37
2013	34,856.84	9,558.95	21.52%	44,415.79
2014	33,507.76	9,757.08	22.55%	43,264.84
2015	30,191.54	8,252.21	21.47%	38,444.12
2016	31,129.80	7,053.15	24.62%	32,809.86
2017	30,066.85	10,233.11	21.97%	46,571.85
2018	26,615.59	7,736.59	22.52%	34,352.18
2019	27,657.67	7,797.53	21.99%	35,455.20

Source: Turkstat Health Expenditure Database, Central Bank, self-calculations.

As can be seen in the public-private expenditures' shares, the public sector's dominance in health spending has remained despite all the marketization trends realized with the HTP. The ratio of private health expenditures to total health expenditures depicts a significant decrease from around 37% to 22%. However, the decline stabilizes after 2008. The following ten years set the existing normal to a low 20 percent. The official data in terms of current expenditures were converted into USD as Turkish Liras would be misleading. Although the 2019 total expenditure is almost 20 times higher than the 1999 expenditure in Turkish Liras[24], the USD adjusted figures do not show a significant increase. Yet, it is

[24] In terms of million TL, the total health expenditure was 4985 for 2009, while it was 201,031 for 2019.

also clear that the increasing trend in current public expenditure seems to become stable after 2008 and decreased slightly in the last two years.[25]

Another critical component in the analysis of health expenditures is the content of the expenditures. The current health expenditures include hospitals, nursing, residential care facilities, ambulatory health care providers, retail sale and other providers of public health programs, general health administration and insurance, and unclassified other expenditures. Hospital expenditures have always constituted the most significant component in total health expenditures since 1999. Moreover, the proportion of hospital expenditures to total spending has increased throughout the years. The percentage was 38 in 1999, 35 in 2005, 40 in 2010, 48 in 2015 and 2019.

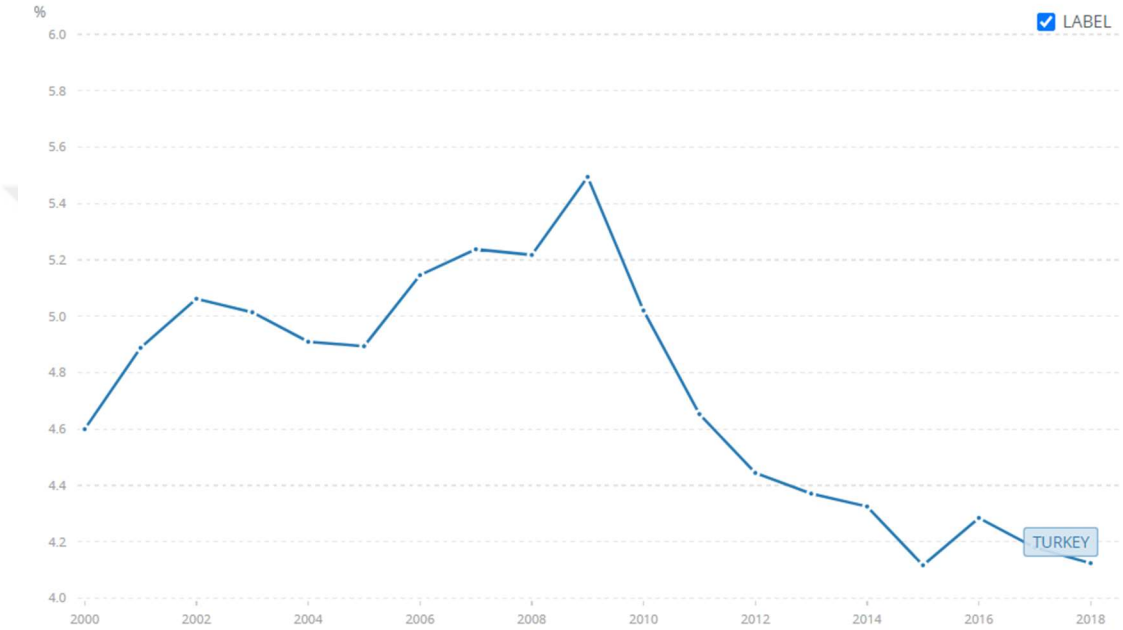
4.3.3.2. Current health expenditure as a proportion of GDP

The health expenditure to GDP ratio, the level of current health expenditure expressed as a percentage of GDP, is also considered an important indicator to understand health spendings. The figure below shows the health expenditure as of GDP for Turkey between 2000 and 2018, based on the World Health Organization Global Expenditure database. As it can be seen in the graph, the stable trend in current expenditures after 2008 denotes a decrease as a proportion of GDP. The highest ratio in 2009 did not result from an

[25] The 2020 health expenditures have not published yet, as of March 2021. However, the inclusion of 2020 expenditures would also problematic comparatively because the pandemic would be expected to be the major component in expenditures.

increase in expenditures, as can be seen in the previous table, but from a contraction in GDP due to the economic crisis.

Figure 4. Health expenditure as a percentage of GDP in Turkey, 2000-2018



Source: World Bank database[26]

Yılmaz and Yentürk (2017), in their study evaluating health expenditures in Turkey, expanded the data to 1988 by conjoining the electronically available statistics and official data obtained from different public institutions. Focusing on public expenditures, the scholars find that the long-term data of public health expenditures shows a trend of increase starting in 1988. Nevertheless, this trend largely stopped after the peak point in 2009. Yılmaz and Yentürk's other important observation is that the rise in public health

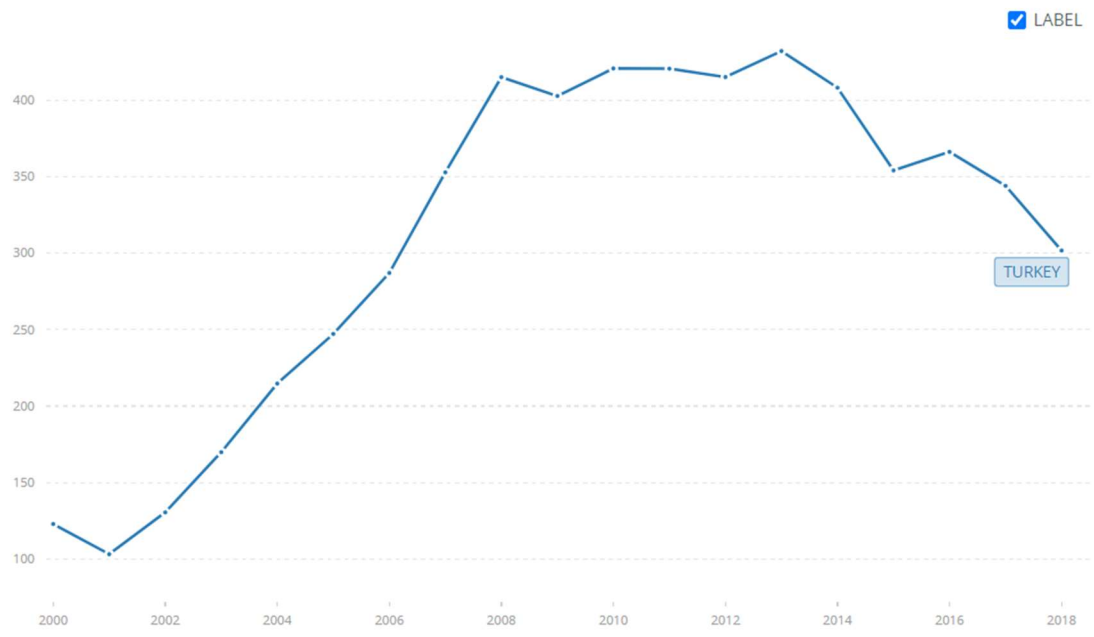
[26] Available at: https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=TR

expenditures, including the pre-HTP period, has resulted from an increase in the treatment expenditures paid by the SSI (ibid:305).

4.3.3.3. Public and private expenditures per capita

Per capita expenditures allow us to adjust the expenditures by population increase, making it more reliable to compare spending levels between countries. The graphs below show government and private spendings per person separately between 2000 and 2018, based on the WHO Global Health Expenditure database.

Figure 5. Domestic general government health expenditure per capita, Turkey (current USD)



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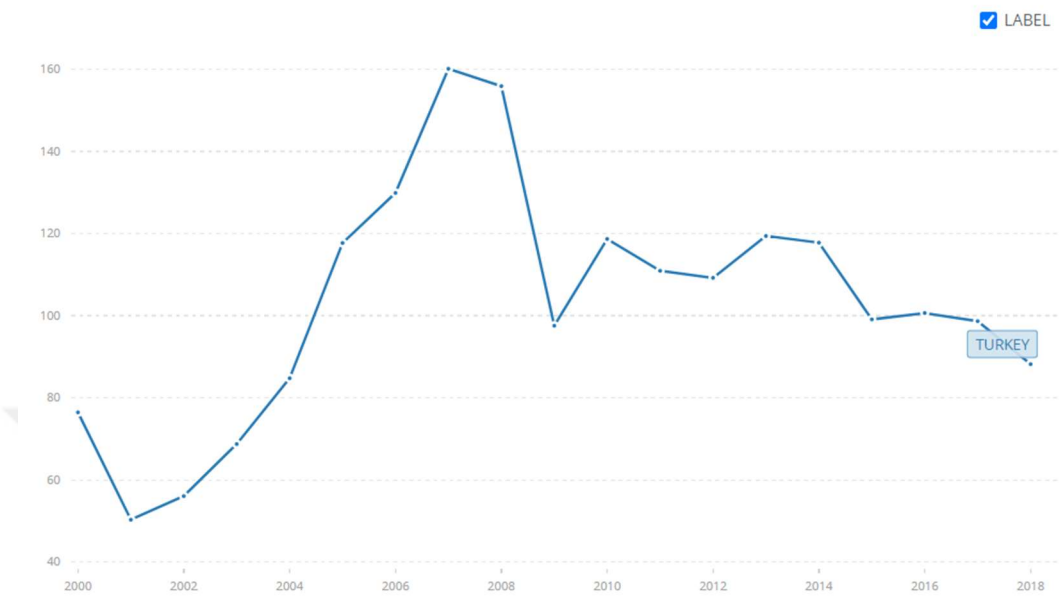
Source: World Bank database

Figure 6. Domestic private health expenditure per capita, Turkey (current USD)



Source: World Bank database

The graphs show that both government and private health expenditures per capita show a significant increase until 2008. After this year, the private health expenditure per capita shows a sharp decline, most probably because of the 2008 economic crisis. On the other hand, the government expenditure per capita after 2008 remains stable with minor changes until 2015 and then shows a trend of decline. The significant increase at the beginning for both can be explained by the factors such as increasing costs of medical treatments, increasing health demand with the expansion of insurance coverage, and the increasing expenses paid to private health care providers by the government.

The year 2008 shows an easily observable turning point for per capita expenditures in the expansion trend, denoting the same situation as previous indicators discussed above.

However, it is worth noting that despite the expansion trends we observe in official statistics, Turkey, along with Mexico, remains to be one of the two countries that have the lowest per capita spending in the OECD (OECD, 2019:32).

4.3.3.4. Investment expenditures

As a different component of the total expenditures, investment expenditures include physical infrastructures of health institutions and medical technology. The table below shows public and private investment expenditures as well as their shares in total investment expenditure.

Table 2. Public and private investment expenditure in health, the portion of public and private expenditure to total, total investment expenditure, Turkey, 1999-2019 (in million USD)

Year	public investment	private investment	% of public in total	% of private in total	total investment
1999	419.05	54.76	88.44%	11.56%	473.81
2000	524.19	56.45	90.28%	9.72%	580.65
2001	252.03	0.00	100.00%	0.00%	252.03
2002	293.38	0.00	100.00%	0.00%	293.38
2003	404.70	0.00	100.00%	0.00%	404.70
2004	613.38	376.06	61.99%	38.01%	989.44
2005	1,069.40	473.13	69.33%	30.67%	1,542.54
2006	1,344.06	837.76	61.60%	38.40%	2,181.82
2007	1,960.77	1,430.77	57.81%	42.19%	3,391.54
2008	3,198.45	1,003.10	76.13%	23.87%	4,201.55
2009	1,534.84	152.90	90.94%	9.06%	1,687.74
2010	1,837.33	199.33	90.21%	9.79%	2,036.67
2011	1,707.78	229.94	88.13%	11.87%	1,937.72

2012	1,752.51	426.82	80.42%	19.58%	2,179.33
2013	1,990.00	477.37	80.65%	19.35%	2,467.37
2014	2,012.33	668.49	75.06%	24.94%	2,680.82
2015	2,389.34	471.69	83.51%	16.49%	2,861.03
2016	1,898.34	491.06	79.45%	20.55%	2,389.40
2017	2,180.27	468.22	82.32%	17.68%	2,648.49
2018	1,679.83	448.23	78.94%	21.06%	2,128.07
2019	1,867.02	488.71	79.25%	20.75%	2,355.73

Sources: Turkstat Health Expenditure Database, Central Bank, self-calculations

The first aspect worth mentioning is that the private sector investment was not included in the statistics in 2001-2003. Both the economic crisis and the political crisis may have disrupted these data. A more systematic flow began after AKP came to power and the start of transformation projects. It can be observed that private sector investments had a large share until 2008 but then showed a significant decline. One of the critical reasons for this decline must be the global economic crisis of 2008. The percentage of the private sector investment never recovers to the level it reached during the first years of HTP. However, it increases and nearly stabilizes starting from 2012, both in percentage and in million USD. This picture implies a less good investment environment after 2012 for the private sector in health care, compared to the first years of the HTP.

4.3.3.5. Concluding remarks from the official statistics

Before evaluating all these statistics together, it is necessary to make an important point. Turkey's statistical agency and international organizations such as OECD, WHO, and

WB use the same method to calculate the expenditures: System of Health Accounts (SAH). Yılmaz and Yentürk (2017) identify that the total health expenditures of statistics produced differ. Accordingly, the total calculated according to OECD data is lower than the total calculated according to the data obtained from other sources. However, I tried to see a trend in the statistics, and the statistics produced by different institutions are compatible with each other in this respect.

The common observation we can infer from the above statistics is that although the first years of HTP show a significant increase in expenditures, the post-2008 period depicts stabilization in government expenditure expansion. Belek (2020) evaluates this situation similarly by looking at the share of the private sector in expenditures, which have started to increase again since 2012. He argues that although the percentage of the public in terms of financing of health services increased during the AKP years, AKP's "was short of breath" beginning in 2012. He attributes the fact that the private sector's share in investment and hospital expenditures has increased again after 2012, and AKP is not likely to increase the percentage of the public anymore. Belek especially mentions the increasing rates of private sector investment and hospital expenditure. The stabilization was also observed by Yılmaz and Yentürk (2017), who concluded that their findings suggest that the expected "explosion" in governmental health expenditures did not happen. Although the AKP government continues to use its health policies and transformation in the health sector as a populist discourse, it is clear that the initial expansion has settled down.

This observation has critical importance in the attempt to understand the determinant dynamics of the later period of the transformation program. It is not possible to argue that the stabilization in the expansion led the general public to be more critical of the health policies of the AKP. The popular support for AKP's health policies has not changed, primarily due to the initial improvements in terms of accessibility. Although physicians' associations and some trade unions opposed the market-oriented transformation, the AKP and Erdoğan himself could hold on to the mass support for health policies.

The next big step of the government to keep the popular support has been the introduction of PPP hospitals by announcing them as super-luxury and massive state hospitals, pushing the involvement of the private sector into the background. However, the PPP projects were presented as a solution to the problems caused by budget constraints and cost pressures for efficient delivery of health care services. The start of PPP projects can be seen as a turning point for a "breathless" AKP. Nevertheless, before discussing this direct encounter between the state and the capitalist class in health policies, a closer look at how Turkey's capitalist class evaluated the HTP and the changes will help us draw a better picture to understand the second phase of the HTP. Considering that this increase goes along with the marketization process in health care, we can predict that the promising environment of the private sector has also shrunk with the discontinuation of this increase.

4.3.4 A closer look at the capitalist class' evaluations on HTP

4.3.4.1. TÜSİAD reports

TÜSİAD's Health Sector Committee mainly functions as an expert group preparing reports and suggesting policies (Yılmaz, 2017). One of the earliest evaluations on AKP's program was the report of Turkey's biggest and voluntary capitalist class organization TÜSİAD (Turkish Industry and Business Association), in 2005. *Charting the way forward: Health care Reform in Turkey* was prepared by public health specialists who worked for various international organizations and Turkey's Ministry of Health.[27] Focusing on the private sector interests in the health sector and related reforms, TÜSİAD supported universal coverage but demanded a field where private insurance providers could also do their business. The capitalist organization recommended an opt-out option for those above a specific income level to overcome the barrier in a potentially enormous market, private health insurance. According to the report, the state should also increase funding for health care for both the public and private sectors (TÜSİAD, 2005).

The organization put that the government should be active in the marketization process of health care through a mixture of provision, subsidy, and regulation. As the report puts it, the public sector would be a payer rather than a provider, and the state should consider contracts to share risk with the private sector (ibid: 25). In the report's introduction, TÜSİAD emphasizes the "need for cooperation between the public and private sector,

[27] One of the writers of the report was a government official working in the Turkish Health Ministry's Health Projects Coordination Department. The report also mentions that the TÜSİAD Health Working Group supervised the preparation of the report. TÜSİAD's president at the time for the health working group was a pro-AKP businessman, Ethem Sancak, who then had a large share in Turkey's drug distribution market and became one of the closest capitalists to the AKP and its leader Erdoğan.

rather than a competition" by referring to the government's program mentioning privatization, public-private partnerships, and the EU accession process. Other than the opt-out option, all recommendations of the capitalist organization in this early report were realized incrementally in the implementation of HTP (Yılmaz, 2017: 215). In general, although this initial report does not go beyond the international policy paradigm remedies for the health sector, it represents the support of the capitalist class for the health transformation program of the AKP government and the necessary legal amendments. TÜSİAD also documented, with this report, its expectations from the government to expand the market for the private sector.

TÜSİAD also published another report in 2010, evaluating the premises of the government for the private health sector. It is possible to say that this second report's language is not as optimistic as the first one. It focuses on the “problems of the sector,” suggesting remedies under the topics of pharmaceuticals, service, medical technology, and financing.[28] The most visible problem for the private health sector, according to the report, was that the limitations in front of the private sector in terms of stable reimbursement rates set by the government, unclear regulations, and barriers to establishing private hospitals. The report also suggested that the government should develop the PPP model in the health sector to overcome the obstacle in front of private actors.

[28] Available at: https://tusiad.org/tr/tusiad/temsilcilikler/item/6849-saglik-sektorunun-oncelikli-sorunlarina-iliskin-gorus-ve-oneriler

TÜSİAD also announced various "concerns" in 2009 and 2012 opinion pieces published by the Health Study Group of the organization. TÜSİAD defined certain risks in the process based on the changes in the initial legislative plan of the 2008 General Health Insurance scheme, such as the introduction of high fees charged from the patients covered by state insurance in private hospitals, inadequate legal regulations for the public and private sector to work effectively. The group's opinion piece published in 2009, for example, complained that the government's work on the health sector was in favor of public hospitals. "Although the Ministry of Health should be at an equal distance to the whole sector, it limits the moves of private hospitals such as employing doctors and acquiring technical equipment with regulations that will create unfair competition conditions in favor of public hospitals," TÜSİAD argued (TÜSİAD, 2009:3). In terms of health insurance, the calls of TÜSİAD for supplementary health insurance continued from the earliest report in 2005 to the opinion piece in 2012. The absence of an opt-out option was partly compensated by the 2013 regulation on private health insurance, allowing for the option of supplementary health insurance sold by private health insurance companies (Dünya, 2017). However, it has hardly resulted in the expansion of the private health insurance market.

4.3.4.2. TOBB reports

In a more recent report of another capitalist organization TOBB (Union of Chambers and Commodity Exchanges of Turkey), it is declared that Private Health Care Sector in Turkey has grown since the transformation program in parallel to the development of

health services. Accordingly, an annual growth of 14% has brought about a 25-27% market share in value, and this percentage exceeds 50% in certain medical services (TOBB, 2017). In addition, the number of private hospitals reached 562 in 2015, and approximately 13% of these hospitals are owned by large hospital chains (ibid:17). However, there is a decreasing trend in market share for private hospitals, which had a 27 percent share in the health care market in 2011 but 13 percent in 2019 (Dünya, 2020). Concerning this decrease, public-private partnerships are also found significantly crucial for the growth of the private sector in health, especially in the projects of city hospitals and health tourism. Arguing that there has been a stable regulatory environment for private providers since 2009, TOBB defines the period between 2003 and 2009, the reform period that laid the ground and guaranteed a sustainable demand later for the private sector with the implementation of the general health insurance scheme. However, the incentives for the growth of the private health insurance sector after this period were unsatisfactory, primarily because of the absence of the opt-out option and unmet premises of the government. TOBB's evaluations, in that sense, are similar to TÜSİAD's, considering the increasing dissatisfaction with the progress of the transformation, especially after 2009.

4.3.4.3. Private hospital owners' association, OHSAD

Another active interest group OHSAD (the Private Hospitals and Health Institutions Association), has been vocal about the AKP government's policies about private hospitals. The organization was established right after the start of the HTP, and the executive board and the honorary committee have members from the health care

bureaucracy and AKP leadership. The organization's power structure favors the large chain hospitals such as Medipol, Memorial, and Medical Park hospitals. However, the voting structure of OHSAD does not let the power of the largest providers be translated directly into the decision-making in the organization. Each hospital votes according to its number of beds in the general assembly, but the largest hospitals have a maximum number of votes. The number of representatives of the largest groups does not increase linearly as their numbers of hospitals. Therefore, the most prominent groups still tend to engage in particularistic relationships, given the visible connections between the bureaucracy and organization members (Yılmaz, 2017: 216). However, the reports and discourses of the organization represent a large portion of the sector, 80 percent of the private health care providers. The organization's press release in 2012 declares that the private hospital market has grown since the beginning of the transformation, relying on the government's promises and implementations. Various press releases after the 2010s reveal that the private hospital owners have faced a crisis because the government's payments for services remained too low for hospitals to make profits (OHSAD, 2012). There is a significant difference between OHSAD, especially its president Reşat Bahat, and other capitalist class representatives in terms of press visibility; OHSAD gives voice to more direct complaints about government policies.

The organization holds frequent meetings with SSI officials, other capitalist class representative organizations, and government officials about the dissatisfaction of the private hospital owners. Arguing that the constant prices set by the government to pay for the costs of health provision in private hospitals led to a period of decline in private

health care, Bahat also visited Erdoğan to voice the demand.[29] However, the Health Application Communiqué (SUT)[30] has been a powerful tool for the state to control the private sector, especially private health care providers. Unless the payment made by the SSI to private health institutions per case is increased, the profits of private hospitals decrease.

Expressing the demands for price increases by participating in many television programs, Bahat also argued that private hospitals should be included in the recent PPP hospitals projects. Following the then Turkish prime minister Erdoğan's initial statements in 2010 giving the start to the PPP hospitals project, he reflected the organization's complaints about the AKP government's policies that did not protect the investors of private hospitals. Bahat stated that "the government will open very nice hospitals, but it will operate them independently. The operation of non-health areas will be transferred to the private sector. This system that will not use the experience of the private sector will fail. With this project, the growth of the private sector is prevented" (Radikal, 2010). Because of these problems, OHSAD also argues that new private hospitals are no longer opening,

[29] Available at: https://www.dunya.com/saglik/ohsad-sutda-fiyat-guncellemeleri-yillik-yapilsin-haberi-487978

[30] SUT is a legislative communique that allows the implementation of the state's health-related social policies, including pricing. All the services and procedures performed in the files of the patients who applied to the hospitals are recorded in the communique list, which has the rules about the prices of all services and materials and the conditions under which they can be applied to patients. The services are invoiced to SSI by the hospital and SSI pays the hospital within the framework of the prices determined in the SUT list as a result of these rules.

and some hospitals that were opened in the early years of HTP have to close.[31]

The private hospital investors represented by OHSAD have to deal more closely with the details, such as the incentives provided by the state to this sector or the legislative changes it has made. Although representatives of the organization have voiced the problems of the private hospital owners and their demands in many speeches, they usually end their statements conveying that compromising with the government representatives is very important, and they thank them for everything. The current situation of the private hospitals' sector will be examined in more detail in the next chapter. However, it is understood from the statements of OHSAD that the AKP government initially developed policies to encourage capitalists to open private hospitals, but the state incentives were not advanced enough to create an advantageous situation for some capitalist groups.

4.3.4.4. Concluding remarks from the capitalist organizations' evaluations

As understood from the reports and evaluations of the organizations, capitalist circles were optimistic about the HTP in terms of its potential to benefit the private sector in the first years. Mentioning the benefits of these years, the organizations started to voice more concerns beginning with the 2010s. In this sense, it is important that the start of the stability in public expenditures and the complaints of the representatives of the capitalist

[31] Available at: https://ohsad.org/yeni-mesaj-ozel-hastaneler-de-kapilarina-kilit-vuruyor/

class about health policies occurred around the same time. One important conclusion drawn from this picture is that the increase in public expenditures also led to the rise in the involvement and investment of the private sector in health care. This can be seen as a characteristic of how market-based reforms are implemented in developing countries.

The discourse on the PPP projects as a remedy to overcome the private sector's problems has been especially significant at the same time. Although private hospital owners were not satisfied with the construction of new public hospitals, the increase of public-private partnerships was highly supported by TÜSİAD and TOBB. When we look at these evaluations, it is seen that a distinction between the first and second phases of HTP is meaningful. It is also clear that the most visible move in terms of AKP's health policies after 2008 is the PPP hospitals project. This is also seen in the critical literature focusing primarily on these hospitals. The need to continue the expansion, which has lost momentum for the AKP government, in a different way and the need for a new investment area for the capitalist class show that the introduction of PPP hospitals is a critical move. Therefore, I will analyze PPP hospitals by defining them as a new phase of HTP.

4.4. PPP hospitals as the second phase of HTP

4.4.1. PPP hospitals era in general

After the 1980s in the world, PPP models date back to the Private Finance Initiatives (PFI) initialized by the leader of the Conservative Party, John Major, in 1992 and expanded by the leader of the Labour Party, Tony Blair, in 1997. With PFIs, private

companies are contracted to complete and manage public sector projects. It was expanded considerably in the 2000s, especially with the much-criticized PFI hospitals that went into a debt crisis. It became a controversial model since it meant a significant financial risk for the government and led to several failed projects financially from the time it was initiated. For example, the first PFI hospital, Queen Elizabeth in Greenwich, which was built in 2001, was technically bankrupt in 2005. During this period, it was announced that the deficit of the hospital budget, which was 19.7 million pounds in 2005, would reach 100 million pounds in three years (theGuardian, 2005). In 2018, the UK decided to abolish PFI contracts for new infrastructure projects (theGuardian, 2018). In the meantime, as Leys (2010) describes, in England, the private health sector showed a textbook case of "state capture." In a few years, the Department of Health's leadership team was composed of those from the private sector and management jobs in the National Health Service (NHS).[32]

The UK's PFI formula for public-private "cooperation" has been considered a policy model by other countries. The post-1980 global policy paradigm has encouraged PPPs' use because the increasing rates of public health spending are claimed to put pressure on government budgets. Therefore, the paradigm pushed forward the idea that governments should look for private capital for additional sources of funding and financing in case of

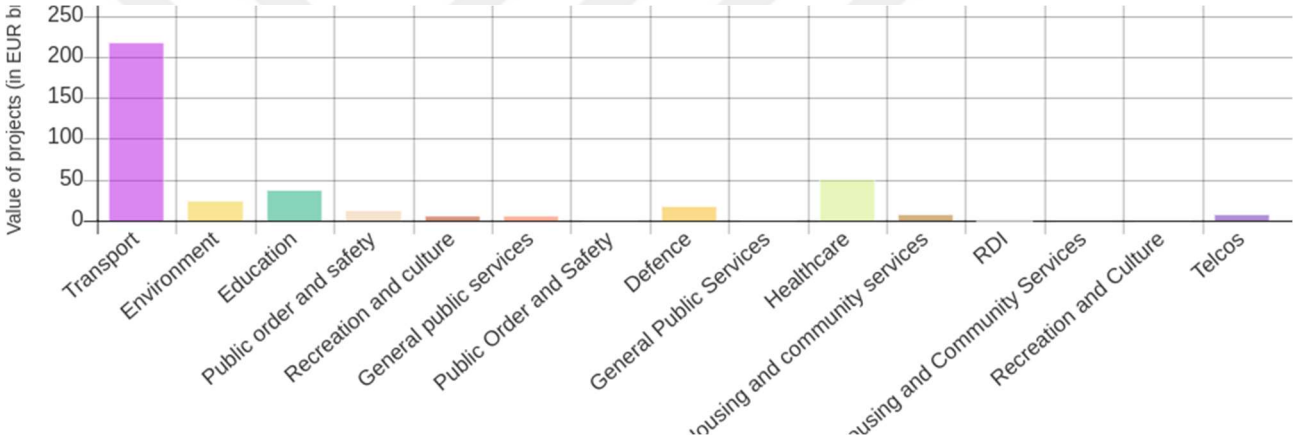
[32] There is a vast critical literature on the transformation of the UK's NHS and the PPP hospitals projects in the UK. I was especially impressed by a 2015 study titled "NHS for Sale: Myths, Lies, Deception" by Davis et. al (2015), which scrutinizes the myths related to the transformation and reveals the true consequences of the transformation. For other inspiring studies on the privatization of the British health care system, see: Pollock (2004); Leys and Player (2011).

insufficient funds and the expertise of the private sector to make the investments "efficient, effective and long-term" (WB, 2017). In a 2010 report prepared by the health research institute of PwC, PPP projects in health care are highly recommended because, as the scope of partnerships grows, the size of the potential market for the private sector grows (PWC, 2010). Although there is no single definition of PPP, the definitions proposed by international organizations and government documents resemble each other. WB (2017) defines PPP as "a long-term contract between a private party and a government entity, for providing a public asset or service, in which the private party bears significant risk and management responsibility, and remuneration is linked to performance."

PPP, therefore, is an investment model for the private sector based on the premise that the state establishes a long-term contractual relationship with firms. In PPP public hospital projects, the hospital that will provide the service is built by private companies and leased to the state. The non-core services in this facility are transferred to the company, while the state covers the core service. According to the policy paradigm's general assumption, the distribution of risk between the public and private sectors seems to be an essential characteristic of the PPP projects. Despite the assumption of risk distribution, the policy paradigm has encouraged introducing government guarantees for PPP investments to mobilize the private sector. The governments in PPP projects give political and regulatory guarantees, revenue and demand guarantees, payment obligations, and termination payments, which constituted the main reasons for criticizing the PPP hospitals project in Turkey (Lu et al., 2019). As mentioned by PwC above, these PPP

areas are seen as sectors with high market growth potential. For this reason, domestic capital and international capital want to expand their market share within the public services. In fact, according to the European PPP Expertise Centre (EPEC) database, the health care sector is the second largest sector after transporting the total value of PPP projects in Europe, as shown in the figure below.

Figure 7. The value of European PPP projects by sector, all countries[33], 1990-2020



Source: EPEC Data Portal.

Developing countries are defined as the most suitable and profitable PPP markets as they are assumed to have problems in the availability of expertise in the public sector (Karahanoğulları, 2011). According to the World Bank's Private Sector Participation in Infrastructure Database, 6,135 Public-Private Partnership projects with a total investment of 1,491 billion USD were realized in developing countries between 1990 and the first

[33] EPEC PPP project data covers transactions in EU-28 countries as well as Turkey and countries of the Western Balkans region.

half of 2018. The countries with the highest investment amount were Brazil, India, China, Turkey, and Mexico (Presidency of Strategy and Budget, 2019: 5). In a survey, 23 percent of the managers of global PPP companies said, in the short and medium-term, the Turkish PPP market is the most promising after the US PPP market (Emek, 2017).

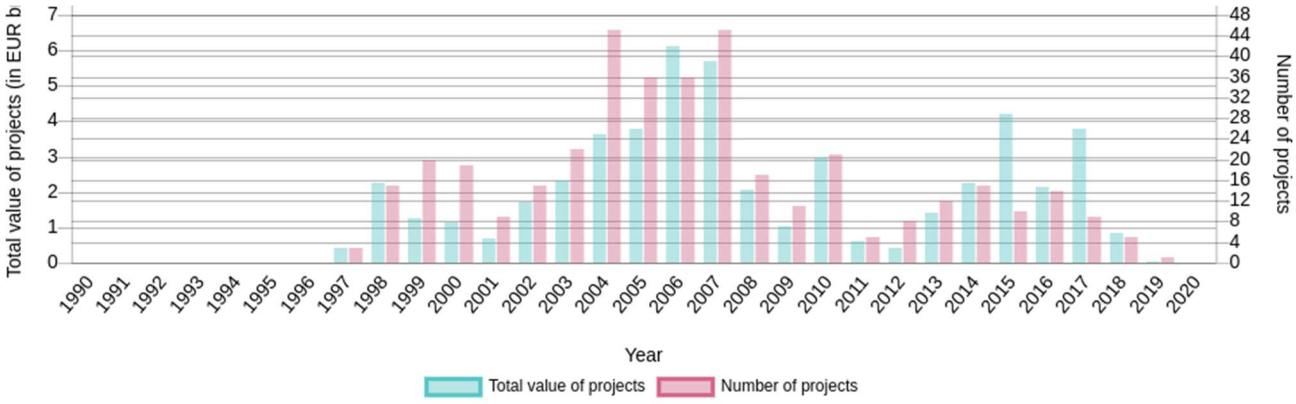
The critical point is that today's public-private partnerships continue during the construction and operation phases. In other words, it should be said that it is not only a model offering a new supply option for public infrastructure but also a model that brings changes in capital accumulation. In these public partnership projects, many factors covering the service production process are transformed to be compatible with the market system. Thus, the partnership is based on the concept of partnership for private enterprises (Gültekin-Karakaş and Yusufi-Yılmaz, 2011). While contracting out public services (such as hospital maintenance and dietary services) involves far less decision-making on the part of the private contractor, in the PPP form, the private sector renders the service. In that sense, the so-called partnerships both "enhance the depth and length of the profitable private accumulation" and "open up investment in long-term capital projects and social services to surplus private capital" (Whiteside, 2009: 85).

4.4.2. PPP hospitals in Turkey

In such an environment, we can briefly define the situation as developing countries, including Turkey, that wanted to eliminate hospitals as a budgetary concern. In the global policy environment, PPPs were offered as a practical solution. In the Turkish case, the start of the PPP hospitals project unsurprisingly coincides with the time when the AKP

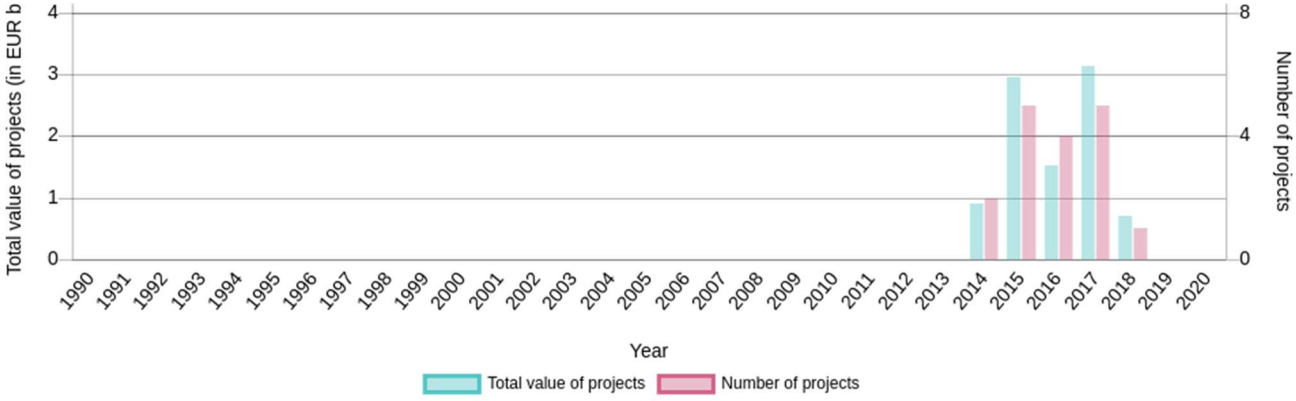
government turned the tide in favor of the private sector as the transformation in health was largely completed. The EPEC database shows that health projects in Turkey mostly came after the projects started in the EU countries. While the PPP projects in health care had been the highest in numbers between 2004-2007 across the world, Turkey showed the same trend between 2014-2017, as shown in the figures below.

Figure 8. Evolution of the PPP market by year/ health care, all countries, 1990-2020



Source: EPEC Data Portal

Figure 9. Evolution of the PPP market by year/health care, Turkey, 1990-2020



Source: EPEC Data Portal

The time difference clearly shows that Turkey had lagged behind European countries in 10 years in increasing the PPP projects in health care. One reason is that the legislative and institutional changes for the already-planned health care transformation came late in the case of Turkey, as discussed in previous sections. The PPP projects in health care have been initiated after the overall transformation in health care was primarily stabilized in terms of initial requirements. Second, the stagnation in public expenditures and the dissatisfaction of the capitalist circles needed a new project to further health transformation. Towards 2008, budget expenditures were above the target, while budget revenues remained below the target. The AKP government was ready to take more risks after the 2008 crisis hit the country, as it aimed to hold its electoral ground and comfort the capitalist circles with new investment areas. These hospital projects are indeed controversial attempts, mainly because they proved to fail in many other countries. In November 2019, Turkish Health Minister Fahrettin Koca announced that the government would no longer use the PPP method for hospitals as proof of the same trend.

4.4.3. The controversy over Turkey's PPP hospitals

State-led privatizations started in the post-1980 period in Turkey. In 1984, the enactment of a law on opening the field of electricity production, transfer, distribution, and trade to the private sector marked the first legislative attempt for establishing the Build-Operate-Transfer model in the country. For the first time, the private sector was allowed to enter into a business where the state was the only producer with a state economic enterprise, the Turkish Electric Administration. Nevertheless, this attempt could not be finalized successfully at that time. The law faced revocations due to the requirement that the public

service concession contracts be pre-audited by the Council of State before signing (Cal, 2018; Senel-Tekin, 2012). Moreover, several government initiatives to treat PPP contracts in the domain of private law were prevented by the rulings of the Constitutional Court in the 1980s and 1990s. These years can be considered years of legal struggles between pro and anti-privatization coalitions (Emek, 2015). The legal and institutional changes had been weak in allowing private involvement in public service provision until the balance shifted from the anti to the pro-privatization coalition, starting with the late 1990s and early 2000s (Öniş, 2011).

A constitutional amendment in 1999 led the public services provided by private actors to be considered under the domain of private law. In the health care sector, a Ministry of Health memorandum in 1985 allowed state hospitals to outsource non-medical services such as catering and security. However, in line with the privatization boom after the 2000s, the first real PPP effort in health care came in 2005, adding a clause to the Principal Law on Health Services. It was followed by the regulation relating to the Build-Lease-Transfer (BLT) model went into effect in 2006, and its use remained limited to the construction of health facilities. With this regulation approved by the Council of Ministers, it was made possible to let public health facilities be built by the private sector in return for lease agreements and renew the hospitals in return for the operation of services and management of areas other than medical services in the facilities (Karahanogullari, 2011). In other words, in the BLT model, “the private sector builds facilities, provides the equipment, operates the areas specified in the contract for the specified period, and finally transfers the facility to the public. Administrations pay rent

to the company every year" (Ministry of Development, 2016: 17). The 2006 regulation marked the beginning of PPP hospital projects (Senel-Tekin, 2012). Later, in 2007, the law on establishing a public-private partnership department under the Ministry of Health was adopted.

However, the public controversy over the PPP hospitals did not start in response to the legal and institutional changes. Discussions mainly started after the first contracts were signed in 2011, and the critical circles targeted the illegal practices in public tenders and contracts. The legal struggle, in this period, turned into a battle mainly between the Turkish Medical Association (TTB) and the AKP government, which will be detailed in Chapter 5. To mention briefly, right after the contracts were signed for Ankara Etlik, Kayseri, and Elazig hospitals, TTB filed lawsuits to apply to the constitutional court for the annulment of the hospital tenders and the concerned law. The Council of State decided to suspend the execution of tenders in 2012. However, in 2013 the government amended laws to make the judicial decisions null, and the implementation of past and future annulment decisions was blocked. At the same time, with a new law, a full treasury guarantee was provided for the debts companies incurred.

Finally, in 2013, the law on "building and renovation of facilities by the Ministry of Health with a public-private cooperation model" was enacted (Cal, 2018). These regulations were called PPP hospitals at the beginning, and in 2013 they were named "City Hospitals." The public debate refers to the projects as City Hospitals, although the PPP model was declared to be abandoned in November 2019. According to the latest data

provided on the website of the City Hospitals Coordination Unit under the Ministry of Health, as of May 2021, there are 13 PPP hospitals in operation across the country, and five others are still under construction.

According to the PPP model in use for hospitals, Build-Lease-Transfer, the private actors winning the tenders build the facility for public service on the land owned by the treasury and provide the services called “support services.” The government pays rent to the firms and maintenance at least for 25 years. As the health service is divided into core and support services, only the medical examination services are left to the state as the core services. The imaging and laboratory services are supplied by the contractor and paid for by the state. The hospitals' contracts indicate that "medical support services" excluding the core medical services but including imaging, laboratory, physical therapy, and rehabilitation services are to be carried out by the contractor company. Also, services such as cleaning, dining, parking, and small shops are left to the contractor as additional income-generating services.

The city hospitals project has sparked enormous public, professional and scholarly debates, criticizing the illegal, pro-market, anti-popular, and anti-labor practices during the hospitals' legislative, construction and operation processes. For this study, I would like to group the controversies the critical circles express into two: One is that the city hospitals project is against public interest and public health; the second is to benefit private interests. I will try to explain and exemplify the most criticized points regarding the project under these groups.

City hospitals are against public interest and public health

(1) With the depreciation of the Turkish Lira against the foreign currency, the rental agreements in foreign currency turned into a debt that increased more than expected for the Ministry and started to constitute a significant part of the Ministry's expenses. The currency used for the lease contracts was USD, while a dollar was 1.80 Turkish Liras at the time of contracts signed. The Lira, however, has depreciated, and the USD rose to over 9 Liras in the last quarter of 2021.

(2) There are no measuring methods to assess the advantages and disadvantages of PPP hospital projects. Draft PPP contracts are not announced in the procurement notices, and there is no standard PPP contract model shared with the public, violating the principles of transparency and accountability (Transparency International Turkey, 2019). Moreover, the terms of contracts have been open to changes, which have never been made public.

(3) The cost of city hospitals to the government turned out to be much higher than traditional public procurement methods. For example, analysis for Ankara Bilkent City Hospital showed that it was 173% more costly than other methods (ibid.). However, the value-for-money analysis conducted by the Ministry of Health for Bilkent Hospital manipulated the cost analysis results by carrying out misleading calculations and material errors based on incorrect assumptions, showing the projects as cost-advantageous (Emek, 2018).

(4) Health care workers who were defined as non-core services personnel were transferred to private companies after moving to city hospitals, as some of the non-core services that were publicly given started to be outsourced from the private sector. Several new problems added to the working conditions of all health care workers in the hospitals due to the mega-size of the hospitals, increase in workload, inadequate number of personnel, inadequate planning on educational activities, long hours of problem-solving processes because of the chaos of too many subcontractor firms, and conflicts in the management of the hospitals. These problems affect the quality of medical services negatively (Yavuz, 2018).

(5) To guarantee demand, the government closed several important and central hospitals in city centers and moved the personnel to new city hospitals, most of which were built far from the city centers. Patients lost easy, fast and affordable access to the hospitals with public and private transportation.

(6) The hospitals are too big to manage effectively and provide high-quality health services. In the biggest city hospital of Turkey, Bilkent City Hospital, the indoor space per bed is 40 percent more than that of new hospitals in the US and EU countries, raising the costs of cleaning, maintenance and decreasing the efficiency of medical services (Transparency International Turkey, 2019).

City hospitals are to the benefit of private interests

(1) At the time of PPP agreements for hospital building, Turkey was the only country to undertake the risks of the direct loans taken by the contractor. The government guarantees to underwrite foreign debt of the companies to be obtained from international credit institutions. With the treasury guarantee for the loans taken by the contractor companies, the undertaker of the financial obligations has become the public, contrary to the risk-sharing rhetoric.

(2) The immovables of the public hospitals in the city center were initially decided to be transferred to contractor companies free of charge to build hotels, residences, and shopping malls. The related contract articles were canceled by a court rule later.

(2) Projects meant more profit to private companies in the private sector. Having won 6 of the city hospital tenders held so far, Rönesans Holding holds 30 percent of the total bed capacity and 35 percent of the total investment amount. CCN Holding, which ranks second, has a 17.5 percent share in bed capacity and 15 percent in investment. The total bed capacity of the two companies reaches nearly half of the total capacity (ibid: 8).

(3) Another guarantee given by the government to the contractors is on the occupancy rate of hospitals. The pricing of the services in the city hospital contracts is calculated based on a 70% occupancy rate. The prices paid by the state for the services are given according to this rate (Tükel, 2018).

(4) Incentives, exceptions, and exemptions introduced by laws make city hospital investments attractive for the contracting sector. Two of the incentive certificates issued in 2015 were given to Adana and Isparta city hospitals. Two of the incentives for 2017 were given to Kocaeli and Izmir, Bayraklı city hospitals (Toker, 2018).

4.5. Conclusion

This chapter tried to historically and politically contextualize current health policies and related transformation in Turkey. The social policy changes after the military coup in 1980 in line with the economic policies show that the field of health care was targeted as one of the most promising markets for the expansion of the private sector. It is clear that the WB and other global actors, directly and indirectly, pushed the agenda of the Washington Consensus. The historical trajectory of the changes in Turkey's health care system also shows that Turkey followed an internationally orchestrated plan with specific differences in legislative changes and implementations. The most prominent characteristic of the Turkish case has been the uninterrupted phase of the transformation with the AKP governments since 2002.

It can be said that there was a state involvement until World War II in Turkey that dealt with preventative care but was insufficient in terms of both institutional and human needs. Until the 1980s, there were efforts to expand this capacity, but health policies remained labor-market attached. After 1980, the Turkish state took quick action to harmonize the laws with the new policy paradigm. The projects that were tried to be carried forward with Washington Consensus organizations, especially the WB, started

after 1990. However, these projects could not be sustained consistently due to political crises. With the 2001 economic crisis, the continuation of these projects became even more difficult.

The AKP government and its rapid intervention in health transformation came precisely after these crises. With the HTP, which the government prepared following the Washington Consensus, the necessary institutional changes were implemented quickly. This wide-ranging change has been studied extensively in the literature. In the literature where AKP is defined as a prominent actor, health policies have been examined "as a state response to structural needs," "as a set of populist policies," and "as a sector to implement market-based policies." These different tendencies can coincide at specific points, and there are inspiring studies. With the inferences we made from previous theoretical discussions, I suggested that a more detailed analysis contributing to the third tendency will enrich the comprehensive examinations.

In this context, I tried to take a closer look at the official statistics of the HTP period, that is, health expenditure statistics and the reports and discourses of capitalist organizations on HTP. According to the expenditure data, the expansion seen in Turkey with certain developing countries stops after 2008. Although public expenditure has preserved its weight, private sector expenditure, which was decreasing, has started to increase again. We see that the increase in public spending has reached a level that cannot proceed further, and the spending rates were stabilized. It is also clear that the private sector representatives were satisfied with the first period of the transformation in their

evaluations about HTP. Still, they started to express conflict points frequently in the later periods. Moreover, the most visible move in terms of health policies after 2010 is PPP hospitals. Trying to continue the expansion that has lost momentum for the AKP government in a different direction and the possibility of opening a new investment area in terms of the capital class puts the PPP option forward for both sides. Therefore, it would be appropriate to examine the initiation of PPP hospitals as the second phase of HTP in terms of both timing and differentiation of dominant activity.

The whole story so far shows us the most significant contribution of the AKP government has been to accelerate the process politically and legally. The populist character and electoral base of the AKP facilitated all the pro-market transformations. On the side of the capitalist class, the transformation was backed with high expectations from the government. The expansion of the general health insurance scheme politically associated with the ruling AKP was also demanded by the transnational paradigm and the capitalist circles on the ground that a "health care sector" should grow. Similarly, the introduction of the PPPs in health care was presented as a solution to the increasing public expenditures and insufficient market growth. One should acknowledge that it is impossible and not expected that the private sector has always been satisfied with the transformation. TÜSİAD, for example, was unhappy with the absence of an opt-out option in the general health insurance scheme as it does not open the doors of the market for private health insurance companies. The organization targeted an interruption in the expansion of public coverage in health for similar reasons. As another capitalist circle, the private hospital owners showed their unhappiness with the PPP hospitals project as it

reduces their chances to expand more in the health care delivery sector.

Looking at the use of PPPs in health care in general, we see that although the PPP hospitals concentrated in other countries between 2004 and 2007 and negative consequences were observed, the AKP government has insisted on implementing projects since the early 2010s. This situation was an opportunity for a new move for the government's concern over furthering the transformation, mainly because it has been a significant part of its popular support and slowing marketization policies. However, this partnership has called for some complexities regarding state-capital relationships in Turkey and between different sections of the capitalist class. While it provided some good opportunities for certain business people in a particular sector, namely the construction sector, it led to more public controversy than the earlier transformation phase as negative consequences for public health and unplanned urbanization became prominent. I will discuss how both state and capital operate this complex process in the next section.

CHAPTER 5 THE STATE AND CAPITAL IN PPP HOSPITALS IN TURKEY

5.1. Introduction

The HTP has brought substantial changes to the dynamics of the relationship between public and private actors. The so-called public-private partnership, represented in the form of city hospitals, has potentially shifted these dynamics. Analyzing the changing relationship between the state and capital, specifically the relationship between the AKP government and actors in various capitalist circles, is vital in understanding the role of capitalists in these hospital projects. Furthermore, the question of why the AKP government moved forward with the PPP hospitals projects as the second phase is also essential. The transformation brought about by the HTP was utilized politically by the AKP government. However, the PPP hospitals revealed that the projects were not cost-efficient for the government and that the private sector does not share an equal level of risk. Considering these controversial points, a closer inquiry into the capitalists engaging in the PPP hospitals projects and their relationship with the ruling AKP would help answer these questions.

Apart from a critical evaluation of the HTP process in Turkey, the previous chapter can also be considered an attempt to understand Turkey's political and historical context from which the PPP hospitals projects emerged. When combined with the theoretical

underpinnings of this study, this attempt also shows us the need to map the state-capital relationship to provide better context and answer additional questions. In this sense, this chapter will focus on mapping the actions of the AKP government and the various capitalist actors in the PPP hospitals projects. The first task of this chapter will be to summarize the evolution of the state-capital relationship in Turkey, especially emphasizing the dynamics of this relationship in the era of AKP leadership. Later, I will discuss the PPP hospitals process in Turkey by looking at the important turning points from both the "state" and "capital" perspectives. This discussion will allow us to evaluate the projects by shedding light on this relationship.

5.2. The capitalist class in Turkey and the AKP governments

In the 1950s, efforts were made to organize the private sector in Turkey, and employer organizations were established. The Anatolia-based small- and medium-scale trade enterprises were organized in 1952 under the Union of Chambers and Commodity Exchanges of Turkey (TOBB), with the headquarters located in the capital city Ankara. TOBB was established as a semi-official, hierarchical organization rather than a voluntary organization. It had remained the most prominent capitalist organization until TÜSİAD, which represents the large holding owners, was founded (Sönmez, 1992). With the state incentives that appeared after the 1960s, industrial capital started to gain importance. The Turkish Confederation of Employer Associations (TİSK) was established in 1961. It first brought together six employer organizations holding industrial capital in Istanbul before later expanding (TİSK, 2020). Until the mid-1970s, the Koç Group, one of the largest capitalist groups, was known to be the leading group in TİSK

(Sönmez, 1992: 162).

However, the larger capitalist groups began to form another fraction as they grew, and the Istanbul-based conglomerates founded the Turkish Industry and Business Association (TÜSİAD) in 1971. This new formation meant institutionally separating significant industrial capital from the Anatolia-based smaller-scale businesses and demarcating the lines between capital fractions (Bekmen, 2014). Scholars of Turkey essentially acknowledge that TÜSİAD remained one of the most prominent actors in the history of Turkey, especially in the process of radical political and economic transformation that was ushered in with the 1980 military coup in the country (Ozan, 2011; Bekmen, 2014; Buğra and Savaşkan, 2014). This powerful capitalist bloc pushed for a rupture in the capital accumulation strategy as the economic crisis deepened, a change marked by a high inflation rate and foreign debt burden. In effect, the institutions of global capitalism were prescribing a structural adjustment process. The capitalists expressed that the country lacked a government that would meet their demands, pointing out a crisis in political representation (Ozan, 2011:70).

The reorganization of Turkey's economic and social structure after the 1980s also ushered in political Islamization and the appearance of a compatible ideological inclination among the capitalist classes. The 1983 Özal government, which took power after the military junta rule, organized itself around so-called neoliberal economic policies and followed a policy of cooperation with Islamic sects and affiliated groups.[34] The export-

[34] For instance, Turgut Özal, 26th Prime Minister and later 8th President of Turkey, had a

oriented industrialization strategy fragmented the production process, and small businesses gained an advantage. In the new global economic paradigm, Turkey was to serve the growing multi-national companies as subcontractors. The country's small- and medium-sized enterprises (SMEs) thrived in this type of division of labor (Balkan et al., 2014).

At the same time, SMEs in Anatolia have been linked with an individual or joint commitment to Islamic principles. Loans from public banks, privileges in public tenders, and government incentives are closely related to the rise of these labor-intensive sectors. Informal networks established in Islamic communities have effectively legitimized commercial activities, marketing products, and creating an obedient labor force with private schools, universities, and dormitories funded and controlled by sects (Hoşgör, 2014; Savran 2014). This capitalist fraction organized under the Independent Industrialists and Businessmen Association (MÜSİAD) was established in 1990. Most of the firms represented under MÜSİAD were established after the 1980s, were located in Anatolian cities rather than in Istanbul, and were SMEs employing fewer than 50 workers. However, it must be noted that the changes in this area occurring until today have complicated the simple Istanbulite vs. Anatolian and big vs. small capital differentiation. The headquarters of both Istanbulite and Anatolian capital tend to come closer to Istanbul, and many Islamist capitalist groups have made it onto the lists of the

close personal relationship with the Islamist National Outlook (Milli Görüş) movement. His brother, Korkut Özal, was known to be one of the important names of the Nakşibendi sect and served as the economy chief under the Özal government for many years (see Atacan, 2005).

richest families of Turkey (Buğra and Savaşkan, 2014: 181).

By the 1990s, foreign investment started to retreat from production in Turkey, and the new foreign exchange policy targeted hot money flows. Amidst these circumstances, financial rentier activities have become almost mandatory for capitalists. Large capitalist groups grew bigger as long as they could incorporate into financial activities and establish their banks. The political and economic environment at the time also allowed pro-Islamist capitalists to prosper. Some of them founded Islamic capital-based banks (Öztürk, 2014). At this conjuncture, Recep Tayyip Erdoğan, the name which the Islamic groups agreed upon, came to power after a period when previous political crises could not be resolved. The apparent result of the 19-year pro-Islamist AKP rule has been to open the way for Islamic capital whose prospects had been previously politically blocked. AKP's long life has directed the scholarly and popular debate on an increasing polarization between capital fractions represented under TÜSİAD and MÜSİAD, placing TÜSİAD in a politically secularist position.

In the early years of AKP, the so-called secularist fraction of the capital did not hesitate to support AKP policies. In particular, having talks with the EU was a policy openly supported by the largest capitalist groups. In the same period, investor councils started to be established in Turkey due to the "improving investment climate" policies of the WB and IMF. In terms of the state-capital relationship, this step represented AKP's move towards institutionally integrating capitalist groups into policy-making decisions (Cebeci, 2010). The AKP government initiated the Investment Advisory Councils (IAC), whose

participants were executives of global corporations, national capitalist organizations, and state representatives, including the prime minister and other ministers. The Council held its first meeting in Turkey in 2004 with the chairmanship of Erdoğan, and the attendees were 19 multinational company executives, TOBB representatives, TÜSİAD representatives, WB and IMF directors. In addition, this Council was turned into a state institution with the establishment of coordination boards and was organized to fulfill the reform demands of the private sector. Aiming to partner the private sector program and government program, this Council and the implementation board became the drafter of many legislative changes that favored the private sector (Özdek, 2011: 118).[35]

Growing in size and power, the pro-AKP capitalist organizations and business owners started to criticize state control over the government-business relationship in general openly and specifically challenge taxation and government expenditure policies, demanding reduced state control for more profitable projects and partnerships (Buğra and Savaşkan, 2014: 217). Following these demands, a large number of amendments in the Public Procurement Law and added exceptions starting in 2003 paved the way for public tenders to be granted to pro-AKP companies. The AKP governments changed the law 191 times between 2003-2020 (Sözcü, 2020).[36] With the first changes made in 2003, the AKP government deviated from the goal of establishing a legal framework covering all

[35] Among the laws prepared by the coordination committee of the Council, there are laws such as labor law, foreign direct investment law, social security institution law, and corporate tax law, all enacted during the 2003-2006 period (Özdek, 2011: 145).

[36] Available at: https://www.sozcu.com.tr/2020/ekonomi/ihale-kanunu-191-kez-degisiyor-6078261/

public procurement (Buğra and Savaşkan, 2014: 126). The changes made the awarding of tenders mostly ruleless and government inspection weaker. (Toker, 2019: 86). In this environment, the attitude of the secular capital fraction, which had been optimistic about AKP's reform policies in the earlier years, started to turn negative. TÜSİAD stated in 2008 that the laws had become incompatible with EU policies (Buğra and Savaşkan, 2014: 215). It is mainly agreed in the critical literature that the amendments made in this law evolved in a direction that led to the formation of a "clientelist" relationship between the government and the pro-government business people. Yet, it should be noted that the relationship between the business circles and the state in Turkey's history, most of the time, did not proceed through institutional channels, and even the largest capitalist organization TÜSİAD did not much complain about this clientelist relationship (Buğra, 1994).

Although TÜSİAD still represents the largest capitalist groups in the country, with higher shares in export figures, a high share in GNP, and high employment figures,[37] the nature of the so-called Islamist capitalist fraction, which had been previously associated with SMEs, is changing due to the clientelist relationships. Around 15 families known to belong to the Islamist bourgeoisie between 2006 and 2010 entered the list of the 100 richest Turkish families of *Economist* (ibid: 167). Many holding companies, now known to be pro-AKP, have had the opportunity to compete with the secular capital fraction in

[37] In 2014, the number of MÜSIAD's member companies was fifteen thousand and TÜSIAD's was three thousand five hundred, while the share of the former in total exports remains one-third of the latter. This ratio is similar for shares in national income (Tanyılmaz, 2014:165).

most sectors. We can say that the development of some companies created a government-business relationship unique to the AKP's second term. Privatizations, public tenders, and public-private partnerships during the AKP era played an essential role in the growth of these pro-AKP companies, rather than a transition from the local to the national level in the capital accumulation process. According to (Buğra and Savaşkan's (2014: 145) analysis, the public institutions that played a role in the development of companies belonging to the new generation capitalists were either part of the central government or the local organizations of the central government. Although the newly grown companies have local investments, their projects are mainly outside the region they come from and their local projects are not preceding the national-level projects.[38]

For these reasons, the analyses considering the dynamics of the state-capital relationship after the first period of AKP leadership in Turkey tend to name this growing Islamist-capital fraction pro-AKP capital. The Anatolian capital, which grew due to the 1980 coup, the Özal-led government, and Islamic banking, is no longer directly representing the SMEs in Anatolia. Instead, this fraction generated today's largest capitalist groups. The growth of these capitalist groups can be seen as a result of investing in AKP's neo-conservatism, which is more integrated with global capitalism than operating within the traditional political Islam tradition. According to many scholars, AKP still represents the class interests of the conservative bourgeoisie, especially the interests of the largest

[38] Buğra and Savaşkan (2014:142-146) take a closer look at the 10 capitalist and capitalist groups that stand out in this period in their analysis: Çalık Holding, İÇ Holding, Cengiz Group, Ethem Sancak, Fettah Tamince, Kiler Group, Kalyon Group, Kuzu Family, Cihan Kamer and Akın İpek.

groups. Erdoğan and his family had no intentions to hide their presence as a part of the capitalist class (Başaran-Lotz, 2019). The AKP leader is directly tied to a significant portion of the large Islamist capital groups through family ties.[39]

While the relationship between AKP and TÜSİAD's capital progressed moderately until 2007, a different dimension of this relationship has evolved since that time. TÜSİAD did not support Erdoğan in the 2010 referendum but withdrew its anti-government rhetoric when Erdoğan won another victory. Nevertheless, the tensions did not result in open economic war. This can be related to the pragmatic perspective of big business, which places political and economic stability before ideological divisions (Saraçoğlu and Yeşilbağ, 2015: 893). In this context, the political divisions are not directly reflected in the field of the economy. In many instances, the political separation becomes invisible, along with various alliances and opportunistic moves to get a share in the markets opened by the AKP. In fact, the capitalist fraction represented by Erdoğan/AKP has a political power that far exceeds its economic control (Tanyılmaz, 2017: 108). It is possible to say that AKP's political stance has not created serious obstacles for the capital in general when it comes to economic policies and economic interests. Therefore, for Turkey's big capital, AKP's most promising act has been its intervention in the economy. AKP policies fulfilled the demands of the capitalist class with an aggressive privatization program, concessions to foreign capital, the commodification of health and education,

[39] Erdoğan owned shares in three distribution companies that work with the largest holdings in Turkey, such as Ülker Holding. Berat Albayrak, Erdogan's son-in-law and also the former Minister of Treasury and Finance, was the general manager of Çalık Holding for seven years. Also, his other son-in-law and his two sons were important shareholders of large companies.

and labor laws that have brought advantages to the capitalist class (Öztürk, 2014).

Therefore, the specific relationship between AKP and the emerging capitalist class, in particular, has in some ways gone beyond the secularist-Islamist distinction. It is clear that apart from supporting the pro-Islamist capital, AKP also had to agree with the more established fraction to a certain extent. As the economic developments of the time continued, AKP maintained the support of both fractions in the end. However, we can observe that in its later and more recent stages of development, the so-called pro-AKP capital has not been strongly associated with pro-Islamism or secular capital, especially after the coup attempt, which broke the relationship between AKP and the Gülenist capital. Although the government continues to set the terms of the relationship, AKP also had to form this relationship according to its macroeconomic interests. It is possible to say that this situation was reflected in the cabinet in the 2018 elections, by which the "corporate state" discussions elevated (Güzelsarı, 2019). In 2015, Erdogan said, "We want to go beyond the bureaucratic oligarchy and govern the state and the country like a joint-stock company." After the 2018 general elections, he moved the political representation of the capitalist groups directly to the cabinet. The political wing of the cabinet, the Ministry of Justice, Foreign Affairs, and Interior Affairs, remained to be filled by former AKP politicians. Yet, Erdoğan appointed an owner of tourism companies to the Ministry of Tourism, an owner of private schools to the Ministry of National Education, and an owner of chain hospitals to the Ministry of Health.

As this study will explain in the next chapter, an important feature of the newly growing

capitalist class is that they are among those in the construction sector and doing infrastructure projects. The construction sector has played an influential role in triggering rapid economic growth, pumping domestic consumption, and absorbing record-high unemployment during the crisis. In this environment, the small-scale and local contractor-dominated construction sector of the past started to be dominated by real estate investment partnerships, which have large capitalist groups behind them (Yeşilbağ, 2016).

Many scholars who analyzed this situation argued that construction-oriented growth is a political choice of AKP (Balaban, 2011; Sönmez, 2015; Yeşilbağ, 2016). As can be seen when examining the capitalist class in PPP hospitals, AKP is also bringing non-Islamist groups, or groups not known as pro-AKP capitalist groups, closer in line with this strategic decision. There are capitalist groups under the umbrella of TÜSİAD, which are indispensable for AKP's large infrastructure projects. When the total investment amounts of PPP projects, as of 2021, in different sectors in Turkey, are compared, it is seen that the construction and energy sectors have the highest stakes with 25.12, 19.43, and 18.92 billion USD, respectively. Health facilities rank fourth with 10.99 billion USD.[40] In this respect, when evaluating the AKP-business world relationship today, it will be helpful to consider this complexity without forgetting that capitalist actors, regardless of their factions, continue to do business with AKP as usual.

[40] https://www.sbb.gov.tr/koi-gostergeleri/

5.3. The "state" in PPP hospitals

5.3.1. Preparation of the legal and institutional base

In 2004, a year after the announcement of the HTP, the UK government made a three-day mission by inviting together officials from the Turkish Health Ministry and businesspeople to present the PPP hospitals projects. After this business trip, the Ministry said it had begun working on the subject (Erbaş, 2021: 67). This visit is mentioned in a report criticizing consultancy companies that market a bankrupt system in the UK to poor countries. According to the report, a spokesperson from the UK stated that "the objective of the visit was to give the contractors some insight into what British companies have to offer." Furthermore, to give the initial start to the PPP projects in health care, the British company Mott MacDonald was reported to be an advisor on Turkey's first six PPP hospitals (Jubilee Debt Campaign, 2017: 18).

Turkey had a Build-Operate-Transfer law, primarily used for energy sector projects, that would provide the same legal basis for other types of projects. However, the AKP government started the PPP hospital projects by creating a separate legal basis, distinguishing these projects from others (Çal, 2017). The government took the first step in 2005 to prepare the necessary legal base for establishing PPP hospitals. A law to add a clause to the fundamental law on health care services was enacted, allowing the Ministry of Health to initiate tender processes for engaging in lease agreements with the private sector to build public hospitals. The related law also states that the Ministry of Finance

may transfer immovables free of charge for these hospital projects.[41] This law clearly distinguishes the PPP projects from projects involving public hospitals built under the public procurement law. Placing the PPP projects under this law would not be subject to the earlier public procurement law (Erbaş, 2017). The bill passed without being discussed in the health commission and without any objection from the opposition party groups (Erbaş, 2021: 68-69).

The text of the law adopted in 2005 had fundamental procedural shortcomings. First of all, it was not regulated that contracts with companies would be subject to private law provisions. Secondly, there was no regulation on arbitration. These shortcomings were interpreted as a political postponement strategy of the AKP government, considering that then-President Ahmet Necdet Sezer would veto the law if these provisions were included (ibid: 71). There was an attempt to fill these gaps by implementing regulation published a year later, in 2006.[42] The regulation defined the areas considered outside of medical services.[43] It was also written that "an independent and permanent construction right will be established" on the immovable allocated to the companies. Moreover, the regulation stated that the payment to the companies would be made from a revolving fund, not the

[41] Law on Adding an Additional Article to the Basic Law of Health Services - Law no. 5396. Available at: https://www.resmigazete.gov.tr/eskiler/2005/07/20050715-2.htm

[42] Regulation on the Renewal of Health Facilities in return for the Construction of the Facilities and the Operation of the Services and Areas Outside the Medical Service. Available at: https://www.resmigazete.gov.tr/eskiler/2006/07/20060722-2.htm

[43] The areas were parking lots, hotel, banks, restaurants, cafes, culture and convention centers, internet and communication centers, pharmacies, assisted living facilities, daycares, work shuttles, cab services and similar transportation services, areas to be defined by the preliminary project and compatible with the subject of health consulting such as weight loss and diet centers.

budget. It also noted that the hospital administration should have the resources to guarantee the rent payments.

Another critical step before the start of the tender processes was enacting a law in 2007 to establish a separate department for public-private partnerships under the MoH.[44] The HTP in 2003 had already established that the Ministry and related institutions would be restructured to turn the Ministry into a planning organization. For the PPPs, the AKP government could only realize this restructuring in 2007, after the related laws and regulations were passed. However, there were objections that when this Public-Private Partnership Department was established, the activities and methods of the Department had not been precisely defined. The Ministry of Development, Public Procurement Authority, and even the Privatization Department had objections that tenders should be centralized and other ministries should also participate in the process. However, the MoH continued to remain closed to sharing information (ibid: 80). Later in 2011, the Department became a separate department under the Health Investments General Directorate. Today, among the powers and responsibilities of the Department, the Ministry lists preparing investment programs, searching for any land belonging to the Treasury (to allocate for the construction of facilities), preparing necessary documents related to the tender process, purchasing consultancy services, verifying and monitoring papers presented by companies, and ensuring coordination between related departments

[44] Law Amending the Decree-Law on the Organization and Duties of the Ministry of Health – Law no. 5683. Available at: https://www.resmigazete.gov.tr/eskiler/2007/06/20070609-1.htm

and the Presidency.[45]

The year 2011 also marks when the Turkish Health Ministry was radically reorganized based on the premises of the transformation program in Turkey and the reforms aimed at global marketization. The AKP government accepted Decree-Law No. 663 on the Organization and Duties of the Ministry of Health and its Affiliated Organizations.[46] The decree-law has been one of the most controversial steps of the AKP's transformation policies in the health sector. Critics insist that the decree-law was the final step that completed the marketizing character of the transformation. As a result, the law was targeted and opposed by the medical association TTB and many other organizations voicing opposition to the general transformation process.[47] With the law, the Ministry restricted itself to planning, standard-setting, and supervision functions. The law mentions the PPP model in the 13th article, clearly referring to the model to realize the construction of health facilities and the renewal of the existing facilities.

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[45] Available at: https://sygm.saglik.gov.tr/TR,33097/kamu-ozel-isbirligi-daire-baskanligi-gorev-yetki-ve-sorumluluklari.html

[46] Available at: https://www.resmigazete.gov.tr/eskiler/2011/11/20111102M1-3.htm

[47] The Turkish Medical Association (TTB) called on progressive organizations and trade unions to participate in a congress after the decree-law. The congress decided unanimously that the Decree-Law was inactive. Several opposition organizations as well as the TTB converged on the streets to protest the law. The technical objection of the TTB regarding the content of the regulation was that the new regulations were unconstitutional. However, the main point that the TTB actually objected to the regulations that were reorganizing the public health system was the "opening of the public health services to the market, commercialization and privatization of the services". The objections of TTB included the regulation of contract work, the regulation of public-private partnerships, foreseeing of the opening of free health zones, classification of public hospitals as private hospitals, allowing for advertising in pharmaceuticals (TTB, 2011).

The government opened the first tender for PPP hospitals in 2009. It has long been considered that this 4-year law and the legislation preparation process that the AKP government was starting to prepare for these projects started from the beginning of its time in power. Moreover, the process was prolonged as construction first began in 2011. The necessary legal basis for the PPP process had not yet been established. Instead of a comprehensive and planned legislation, we see a legislative process inadequately implemented and patched together according to short-term needs (Emek, 2019: 128). The most comprehensive draft law was prepared in 2013 when several legal challenges blocked the tender and construction process. Law no. 6428 was enacted by the government to determine the details of PPPs in health care as an investment model, especially as an answer to the existing legal challenges against the realization of the projects. According to this legislation, PPP hospital tender processes would no longer be subject to state procurement and public procurement laws. The government gave a full treasury guarantee for all kinds of debts of the companies and allocated treasury land free of charge to companies that won the tenders.[48]

After this change, laws, and regulations adopted in 2014, 2015, and 2016 included amendments that favored contractor companies. The legal amendments provided that annulment decisions in the lawsuits would not be implemented, changes could be made in

[48] Law on Building, Renovating and Purchasing Service for Facilities Built with Public-Private Partnership Model and Making Amendments in Certain Laws and Decree-Laws by the Ministry of Health. Available at: https://www.mevzuat.gov.tr/MevzuatMetin/1.5.6428.pdf

contracts with the minister's approval, dispute cases would be subject to foreign arbitration at the request of credit institutions (Erbaş, 2021: 28-29). Following demands from the credit institutions, there was also a discussion in the Planning and Budget Committee in the Parliament about whether legal regulation would be subject to foreign arbitration. According to the deputy undersecretary of the Ministry of Health, companies can find 20 percent of the necessary funding from foreign organizations and the rest from institutions in Turkey. Foreign companies that would lend to Turkey could ask for foreign arbitration or recourse to foreign courts in disputes (Toker, 2015).

In particular, with the legal amendment in 2013—although some of the amendments were deemed unconstitutional—the AKP government overcame the most prominent legal obstacles for PPP hospital projects, including hospitals whose tender and construction processes had started. When we look at this process, it is apparent that the AKP government initiated hospitals' tender and construction processes without preparing the legal groundwork. Then, despite all the irregularities and unconstitutional violations, it started the projects by closing or ignoring the legal gaps. Relying on its parliamentary majority, the AKP government suppressed the opposing voices, which claimed that PPP hospital projects are against public interest and would not serve health goals.

5.3.2. Projects started and continued despite opposition

The Turkish Medical Association (TTB) has been the primary institution that explicitly confronted the irregularities and unconstitutionality in all the legal processes mentioned above. In my interviews with the former president of TTB and its lawyer, I discovered

that the opposition party deputies, and other institutions opposing the law who wanted to publicize their objections against the PPP hospitals process, had applied to the TTB to receive the necessary information. Before the lawsuits filed by TTB against the first tenders signed in 2011, the first lawsuit filed against the new legislation came from the Turkish Pharmacist Employers Union in 2006 because pharmacies would not be among the areas that could be transferred to the companies. The regulation was changed before the case was concluded, and pharmacies were removed from the list (Erbaş, 2018: 156). Since this lawsuit, the lawsuits filed by TTB regarding the PPP hospital legislation and tender processes have constituted the most significant part of the legal objections.

The first obstacle encountered by TTB during the collection of evidence and information for technical preparations was either incomplete or lacking information coming from the state institutions. For example, the Public-Private Partnership Department of the MoH responded to some of the questions by writing the provisions of the regulation. However, regarding the questions about the costs, the Department refused to give information on the grounds of "trade secret" and "privacy of private life" (ibid: 157). The TTB made its first and most important legal objection because the non-publicized contracts were illegal. During the process, details regarding some of the work that the government had carried out on the projects and a part of the first contracts were publicized as some of the state institutions responded to the questions. The 2013 legal amendment voided the suspension of execution cases filed by TTB for the first three hospitals (Etlik, Bilkent, and Elazığ) and the decision of the Council of State for suspension. Upon the objection to this contradictory law, the Constitutional Court decided that not applying the court decisions

could not be considered unconstitutional. Within the amendments made in the same rule in 2014, the annulment results that would arise from ongoing cases were also prevented (Erbaş, 2021). During this period, Mehmet Müezzinoğlu, the Minister of Health, stated at a ceremony in 2014 that the legal amendment was made to overcome annulment decisions in the cases opened by TTB.[49]

According to my interview with the TTB legal commission representative, after the amendment in 2014, any legal struggle mounted against the legislation related to the PPP hospitals no longer held any significance. The legal challenge of the TTB was limited to monitoring the function and operation of the hospitals that were opened. With the start of opening hospitals in 2017, the TTB established the City Hospitals Monitoring Group to monitor any issues and provide legal support. The TTB started an active struggle aimed at the reopening of hospitals that had been closed in Ankara. The emphasis of opposition parties and opposition newspapers on the risks of PPP hospitals started to increase after this law was passed.

Although the TTB brought the most systematic objection to the irregularities in the legislative process regarding PPP hospitals, public reaction continued with opening the first hospitals. One of the essential privileges provided by the AKP government for the contractor companies was treasury guarantees. Accordingly, the loans used by the private

[49] Available at: https://www.ttb.org.tr/kollar/_sehirhastaneleri/haber_goster.php?Guid=5c10951c-164b-11e8-af60-25b4195f91bb

sector to build the facility would be overseen by the Treasury. The government took this controversial decision despite objections from experts. According to Çal (2017), a former employee of the Undersecretariat of Treasury, MoH representatives had come to the Undersecretariat of Treasury to ask for treasury guarantees for these projects from the very beginning. However, the Undersecretariat of Treasury, with the warning of the IMF and World Bank officials, stated that granting treasury guarantees for these projects would lead to significant economic damage. The MoH, which had initially stopped asking for treasury guarantees, brought this issue back to the agenda in the following years on the grounds that the private sector had requested treasury guarantees to secure financing under pressure from creditors. The 2013 legal amendment provided the guarantees.

Apart from the abovementioned processes, there was also opposition to the projects related to the functioning of the completed hospitals that had been opened. The Health Workers Union (SES, in Turkish) actively shared the challenges of health care workers working in hospitals. For example, in a survey conducted among the employees of Mersin City Hospital, more than 70 percent of the employees said that they were not satisfied with the workload and expressed concern about the insufficient break times. More than 80 percent of the employees said their rights were being violated (Uğurhan, 2018: 271-272). Many hospitals experienced problems due to a lack of personnel. Health care workers who could not fulfill their medical responsibilities under these conditions showed passive resistance (Ökten, 2018: 284). Due to the dismissal of some of the workers, their transfer from other hospitals, or not being able to obtain personal rights,

health care workers went on strike.[50] Despite an improvement in some areas after the first unplanned hospital openings, which were also done with no preparation, medical chambers frequently explain that the private sector management within hospitals threatens the health of the public and the rights of health care professionals.

In short, the AKP government was initially slow in preparing the legal means toward realizing these projects and faced objections from opposition groups. However, from the first tenders, it managed to overcome the objections legally and acted quickly in doing so, albeit in an ill-planed manner, signing contracts and starting construction. Despite all the irregularities and problematic working conditions in hospitals, the government opened many projects, one after another, with grand ceremonies. When the tender agreements were starting to be carried out, the AKP government began to turn the projects into a subject of political propaganda and took steps towards convincing the public.

5.3.3. AKP assigns politically strategic importance to PPP hospitals

Although legal preparations have been made since the AKP government came to power, we see that the PPP hospital projects came into being after the 2010s. Before the 2007 local elections, Erdogan announced hospital projects as one of his "crazy projects," but

[50] See: https://haber.sol.org.tr/toplum/isparta-sehir-hastanesinde-hekimler-birakmaya-hazirlaniyor-199164

https://haber.sol.org.tr/haber/basaksehir-sehir-hastanesi-calisanlari-eylemde-binaya-yatirim-var-ama-insanlara-yok-15996

there were minimal concrete steps (Cumhuriyet, Sept 12, 2013).[51] In his public statements, Erdogan started to mention PPP hospitals, namely city hospitals, coinciding with the acceleration of the legal processes. Announcing the completion of the tender for Kayseri City Hospital, Minister Recep Akdağ announced in one of his first statements about the realization of the projects in 2012 that they would complete all the projects at the end of 2015.[52] At that time, Erdogan, then the prime minister, frequently spoke about city hospitals at the opening ceremonies of different projects, declaring that the PPP projects were his "dream." He said that PPP hospitals had been his dream for nine years at the opening of a private hospital in 2012, for six years in another statement in the same year, and 12 years in an opening speech he made in 2014.[53]

The construction process, which started with the tenders in 2011, took longer than the government had anticipated. The projects that were initially planned to be completed in 2015 had only just begun to result in hospitals being opened in 2017. Part of the

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[51] See: https://www.cumhuriyetarsivi.com/oku/?clipId=20410692&home=%2Fmonitor%2Findex.xhtml

[52] See: https://www.cumhuriyetarsivi.com/oku/?clipId=14335048&home=%2Fmonitor%2Findex.xhtml

[53] See: https://www.cumhuriyetarsivi.com/oku/?clipId=17105744&home=%2Fmonitor%2Findex.xhtml

https://www.cumhuriyetarsivi.com/oku/?clipId=21101184&home=%2Fmonitor%2Findex.xhtml

https://www.dunya.com/gundem/03912-yildir-bunun-hayaliyle-yasiyorum039-haberi-250479

prolonging of this process was due to the legal preparation issues mentioned above. Another reason for the delay was that the companies that won the first tenders were not skilled at finding loans. Considering all the treasury guarantees and the size of the hospitals, some of the companies that needed to obtain loans from abroad could not secure them, and contract agreements changed hands several times. However, this situation found a different meaning in the political propaganda of the AKP government. In addition to mentioning his "dream" in his first press releases, Erdoğan attributed the delay to obstacles Turkey's legislative, executive, and judicial systems placed before the government.

Erdoğan targeted the countersuits that were being pursued by the TTB and the decision of the Council of State for suspension of execution. In a speech he gave in December 2012, he said:

> The system is not set up correctly; we have problems with the system. At an unexpected place and time, the bureaucratic oligarchy is standing in front of us. The judicial system confronts us. The legislative, the executive, and the judiciary systems must first consider the interests of this nation and then consider the interests of this state. Unfortunately, we have not realized our city hospitals project, which this poor person [Erdoğan] has been trying insistently for six years to complete, due to bureaucratic oligarchy and the judiciary... The so-called separation of powers stands as an obstacle in front of us" (Cumhuriyet, 2012).

These actions of AKP resulted in Erdoğan's escalating statements calling for a move towards the presidential system in Turkey starting from 2015. Ultimately, Turkey switched to the presidential system with the 2017 referendum. The push for the presidential system was related to the economic slowdown and other critical incidents in

recent history, such as the Gezi uprising, the 2013 corruption scandal, the 2015 election setback, and the failed Gülenist coup attempt in 2016 (Akçay, 2018). Erdoğan started to add the Gezi uprising and the 2013 scandal to the list of attempts to prevent the realization of the PPP hospital projects, among other things. He argued in one of his speeches that this "parallel structure" is trying to avoid the construction of hospitals by pushing forward "fake pieces of evidence." In this sense, the AKP government and Erdoğan tended to associate the legal and publicly stated objections to the PPP hospital projects with all kinds of movements and political moves that oppose AKP's policies, despite their unproven relevance to one another.

Just before the Presidential system referendum in April 2017, the first three PPP hospitals were opened. The first official opening ceremony was made for Mersin City Hospital. President Erdoğan and Prime Minister Binali Yıldırım attended the ceremony. The President started his campaign for the referendum with a speech in the opening ceremony. After both the Prime Minister and the President spoke about how comfortable the hospitals were, they once again linked the delay in the openings of the hospitals to the legal objections of the opposition. The speeches criticized Turkey's 30-year history, the "old" health care system, and the opposition party. The call to support the constitutional change for the presidential system was presented as a choice to say "yes" or "no" to this "old" system.[54] The second official opening was held for Isparta City Hospital in March with the prime minister, the Minister of Health, and the contractor company Akfen

[54] See: https://www.sozcu.com.tr/2017/saglik/turkiyenin-ilk-sehir-hastanesi-bugun-aciliyor-mersin-sehir-hastanesinin-genel-ozellikleri-neler-1658514/

Holding executives. The prime minister delivered a speech criticizing the old health system and calling for yes votes in the referendum to continue innovations.[55] The opening of the Yozgat City Hospital was also held in early April, although the hospital had started its operations in January. Again, in the opening ceremony held with the participation of the Prime Minister, Minister of Health, and Minister of Justice, the AKP representatives emphasized that they had made these "monuments" despite objections and opposition parties.[56] Erdogan and AKP officials also attended the official opening ceremonies of large hospitals such as Kayseri, Adana, Ankara Bilkent, and İstanbul Başakşehir, which were opened later.

5.3.4. Secret but public tenders

Regarding the scope of health PPP contracts, Turkey has adopted a mixed model among EU member states. According to the 2013 law, the private sector can build new health care facilities with PPP contracts and renew existing health care facilities for 25 and 15 years, respectively. At the end of the contract period, the facility is returned to the Ministry of Health free of charge. The private sector can provide commercial and medical services such as laboratories and imaging (Emek and Sevindik, 2019: 130). Since the start of the tender processes for PPP hospitals, the most controversial and criticized practice has been not disclosing details about the contract agreements because they are trade secrets. In the tender process, the bidders must primarily be economically,

[55] See: https://www.dailymotion.com/video/x5g2oeo

[56] See: https://www.youtube.com/watch?v=MjWl4rG_Hr0

financially, and technically sufficient. Those who meet the prequalification conditions submit their financial and technical proposals based on the pre-feasibility reports. As a result of the auction, contracts are signed after final bargaining with the lowest bidder. PPP contracts are shown as off-balance sheets, and liabilities arising from contracts are not seen in the financial statements (ibid: 136).

However, the pre-feasibility reports of the contracts, the articles of the agreement, the guarantees given by the state, and the right to obtain any information on these contracts were closed to the public because they are considered a "trade secret." This has been the most significant criticism towards applying the PPP projects since the very beginning of the legal processes. As mentioned before, partial information about the content of the contracts had to be divulged because of requests from the TTB about the legal information or some of the government's presentations and documents. The fact that enterprises providing public services is a secret to the public can be considered the AKP government's method of eliminating objections.

The first problem encountered by the AKP government in contracts with contractors was that the first companies that won the tender were not large enough to receive loans abroad. To overcome this problem, a law was enacted in 2014 that allowed for changing the terms of the project contract. In a completed tender, the lease price or the period that the credit institutions deem insufficient can be changed with a single signature, which Toker (2014) referred to as "legal collusive tendering." In addition, issues neglected in the design and drafting of the contracts in Turkey and any deficiencies that are not

covered by the laws have already aggravated the problem of long-term and complex PPP contracts. According to the EBRD, for contractor companies that apply for the most financing, access to funding has become difficult due to the size of hospital projects in Turkey and the complex tender processes (Emek and Sevindik, 2019: 140). In the Public-Private Partnership Special Report of the Ministry of Development, the contracting methods applied for PPP hospitals are also criticized. According to the report, the project development studies are not carried out wholly and successfully; companies approach the issue with the logic of "we can solve it by compromising after we win the tender." Afterward, however, systemic problems arise following the start of construction (Ministry of Development, 2014). The fact that the contract agreements are not publicized, that the contractors are changed frequently, and that the agreement's contents could be changed led to the fact that each hospital tender has been individually scrutinized, with separate issues pointed out.

For example, after the contract for Etlik City Hospital was signed in 2013, another hospital in the same district was immediately evacuated and left idle. However, considering that the Etlik City Hospital has still not been opened today, we understand that although the contract terms have not been complied with, the companies have also not been sanctioned. After this delay, which was attributed to financing difficulties, it was reported in 2020 that the debts were restructured.[57] In addition, in the pre-feasibility

[57] See: https://www.cumhuriyetarsivi.com/oku/?clipId=38270284&home=%2Fmonitor%2Findex.xhtml

reports prepared for the same hospital in 2009, it was stated that the annual rent should be at most 53.8 million TL. When all tender approvals were being submitted, Astaldi SPA-Türkerler Inc. submitted "the most advantageous bid" with 319 million TL and won the tender (Erbaş, 2021: 88,89). For Bilkent City Hospital, it was understood from the case file that a health ministry service building was added to the contract, although the tender document did not include the building (ibid: 99). In other projects, we see that companies that did not receive prequalification and did not participate in the first tenders emerged as the companies that received the tenders, and furthermore that the plans in the tender announcement had been changed.

Another controversial guarantee standard for all project contracts was that government payments were calculated according to a 70 percent occupancy guarantee. The first time that this guarantee started to be questioned was when the Ministry of Health stated in a training video for companies that "The Ministry of Health gives a guarantee of 70 percent occupancy; payment for laundry, food, imaging, and other services is made accordingly" (Erbaş, 2021: 112). TTB identified this situation in 2012, but it was not clarified for a long time what the guarantees included.[58] Later, it was reported by the Court of Accounts that "demand guarantees" were given to the companies for paying for a minimum amount of services in areas such as cleaning, laboratory, and catering even if the services are not delivered.[59] It has also been reported in the audit reports that these promised demand

[58] Available at: https://www.ttb.org.tr/375yerm

[59] As an extreme example, according to the 2019 report, although there is no IVF unit in Elazığ City Hospital, a guarantee fee is paid for the IVF unit under laboratory services (Turkish Court of Accounts, 2019).

guarantee amounts are not recognized and shown in the balance sheets by the MoH.

Besides the irregularities in the existing projects, there had also been projects for which tenders were announced but then canceled by the state after a few years. In 2013, three million three hundred fifty thousand square meter area (3.35 sq km) in the Sarıgazi neighborhood of Istanbul was transferred from the Ministry of National Defense to the Ministry of Health, with a protocol signed to build a PPP hospital. The tender was announced for the first time in 2018, but the tender announcement was canceled in October 2019 (Sputnik, 2019).[60] In the first months of the pandemic, the AKP built a pandemic hospital with Rönesans Holding on the same land.[61] Two pandemic hospitals built by Rönesans Holding in Istanbul were launched without a tender. According to the omnibus law prepared by the AKP government in the same period, the President was given the authority to go beyond the public procurement law and directly assign a company in extraordinary situations such as an epidemic. However, when the construction started, the omnibus law had not yet been passed.[62] In addition, there had been projects for which the land allocation process was started, but then the project was

[60] Available at: https://tr.sputniknews.com/turkiye/201910241040459334-sancaktepe-sehir-hastanesi-ihalesi-iptal-edildi-proje-5-yildir-devam-ediyordu/

[61] Available at: https://www.hurriyet.com.tr/gundem/sehir-hastanesinin-arazisine-yapilacak-41489090
https://haber.sol.org.tr/turkiye/ronesans-duyurdu-istanbula-iki-sahra-hastanesi-yapiliyor-284382

[62] Available at: https://www.sozcu.com.tr/2020/yazarlar/cigdem-toker/ronesansa-bu-zirh-neden-5759315/

canceled. In Ordu, the PPP hospital project was abandoned due to the fact that the land was on a stream bed only after the newly built Botanik Park had been taken apart to allocate space for the hospital.[63]

In November 2019, during budget negotiations, Health Minister Fahrettin Koca announced that the AKP government would no longer continue to construct hospitals with a PPP model. Koca stated that the "city hospitals" to be built from then would be funded with state budget resources.[64] Nine hospitals whose tenders had been completed will be finished according to the PPP model, but the PPP model would not be used for other projects. Accordingly, ten hospitals that were to be completed with the PPP model will initially be built using the general budget.[65] Finally, the number of projects decreased to 18 from the 31 planned and announced in the beginning.

Although we do not know the costs contained in the contract agreements, one of the few things we could learn is how much in monthly rent and service fees has been paid so far to the contractor companies from the Ministry of Health budget. The functional classification table in the financial statements accessible on the Ministry's website allowed the calculation of the costs of the hospitals built according to the PPP model.

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[63] Available at: https://www.cumhuriyet.com.tr/haber/15-milyon-tl-harcanarak-yapilan-116-donumluk-botanik-parkta-simdi-koyunlar-otluyor-1801898

[64] Available at: https://p.dw.com/p/3T83i

[65] Available at: https://www.ttb.org.tr/kollar/_sehirhastaneleri/haber_goster.php?Guid=8aff1c68-06b8-11ea-9197-77d5c768b243

Although the statements do not allow us to calculate the costs for each hospital project, they enabled us to see the total costs until the beginning of 2021 (See Table 3). However, the government decided to classify all the payments made for all PPP projects under a single heading at the beginning of 2021, not allowing to follow the PPPs in health specifically. Considering that the lease agreements were made for 25 years in general, the costs will devastatingly affect the state budget. Emek (2020) calculates the price for 25 years as 81.2 billion USD. For 2021 alone, approximately 20 percent of the MoH budget is allocated for the expenses of PPP hospitals.

Table 3. Rent, service cost and total cost MoH paid for PPP hospitals by year

Year	Rent (in USD)	Service cost (in USD)	Total cost (in USD)
2018	239,636,614.77	217,868,708.19	457,505,322.96
2019	486,043,307.66	411,319,329.72	897,362,637.38
2020	788,002,486.80	460,407,320.43	1,248,409,807.23

Source: MoH financial statements

It is possible to argue that the reason why the contracts were kept from the public as trade secrets, which attracted a lot of criticism in the early 2010s, had revealed itself towards the end of the 2010s. AKP representatives have persistently implemented the decision to keep the contract documents secret from the very beginning of the projects. I can clearly understand from the meetings I took part in with the representatives of the two companies involved in the tender process that not sharing the contracts with the public was not one of the special requests of the companies. Since the biggest responsibility of the legal process is on the side of the state, according to companies there is nothing out of the

ordinary about the process or about complying with the practices of the law. One of my interviewees commented that “the trade secret is a strategy to gain time against the opposition circle.” In this case, we can understand that the AKP government refrains from carrying out all tender processes transparently to realize these projects, predicting that the realization would require various uncommon practices. At the same time, considering that financial resources are wasted, and the abandoned hospital projects cause environmental damage, the AKP government’s approving the tender without completing the necessary research and preparation creates a severe problem. In this sense, keeping the contract secret means not showing the advantages provided to the private sector on the one hand and hiding the state’s non-fulfillment of its responsibility to the public on the other.

5.3.5. The upper hand of the government: Laws, regulations, and guarantees

When we look closely at the legal framework of Turkey's PPP hospital projects, we can see that the AKP government created the basis for the projects with the earliest legal regulations and institutional arrangements. With the opening of tenders, we see that every legal regulation that makes problems for companies and projects continue is either unlawfully disregarded or amended. Countersuits, mostly carried out by the institutional efforts of the TTB, helped inform the public at first, but within a few years, the AKP government removed the obstacles placed in front of the projects in various ways. The legal arrangements made to remove controversial situations eased the hands of the companies and the AKP government in the subsequent tender processes. Looking at the

process, we understand that the legal basis for the projects is not being set up. Still, aided by the sole advantage of being in power, the AKP government has used the judicial and legislative processes to promote the continuation of tenders and projects.

The legislation specially enacted to realize state and capital partnership hospitals in Turkey shows that the AKP government has drawn its particular route to circumvent obstacles related to these hospitals. Legal challenges to this route have played an essential role in advancing the AKP's political propaganda and legitimizing constitutional changes. However, when looking at the state-capital relationship here, apart from political gains, the biggest trump card the state can use to open the way to capital is to make the necessary legal changes according to the needs of the private sector. We see that the AKP government, as the single-party government, does not have much trouble overcoming the obstacles to legal changes. Although the preparation of legal and institutional processes was insufficient, we can say that when the will to initiate projects was strong, preparations were completed quickly.

These legal processes do not have to proceed similarly in every case. As mentioned before, AKP's rise to power and the uninterrupted implementation of reforms in line with the Washington Consensus policy paradigm stemmed from the party's long life as a single-party government. The particular situation of AKP after 2010 is that it has consolidated its voting base and can control opposition circles more easily, with the confidence that it will maintain its power. Thus, AKP overcame the debates arising from injustices, irregularities, and unconstitutionality created in legal processes without risking

the projects and its power. For the same reason, the AKP government, which can provide a treasury guarantee for companies' loans and a 70 percent occupancy guarantee for service payments, is another important trump card to persuade the private sector on these projects and realize the projects.

5.4. The “capital” in PPP hospitals

5.4.1. Capital in the health sector

This section aims to take a closer look at the private side of the partnership for a more detailed analysis of PPP hospital projects. Better results can be obtained by making a detailed examination of the character, expectations, and relations of the capitalist groups investing in these projects with the state. One of the most striking results in Turkey's PPP hospital projects was that the main contractors of the projects were construction companies, not health care companies. It is worth asking questions such as how the construction companies invested in hospital projects, why the private hospital owners may have been excluded from the projects, and what expectations the businessmen in the health sector might have from hospital projects.

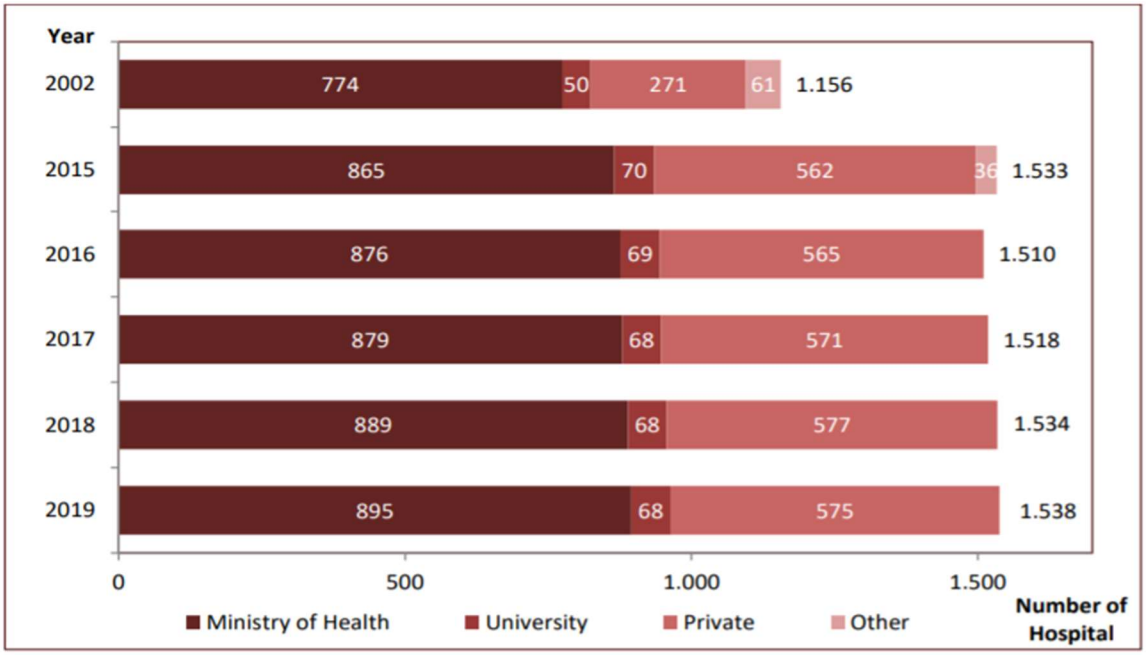
In the previous chapter, I mentioned AKP’s particular health policies and the capital accumulation opportunities the policies create for the health capital. Also, at the beginning of this chapter, I touched upon AKP’s relationship with national capital actors and organizations. However, we have not looked at which areas in health services capital accumulation was directed towards in Turkey and the relation of the owners of this capital with AKP. To understand the “capital” side of PPP hospitals in more detail, I will first look at the capitalist class in the health field. As understood from the reports released

by the organized capital in the health sector, the most important and growing market is the private hospitals. Despite specific conflicting points I mentioned in the previous chapter, the private hospital sector has benefited from a stable environment, continuing to make investments as demand is expected to grow. However, the health field is not limited to the private hospital sector since the health sector is closely related to medical devices, pharmaceuticals, and insurance. After studying the private hospital sector, I will briefly mention these health care sub-sectors to illustrate the overall picture.

5.4.1.1. Private hospitals

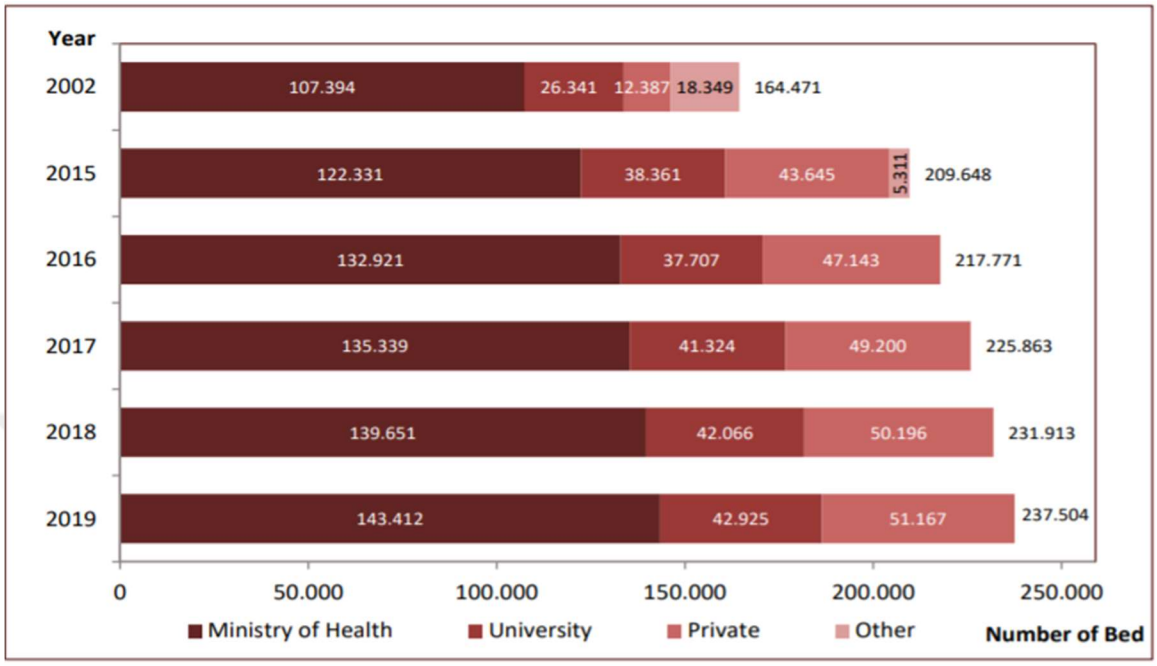
One of the most decisive statistics used to look at the hospital sector is the change in hospitals and hospital beds over the years. The Health Statistics Yearbook 2019 provides the latest information as follows:

Figure 10. Number of hospitals by year and sector in Turkey, 2002-2019



Source: Health Statistics Yearbook 2019

Figure 11. Number of hospital beds by year and sector in Turkey, 2002-2019



Source: Health Statistics Yearbook 2019[66] [67]

According to the tables above, while growth in the number of public hospitals between 2002 and 2019 is around 16 percent, the growth in the number of private hospitals between the same years is 112 percent. The share of private service providers in the total number grew approximately two times faster than the sector in total, reaching 37%. In

[66] Online available at: https://dosyasb.saglik.gov.tr/Eklenti/40566,health-statistics-yearbook-2019pdf.pdf?0

[67] It should be noted that recently many foundation universities in Turkey started to open medical faculties. With a decision made in 2017, it was conditioned that foundation universities should have hospitals, and regulations were made in order for private hospitals and foundation universities to comply with this condition. Until now, most of the foundation universities have cooperated with existing private hospitals. These hospitals are not considered university hospitals immediately; they must complete and submit applications in order to be qualified as university hospitals. On the other hand, according to the legislation of the Ministry of Health, these hospitals are subject to private hospital regulations. However, this unresolved complexity is not a contrast to show that the number of private hospitals is increasing for the analysis here.

addition, the hospitals grew not only in number but also in size. While the number of beds per private hospital was 45 in 2002, it was 89 in 2019.

The distribution of hospitals by region also gives us important information about the role of the private sector. Although the Health Ministry does not publish the number of private hospitals distributed to the provinces, according to the number of beds per 10 thousand people, Istanbul is the only province below average (Belek, 2020: 157). It seems clear that the private sector has filled this gap. Istanbul is the city with the highest number of private hospitals. 37.7 percent of the 39 thousand 328 beds in Istanbul belong to private health institutions (Birgün, 2020)[68]. Private hospitals are mostly concentrated in three major cities. Only one-third of the private hospital capacity is in cities other than Ankara, Istanbul, and Izmir. Almost half of the private hospitals are located in Istanbul (TÜSPE, 2018).

According to the latest health sector report of TOBB (2017), the oldest organized businessmen's association, the private service providers sector has achieved a stable market share of approximately 25-27 percent in total service provider expenditures. In addition, the capitalist class predicts that the demand for private hospitals will increase due to the further growth of the high-income segment. The CEO of Memorial, one of Turkey's largest chain hospitals, also thinks that the private hospital sector will show growth because per capita income is increasing. However, he adds, consolidation is not at

[68] https://www.birgun.net/haber/4-soruda-hastanelerin-yatak-kapasitesi-gercegi-5-yataktan-biri-ozel-hastanelerde-292197

a sufficient level (PWC, 2014). However, the private hospitals' sector, which performs approximately 53% of the most complex surgeries and owns 43% of intensive care beds (TOBB, 2017), shows a trend of monopolization. As reported in their websites, large chain hospitals especially invest in the sector through geographic expansion or acquisitions. The following table lists the largest private chain hospitals in Turkey by the number of hospitals and beds.

Table 4. The largest private hospital chains, their number of hospitals, number of beds and share of number of beds in total, Turkey

	Number of hospitals	Number of beds	Share of number of beds in total
MLPCARE	29	5900	%11.5
Acıbadem	22	3500	%7
Medicana	12	1755	%3.5
Memorial	11	1752	%3.5
Medipol Hospitals	10	≈ 1600[69]	%3
Baskent University Hospitals	6	1617	%3.2
Bahat Hospitals	4	973	%2
Florence Nightingale	5	900	%1.7

Source: TOBB (2017), company websites (the most recent numbers available)

As can be seen in the table, the five largest private chain hospitals account for 28% of the total number of private beds. In addition, chain hospitals tend to eliminate smaller

[69] While the 2017 TOBB report says there are 5 Medipol Hospitals, as of now the hospital website reports there are 10 Medipol Hospitals in total. However, the information for the bed capacity is not given. 1600 is the estimated number.

hospitals from their portfolio. For example, the largest chain, MLPCARE, recently transferred to the Uşak Hospital as of August 7, 2020, in line with its strategy to grow with large-scale hospitals in metropolitan areas (MLPCARE, 2020). Moreover, the mergers and acquisitions reports of audit companies show that the Acıbadem health care group acquired several medical groups in 2017, foreign and domestic investors became partners in Acıbadem and Memorial groups in 2018, and MLPCARE bought two medium-sized hospitals in 2019 (Deloitte, 2020; Yıldırım, 2019). It is worth noting that the share of foreign capital in partnerships is high. A Netherlands-based investor company owns 30.69% of MLPcare.[70] In Acıbadem, the share of Aydınlar family, which had a 50 percent share before the transfer in 2011, fell to 25%, and Integrated Health care Holdings (IHH) now holds 60% of the shares. IHH, with 70 percent of Malaysian origin Khazanah and 30 percent of Japanese origin Mitsui, owns the largest health care assets in the Asia-Pacific region.[71] Within the latest partnership structure of Memorial hospitals, Argus Capital based in England has a 20% share.[72]

5.4.1.2. Medical devices

The medical devices industry is mostly made up of importers in Turkey. Statistics on the

[70] Available at: http://investor.mlpcare.com/en/mlp-care-at-a-glance/shareholder-structure/

[71] Available at: https://www.milliyet.com.tr/ekonomi/acibadem-in-75-i-1-26-milyar-dolara-gitti-1479781

[72] Available at: https://www.ntv.com.tr/ekonomi/katarli-ortak-memorialdan-cikti,R0MUkrVvRUK2859PDY5qug

medical devices market show that the market is expanding; however, the share of imports in the total market is also gradually increasing (SASAM, 2017). Recent reports show that approximately 85.1% of medical devices are imported (MoH, 2018). The majority of manufacturing companies are medium-sized; furthermore, large-scale industrialists not investing in medical devices is considered a disadvantage for the sector. The local small- and medium-sized producers and importers are organized under the Medical Device Manufacturers and Suppliers Association Federation (TÜMDEF).[73] In general, the SSI's low prices are considered one of the problems discouraging investors (SASAM, 2017). As a result, the capitalist organizations representing medium-sized enterprises mostly voice their support and receive incentives for domestic production from the government.

5.4.1.3. Pharmaceuticals

The pharmaceutical sector is also a net importer in Turkey but has important domestic capitalist actors and organizations. Turkey's Pharmaceutical Industry Association (TİSD), established in 1951, represents domestic pharmaceutical manufacturers and companies. The Pharmaceutical Manufacturers Association of Turkey (İEİS), established in 1964, has turned from representing domestic industrial companies to representing the generic pharmaceutical industry over the years (Şencan et al., 2017). The other important employer organization in the sector, the Association of Research-Based Pharmaceutical

[73] Turkey's Health Industry Employers' Association (SEIS), the Association of Medical Equipment and Device Manufacturers (TÜDER), the Researcher Association of Medical Technology Manufacturers (ARTED), the Aegean Association of Medical Device Manufacturers and Suppliers (EGEDER), and the Association of Health Care Products Manufacturers and Representatives (SADER) are the main organizations. These SMEs are also represented in the TOBB medical sector assembly.

Companies (AIFD), represents international pharmaceutical companies in Turkey, such as Abbvie, Pfizer, Novartis, and Roche.

The large domestic companies in pharmaceuticals are mostly well-established capitalist groups rather than the so-called Anatolian capital, which has no particular interest in the pharmaceutical policies of the government (Dorlach, 2016)[74]. In 2009, the AKP government implemented a policy change increasing the stringency of its pharma pricing and control policies. This reduced the profit margins of pharmaceutical producers and distributers, where the primary losers are foreign pharmaceutical producers. This policy of the AKP government can be regarded as a result of both its willingness to achieve macroeconomic stability following the 2008 crisis and to maintain electoral support (Dorlach, 2016). It can also be seen as AKP's determination to secure a wider class alliance between national and transnational capital and an example of how it mediates the contradictory interests of capital within the process of wealth accumulation (Eren-Vural, 2015).

5.4.1.4. Private health insurance

The private health insurance industry in Turkey has a small market compared to other developing countries (TOBB, 2017). The first application of private health insurance in

[74] One of the most well-known actors in the pharmaceutical sector in Turkey, Abdi Ibrahim, was listed as the 97th largest industrial company on the ISO 500 list based on sales. The list also includes 6 pharmaceutical companies. Besides being the chair of the IEIS board of directors, the CEO of the Abdi İbrahim company, Nezih Barut, was also a board member in TÜSİAD.

Turkey emerged in the form of supportive health insurance. In 2014 complementary health insurance was introduced, and it covered the services outside the scope of public health insurance. However, only 2.5-3% of the country's population has private health insurance, and it is limited to a small segment of the high-income group who did not request services from the Social Security Institution (Özsarı and Güdük, 2020). Today, a total of 39 companies provide services, although the top two companies own more than 50% of the market (TOBB, 2017). The first is Germany-based Allianz SE, and the second is UK-based Bupa International Markets Limited which acquired Acıbadem Sigorta in 2019. The most important reason for the sector's limited growth seems to be the broad coverage. Despite the well-established capitalist organizations' dispute with the government, as I mentioned in Chapter 4, the AKP government has not directed its policies towards supporting this sector. According to the interviews with the senior executives of private insurance companies, the sector does not foresee significant growth in the short and medium-term due to no expectations of change in governmental health policies (Özsarı and Güdük, 2020).

5.4.2. PPP hospitals exclude most of the capitalist actors in the health sector

When we look at the capitalist class in the health sector of Turkey, we see that the subsector which expanded the capital accumulation opportunities in the post-1980 period—especially with the help of AKP's health transformation policies—was the private hospital sector. It is clear that the marketization process, which the AKP government wants to promote in health transformation, does not explicitly expand the capital accumulation area of private health insurance, the medical device sector, or the

pharmaceutical sector.

The actors in the medical device sector have stated their problem with the lack of potential benefits from the PPP hospital projects. The chairman of Turkey's Health Industry Employers' Association argued in 2019 that these hospitals create an essential opportunity for the medical devices sector. Still, the domestic actors in the industry have no chance to catch up with the speed of these projects. He stated that "although the regulations say that city hospitals should supply 20 percent of their medical devices from domestic sellers, the sector has not grown yet to meet this rate." Therefore, the domestic medical devices sector based on SMEs has a limited impact on the state-capital relationship in the health sector. It is clear that PPP hospitals did not provide the domestic producers with new opportunities, leaving room for international technology giants like GE and Siemens. These giants have been included in the consortiums created for the construction of PPP hospitals. General Electric and Siemens' medical device divisions stand out as the "solution partners" among these hospitals' investments. The agreement amount that GE Health has announced to have signed with two hospitals is approaching 15 percent of the total cost of the project (soL, 2018).[75]

Although the agreement includes sizeable capitalist actors, the decision taken by the pharmaceutical sector in 2009 showed that the AKP government had not done them any special favors and that the pro-AKP capital did not invest specifically in this area. In the

[75] Available at: https://haber.sol.org.tr/emek-sermaye/sehir-hastaneleri-kimler-nasil-kazaniyor-240260

medical devices sector, it seems that there is no effort to substitute for imports. Yet, SMEs continue to compete to maintain a place in the market as importers. On the other hand, despite their demands, the private insurance sector has found no important opportunity to expand in the Turkish market. What's more, this relatively small market is dominated by two actors, backed by foreign capital. Neither the pharmaceutical sector nor the medical devices sector has opened up points of dispute with the government over the PPP hospitals projects. This situation is not unexpected since these projects have not made any promises to actors of these subsectors. However, business associations' reports covering the health sector conclude that the PPP hospitals have a minimal impact on the growth of the health sector (TOBB 2017; PWC, 2014). Yet, as expected, the PPP hospitals have created a more serious conflict for private hospital providers.

When we look at the first months of the tender processes, we see the names of the biggest private hospitals. However, they ended up withdrawing from the partnerships. For example, for Elazığ City Hospital, Medical Park was listed as part of the business partnership that submitted a tender offer, although it did not receive prequalification. The Ministry of Health acknowledged that the company was subsequently included in the tender process "with the approval of the administration." The tender approval came out one-and-a-half years after the commission's decision, and it was seen that Medical Park had withdrawn from the partnership and had been replaced by Rönesans Holding (Erbaş, 2021: 101, 102). The same situation happened in Bursa, Yozgat, and Adana city hospitals. The hospitals for which Medical Park was seen as a partner in 2012 were eventually built by Rönesans Holding (TTB, 2012). Another interesting point in these

tenders is that Rönesans Holding's sub-company, Rönesans Medical Investments Inc., whose name appears in the tender, did not have the 15 years of experience required for construction work and five years of experience needed for imaging and laboratory services (Erbaş, 2021: 106).

According to the information provided by one of my interviewees, Acıbadem also participated in meetings for partnership in tender processes. It is not possible to find this information in the public records because the company in the end withdrew. Trying to form a partnership with Rönesans Holding, Acıbadem would enter as the partner responsible for design and health care services. The final reason for Acıbadem's withdrawal from partnership negotiations was that it could not agree on profit shares with Rönesans Holding. Apart from that, my interviewee argued that one of the reasons for one of the largest actors in health capital to withdraw from this profitable investment, which is predicted to make a return in 6 years, is that they did not want to deal with the negative public opinion towards these hospitals. Prominent actors who have already achieved some growth with their private hospitals also thought that partnering with the Ministry of Health was risky because PPP hospitals are multi-partnered and bring a complex model of public-private cooperation.

During the partnership negotiations, the answers given by the Ministry of Health to the questions of Acıbadem and other companies about the Yozgat project revealed the complexity of the process. The Ministry, which does not specify the commercial areas, the needs of oncology services, and whether the rooms are suitable for some patients, said

that it would evaluate these possibilities with offers. The MoH also stated that it would not take any steps regarding several issues, specifically providing efficient health services, addressing problems with areas reserved for hospital staff, and the issues with the facility design that do not make it possible to conduct education and research.

As understood from the reports and discourse of the private health sector representatives, dissatisfaction in the sector is not solely related to not participating in the projects. One of the recent reports examining private health institutions criticizes the PPP hospital projects because they create a competitive environment, but they do so at the detriment of private hospitals. According to the Health Institutes of Turkey (TÜSPE, 2018), although not much additional bed capacity will emerge with the ongoing projects, these hospitals will have brand new buildings, technologies, and space, among other benefits. Thus, public hospitals will still have the potential to provide a serious competitive advantage over private hospitals. The report also suggests consolidation for small- and medium-sized healthcare institutions to eliminate the costs related to these developments.

However, despite these points of dispute, it should also be considered that the location of the PPP hospitals has, in practice, created an indirect benefit to the private hospitals. In the interview I conducted with the former TTB president, the expert said that due to transportation difficulties, the chaotic structure of PPP hospitals, and the closure of old hospitals in the city centers, patients with a relatively high-income level were indirectly transferred to private hospitals in the city centers. The former TTB president stated that it is clear in the case of Ankara that the demand for private hospitals in the city center has

increased with the transfer of 6 public hospitals in the center to PPP Bilkent hospital, which is very far from the city center. My interviewee from Acıbadem also mentioned the same advantage for private health care providers, as they have started to attract more middle-class citizens who can afford doctor visits and minor operations in more central and less chaotic hospitals.

5.4.3. Tenders go to construction firms

During the period that marks the start and end of the PPP hospital tenders, the capitalist actors themselves have been in a constant state of change. We see that the first actors announced to win the tenders did not become the final contractors. In this process, although large private health care providers such as Acıbadem and Medical Park intended to be included in PPP projects, they withdrew from the partnership processes in the end. Thus, the main actors benefiting from the accumulation opportunities created by the state for the construction and operation of PPP hospitals became construction firms. As I noted in the section above, capitalist groups in the health field do not traditionally include actors within the construction industry. However, the traditional capitalist groups in health report that they, especially those representing private hospitals and the domestic medical device sector, have been excluded from these projects and that the government carries out these projects exclusively within the construction sector. The construction companies have even started to establish their own medical divisions to perform the services outlined in the tenders. The table below shows the contractor companies, their shares in the total bed capacity, and the investment amounts.

Table 5. Contractor companies in PPP hospital projects, bed capacities of the hospitals and shares in total bed capacity, investment amounts of the contractor companies and shares in total investment, Turkey

Contractor company	PPP hospitals	Bed capacity and share in total	Investment (in million USD) and share in total
Rönesans Holding	Adana, Elazığ, İstanbul Başakşehir, Bursa	8922 %30	3900 %35
Astaldi SPA-Türkerler	Ankara Etlik, Kocaeli, İzmir	6891 %24	2200 %20
CCN Holding	Ankara Bilkent, Mersin	5098 %17.5	1700 %15
YDA Construction	Kayseri, Manisa, Konya	3415 %12	1200 %11
Akfen Holding	Isparta, Eskişehir, Tekirdağ	2316 %8	1000 %9
Kayı Construction	Gaziantep	1875 %6.5	932 %8
Güriş Construction	Kütahya	600 %2	187 %2
7 companies	18 projects	29117	11.119

Source: MoH, company websites, Transparency International Turkey (2020)

As seen in the table, Rönesans Holding is the company that benefits the most from the privileges of PPP hospitals by winning the highest number of tenders. The two largest companies accounted for more than 50 percent of 18 projects in total, both in the categories of bed capacity and investment amount. Erman Ilıcak established Rönesans Holding in 1993 in Russia. Once established in Russia, the company entered the Turkish market with shopping mall construction in 2004. In the meantime, it became Russia's second-largest contractor in the 2000s. After starting with shopping malls and some infrastructure projects, the company began to invest in health care in 2012. Currently contracting and investing in 28 countries, Rönesans Holding became partners with IFC, a

member of the World Bank Group, purchasing 7% of the shares[76]. Erman Ilıcak ranked second in Turkey's top 100 richest people by *Forbes* in March 2020 and came in first place in 2019.[77] Also, at the beginning of 2020, his name was announced among the world's dollar billionaires.[78] Ilıcak was a member of TÜSİAD's board of management.

Rönesans Holding was later included in the PPP hospital projects tenders. In fact, as mentioned earlier, the company was incorporated by an extraordinary decision without the qualification required by the law. According to the information I received from the representatives I interviewed, for a long time, Rönesans has been implementing the build-lease model on the shopping malls, hotels, and offices it owns. Based on the department's recommendation responsible for researching investment opportunities within the company, Rönesans decided to invest in PPP hospitals. The company did not participate in the already complex and huge hospital projects such as Kayseri, Ankara Bilkent, and Ankara Etlik because they thought securing financing would be a problem. There would be no issue in terms of financing for the projects they entered into, and they could have the greatest amount of input with the contract. In the projections made on the return of the projects, it was concluded that the return on capital is very high, with 15 percent contractor profit and 75 percent bank funding.

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[76] Available at: https://www.dunya.com/sirketler/ifc-ronesans-holding039e-ortak-oldu-haberi-322382

[77] Available at: https://www.dunya.com/ekonomi/forbes-turkiyenin-en-zengin-100-ismini-acikladi-haberi-464367

[78] Available at: https://www.dunya.com/dunya/milyarderler-listesinde-2-turk-haberi-463523

The second-largest contractor in PPP hospitals is Türkerler Holding and its Italy-based Astaldi partnership. Türkerler Holding, which entered the construction area after 1995, has become a holding with the tenders it received from the Ankara municipality. Later, large energy investments were made during the AKP period.[79] Energy projects done in partnership with international giant GE represent the largest share in the company's portfolio. It obtained loans from institutions such as EBRD and IFC for PPP hospitals. In one of his few interviews, Kazım Türker, the company owner, stated that he wanted to make it clear that he did not wish to be associated with pro-AKP business people.[80] The hospitals for which this partnership was awarded the tenders could not be completed for a long time. For example, Ankara Etlik Hospital was contracted out in 2012 but has not yet been completed. According to information from my interviewees, Astaldi withdrew from the partnership, but its name remained. Türkerler Holding, on the other hand, is not large enough to find financing. It has been reported that the company accumulated debt to the subcontractors and workers who carried out the construction. Therefore, the construction was halted for a significant period. The company released a written statement arguing that the project's delay was due to the MoH, while the MoH stated that the company caused the delay.[81]

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[79] Available at: https://www.patronlardunyasi.com/haber/Kazim-Turker-nasil-rekortmen-oldu/42521

[80] Available at: https://haber.sol.org.tr/devlet-ve-siyaset/piyasaci-saglik-sistemi-hayaldi-gercek-oldu-haberi-60747

[81] Available at: https://www.sozcu.com.tr/2020/yazarlar/cigdem-toker/etlik-sehir-hastanesi-2021e-kalmis-5743704/

The other major actor, CCN Holding, completed its first construction projects in Azerbaijan after its establishment in Dubai in 2007. The firm entered the Turkish market via PPP hospitals. Thus, it grew by establishing sub-companies such as health care, biomedical, and clinical support service providers. CCN Holding has built Turkey's largest PPP hospitals thanks to a joint venture with GE Health care. [82] CCN Holding has a history that began before 2007. İbrahim Çeçen, the father of CCN holding owner Murat Çeçen, is the owner of IC Holding, which was established in 1969 but became known in the construction sector during the AKP period. CCN health care group was found only in 2016 after the tenders for PPP hospitals projects and financial closures for loans were finalized.[83] CCN Holding has built and completed the two largest hospitals in Turkey. With the privileges obtained in the privatizations and transportation projects in the 2000s, the company is also sixth among the companies that have received the most public construction tenders in the last five years.[84] IC investment company is represented in TÜSİAD. YDA construction, Akfen, Kayı, and Güriş are among the old and long-standing capitalist groups in the construction sector involved in large infrastructure projects in Turkey. They all expanded their markets with various large PPP projects in the AKP era.

[82] Available at: https://www.dunya.com/gundem/ge-saglik-ve-ccn-holdingden-turkiyenin-en-buyuk-ppp-projesi-haberi-441402

[83] Available at: https://www.ccngroup.com.tr/dunden-bugune-ccn/

[84] Available at: https://haber.sol.org.tr/toplum/iste-akpnin-seckin-sirketleri-yandas-insaat-sirketlerine-3278-milyar-liralik-ihale-277292

If we make a general assessment of these actors, we see none particularly invested in AKP politics. They did not necessarily expand their accumulation opportunities during the AKP period due to their pro-Islamist origins. Still, they benefited from the particular opportunities with the privatization and infrastructure projects of the AKP. The fact that the entrance of Rönesans Holding in particular into the Turkish market came with the appearance of the AKP government, and that the top companies started to grow with health investments shows a link between these companies' growth AKP's health policies. This link has to do with the AKP government and a domestic economic policy based on construction. As I mentioned at the beginning of this chapter, the AKP governments have attached strategic importance to the construction sector from the very beginning. This importance was effective in propelling the construction sector and placing it in the focus of the economy. It is also worth noting that Rönesans Holding's construction division, IC İçtaş and YDA Construction, are among the top 25 largest construction companies in Turkey.[85] Still, in PPP hospitals, we do not see actors such as Limak, Cengiz, and Kalyon, which are usually listed among the pro-AKP companies that received the most public tenders in the AKP period. Why these actors do not enter the field of health may be another interesting research topic. The conversations I have had with company representatives allow me to argue that it is much more profitable to cooperate with the state on other projects such as energy, roads, and bridges.

[85] Available at: https://csnturkiye.com/top300-2021/

5.4.4. The upper hand of the construction capital: No concern over health

In the PPP hospitals projects implemented in Turkey, taking a closer look at the private sector has been essential to understanding the partnerships associated with these projects. In addition to the complex and highly controversial tender processes I explained that exist on the "state" side, the projects also created a complicated process for the "capital" side. With the process that started without adequate institutional and legal preparations, some of the capitalist actors involved in the projects withdrew (Medical Park, Acıbadem). For some, the projects turned into ones that could not be completed due to financial insufficiency (Türkerler-Astaldi). The most crucial output in this picture was the withdrawal of the capitalist actors in the private health sector from the projects. Even the most prominent private health care providers, which are the ones to benefit from marketization in health, left their places to construction companies.

We understand that projects are a risky area for capitalist actors in the health care field. Considering that the PPP hospitals, whose political significance is more prominent for the AKP, pose a threat to public health in many ways, it becomes understandable why health-related companies never even entered into such a profitable business. The fact that Rönesans Holding, which is the contractor on most of the projects, later opened its own medical division is a sign that the projects will be dominated by the construction sector, which possesses no experience in any medical field. However, the lack of experience in health did not cause any problems for the company, as I understood from the interviews I made. Since the core areas of the health service were under the state's responsibility and the other areas were distributed among the subcontractors of Rönesans Holding, the

company was not required to take much responsibility in terms of the quality of health services. In this respect, the company does not accept any criticism that hospital projects will not positively affect public health. Thus, for the actors in the construction sector, it was possible and non-risky to ignore the complexities involved in the tender processes, the project designs, and any controversies related to the interests of public health. The only paramount concern for construction companies that completed the projects was finding enough financing by connecting with international networks and possessing enough experience to manage the various financial issues.

5.5. No more PPP model in health care: What awaits existing hospitals?

During the budget discussions in the parliament in November 2019, it was publicized that the AKP government would abandon the PPP model for hospital constructions. After 18 PPP hospitals, it was announced that the other hospitals initially planned as PPP hospitals would be built with the public procurement method. On the silent legislative change officially announced in January 2020, the AKP government did not make any statement other than that hospitals are costly with this method. Some bankers and advisors talking to *Reuters* claim that bankruptcy risks are still significant, especially for delayed projects. With the 2018 currency crisis, the investors of the projects that were not completed are running low on cash and even face bankruptcy.[86]

[86] Available at: https://www.reuters.com/article/turkey-economy-hospitals-idUSL1N2AE0E0

The measures against the pandemic started in Turkey right after the decision that the PPP model would no longer be used. The AKP government declared the hospitals built and opened with the PPP model as the center of the fight against the pandemic. The government praised PPP hospitals as "the pandemic's first great success story," citing the hospitals' scale making isolation easier and allowing to accept everyone applying to the hospital. However, TTB and medical chambers declared that the health system is further weakened due to the closure of other hospitals in cities where PPP hospitals are opened, the fact that hospitals are too large, there are too many closed areas, windows can't be opened, and patients are directed to a single center. Apart from expert opinions, it is difficult to say that there is a public controversy regarding the use of PPP hospitals in the pandemic, as before. However, it can be said that the pandemic crisis prevented the formation of a public opinion about the changed decision of the government, the increasing rent payments, and the unfinished projects. There is limited opportunity to find detailed data or comments from government sources about abandoning the PPP model in health care.

To predict the future of hospitals in Turkey, we can look at what happened in the case of England, one of the first practitioners of the PPP model in health care. In health care, PPPs began to be implemented in the UK in the late 1990s, but new projects have started to decrease gradually since 2008. A similar public controversy arose in Turkey because oppositional circles claimed that the projects were highly costly. They reduce service standards and provide tax avoidance and significant gains for private companies. Unlike Turkey, there is broad and organized public opposition to the PPP model in the UK.

Surveys say that around 70 percent of the public thinks PPPs should be banned (Jubilee Debt Campaign, 2017). While there were solid and resonant anti-PPP public campaigns in the UK case, such public opposition against the idea of PPP projects has not emerged in Turkey. The objections expressed by the TTB and medical chambers did not turn into a more organized and broad opposition against the PPP projects in health care. [87]

In the UK case, a back step was taken to recover from the losses in some of the cases. For example, NHS borrowed money from the local authority to buy out the contract for Hexham General Hospital. Even though the private contractors would be repaid in full, the buyout saved money because the interest rates on government debt were lower than the rates on PPP contracts. However, for Turkey's hospitals, the possibility of buyout and termination terms are not even known since the terms of contracts are not publicized. With the ongoing currency crisis and budget deficits in Turkey, it remains unclear how the debts to the contractors of PPP hospitals will continue to be met from the state budget. Moreover, in addition to the increasing financial obligations of the hospitals opened, the financial crisis for those that have not yet been completed and opened is growing.

Two main future alternatives have come forward so far; however, the discussions on these alternatives have been minimal. One alternative voice says that: As in the UK example, the AKP government itself or a new government may try to pay off the debts by borrowing again with lower interest rates and make a move to transfer the hospitals to the

[87] In fact, a limited number of patient satisfaction surveys show that patients are generally satisfied with PPP hospitals in Turkey, although it varies according to demographic factors and different cities (Gökkaya et al., 2018; Talmaç and Soysal, 2021).

state in less than 25 years. However, one of the crucial points here will be the kind of agreement made or can be made with private contractors on the pay-off option. Güngen (2020) says that this could be a path forward for the AKP government for all PPP projects, given that the government has a close relationship with most of the contractors to agree on a deal. However, as I mentioned in this chapter, the contractor companies in PPP hospitals do not have a close political tie as the other construction companies known as pro-AKP have. Considering the recent political crisis that the AKP has been through, it does not seem realistic that such an alternative could be realized in the near future.

The main opposition CHP already voiced another alternative. The party made a statement in 2020, saying treasury guaranteed enterprises constructed as PPP projects would be nationalized when they are in power. However, they did not reveal the details of the nationalization regarding the PPP hospitals.[88] A similar expropriation plan had come from the Labour Party in the UK for enterprises in the energy sector. According to the Labour Party's plans: "The assets to be nationalized are transferred to public ownership through an Act of Parliament, and (2) provision is made for compensating the former owners through a bond issuance by Treasury" (Labour, 2019). Thus, shareholders who currently own the properties will be compensated with bonds. Karahanoğulları (2019) also suggests that this method for Turkey's PPP hospitals would be proper to prevent companies from involving the public health field with their own economic interests. However, Turkey's biggest capitalist organization objected to these proposals even before

[88] See: https://www.cumhuriyet.com.tr/haber/kemal-kilicdaroglu-yazdi-yeni-devletcilik-guclu-sosyal-devlet-1752442

they found any public support. TÜSİAD made a statement quickly after CHP's move, saying, "The expropriation of any private company in a way that violates its property rights should never be in question."[89] It does not seem easy to make realistic predictions about the future of hospitals and PPP projects in general. It does not seem possible at the moment to know the factors such as the continuation of the AKP's political power in Turkey, how its relationship with the capitalist class will evolve, and in what direction the public opinion will strengthen.

5.6. Conclusion

Health reform in Turkey has been a policy implementation essential for both AKP's political success and the commodification and marketization process in health care. The PPP hospitals project started as an idea which the government first put forward in its first years in power and then became a significant part of the transformation in health in the 2010s. PPP projects have been the most visible projects showing the relation between the private sector and the government. We can infer two crucial points after looking at the "state" part of this relation. First, in terms of PPP hospitals, the AKP government did not want to expose these relations. From the very beginning, the concealment of the contract agreements, and therefore the terms of the agreements, has been the main feature of these projects. This hidden information was revealed to a certain extent due to the legal efforts of the TTB during the first years of the project tenders. However, the revealing of details

[89] See: https://www.cumhuriyet.com.tr/haber/tusiaddan-kamulastirma-tepkisi-1768687

over time about the first few hospitals set the stage for the government to deny access to similar information for later projects. With the advantage of the one-party government, AKP had the power to overcome any legal challenges. This advantage also allowed the government to construct the legal basis it needed to move forward in some instances and ignore the opposition in others. Throughout the legal processes, the AKP governments actively eased the capitalist class's way to be involved in the projects. The government's most crucial trump card was its legislative power and state guarantees in the agreements. Fed by its political ambition, the AKP government raised its offers in both legislative changes that became unconstitutional over time and in its guarantees as Turkey became the first country to provide treasury guarantees to relieve the contractor's debt.

Second, in various aspects such as an agenda item in the news, parliamentary debates, or as propaganda platforms in the openings, PPP hospitals have become a serious political propaganda tool for the AKP. The government utilized many parts of the projects as part of a war to fight against all political obstacles against the AKP. The government was proved to be partially successful in bypassing the opposition circles who say hospitals harm the public and public health as the projects were realized in the end. However, the AKP government widened the use of the hospital projects as an agenda to reinstate its power against the opposition in general. Beyond being a propaganda tool for health policies, the hospitals have been a significant part of the AKP's mega projects in economic development along with highways, bridges, and investments in the energy sector. AKP's agenda to respond to the opposition circles has been determined by the assumption that anti-government politics focused on undermining the rapid economic

growth brought by AKP. In this sense, the PPP hospital projects represented the legitimacy concern regarding health policies and related reforms. They were a government plan to serve as a tool to consolidate the power of Erdoğan and the AKP in general.

When looking at the "capital" side in this picture, one should evaluate together the state-capital relationship that PPP hospitals require, as well as the state-capital relationship created by the AKP in its second term. The AKP government, which initially established direct relations with the pro-Islamist fraction without turning its back on the large and established capitalist segment, created a pro-AKP capitalist fraction after the 2010s. These pro-AKP capitalists pioneered in the infrastructure and real estate sector, which also fulfills the economic strategy of the AKP government. We see that politically important projects to the AKP did not specifically go for the pro-Islamist fraction. The fact that TÜSİAD and MÜSİAD did not make any particular statements about PPP hospitals shows that the AKP focuses entirely on its own power in these projects, not on this political separation. At the same time, the size of these projects could not open any space for the medium-sized MÜSİAD capital in the health sector. The weight of CCN and Rönesans Holding in hospital projects shows that TÜSİAD is more representatively involved in these projects.

The fact that the AKP government did not especially try to open up new areas of accumulation for health firms in PPP projects and continued its projects with construction capital fits into the overall picture. In terms of the "capital" side, the fact that the projects

were non-standardized in terms of the medical needs and that the facilities were unnecessarily large in size led the largest private hospital owners to leave the area. After that, all projects fell into the hands of the construction capital, with the only criterion of importance for the actors being to find financing. It is understood that those who completed the projects saved themselves from further financial risks of the projects compared to those who could not deliver the projects to the MoH yet. The most outstanding comfort for the construction capital, the creator of all these complex and controversial public health projects, was that they did not have to be concerned with health issues.

In this picture, it is necessary to ask whether the political plans of the AKP have come true. It does not seem possible to confirm that. Although users' dissatisfaction with the distance of the hospitals from center cities and the employees' dissatisfaction with the working conditions have been cited in some studies, a negative public idea about the user experiences of PPP hospitals has not developed. One reason may be that private sector involvement has not yet had a direct negative consequence for patients. In PPP hospitals, medical treatment is still provided by the public sector, and receiving health services does not constitute a new cost for users. It is clear that the AKP government thought of the PPP hospitals as another element in their monumental architectural arsenal and wanted to finish them quickly to boast of them in campaigns. I suggested that it was not a coincidence that the PPP hospital projects started after the first phase of HTP stagnated both financially and politically. AKP had to continue to show its presence in health, which has been an essential determinant for popular support.

However, the criticism that the state has to pay "rent" for a long time and thus mortgage the state budget for decades has generally become accepted and made the projects suspect. Moreover, the fact that the AKP government decided to abandon the PPP hospitals projects before they could complete all of them is an indication that the projects no longer had potential benefits. On the other hand, while the health sector businessmen remained almost neutral about the projects, AKP's usual private sector partners in the construction sector have been left out. In this sense, the government did not gain a particularly significant advantage to work with the existing contractors of the PPP hospitals. The most visible result may be that AKP maintains its close relationship with Rönesans Holding, but the firm has not taken a close side to AKP politics. It is plausible to conclude that PPP hospital projects, which mean more than obtaining popular support with health policies, mean a sign of eroding power for the AKP because the projects did not produce more public support nor completely fulfilled the promises made to the capitalist class.

CHAPTER 6 CONCLUSION

This dissertation aimed to examine Turkey's AKP-associated health transformation both in its global and national context. One political actor, the governing AKP, is significantly dominant in Turkey's transformation. However, I suggested that a comprehensive picture of the Turkish health care transformation would require a political-economic approach, strengthened by contextualizing the impact of global changes in health policy formation in the country and analyzing country-specific political and economic developments simultaneously. Before starting to study for this dissertation, my preliminary observation was that AKP's PPP hospitals project had become a controversial issue because of private sector involvement compared to the earlier phase of AKP's health transformation project. Therefore, this study had a particular focus on analyzing PPP hospital projects as the latest development of Turkey's health transformation project. However, it started with a broader perspective to capture the multidimensional contexts of the policy formation processes theoretically and practically. The literature review and the following discussions aimed to provide a background for a political-economic approach that will incorporate the complexity of different pressures, actors, and relationships regarding the policy formation processes.

The vastness of the social policy and health policy literature made one of the first questions of this study about how we could provide a framework for health policy transformations in developing countries in global and national contexts. In this sense, after briefly understanding related transformations, I tried to draw the theoretical framework of this study by reviewing the discussions that would be useful for analysis in developing country contexts. When we look at the developments that came with the neoliberal agenda after 1980, the first thing that attracts attention is that the state's involvement in the field of health has not decreased, contrary to expectations. Certain developing countries have interestingly shown a trend of expansion. The rates of public social spending and public spending in health care as a proportion of GDP have increased in countries such as South Korea and Mexico. Although the expansion of public expenditure in these countries, including Turkey, structurally has many differences from the post-1980 neoliberal transformations, it brings to mind the earlier post-WW2 expansion, which was the major development to explain in welfare state discussions. Therefore, it has become essential to revisit the pre-1980 discussions to understand the post-1980 transition.

Among the theoretical approaches to welfare systems before the 1980s, neo-Marxist approaches provide a framework to understand the relationship between the capitalist state and social policies. This approach may also be considered beyond advanced welfare regimes and for the post-1980 transition in countries like Turkey. However, the post-1980 theoretical explanations focus on the countries' structural factors or political-institutional characteristics. The first one has been chiefly applied to advanced welfare regime cases

and sometimes ignores the political forces that act upon policy formation. In contrast, the second, political-institutional approach, has tended to limit the analysis to compare and classify different welfare regimes and emphasized institutional or political failures in establishing a stable welfare regime in developing countries. After critically examining the studies on social policy transformations after 1980, I suggested the following: Social policy formation processes need to be evaluated together with capital accumulation processes and also take into account the motives of different actors. This approach will help us understand social policy transformation as a common result of economic restructuring and the response of the state and political-institutional factors changing with this restructuring.

Mainly informed by neo-Marxist explanations, I concluded that social policies are shaped by several pressures in the post-1980 period, especially for developing countries: The international policy framework, structural needs of the system, legitimation needs of the system, demand of the working class, and the specific capitalist development of the particular country. By looking at this basis created by the Marxist perspective, it is possible to advance more comprehensive interpretations of the social policy formation process. I should note that although I appreciate how significant the pressure created by working-class demands was for similar studies, I could not address it in this study because it requires a more extensive and separate examination. However, I have examined other pressures that emerged with various developments in the global and Turkish context. At the global level, I have defined the Washington Consensus as a social policy paradigm without which we cannot understand and interpret developing country

cases after the 1980s. As complementary paradigms, the Washington Consensus and the post-Washington Consensus dictated together a framework for economic policies first and social policies later for developing countries. The Washington Consensus framework, which was carried out to ensure that the neoliberal economic agenda was implemented worldwide, tried to respond to the problems this economic agenda created after a while by increasing public social expenditure without changing the basic logic. The term also acknowledges different actors, such as transnational and national capital, powerful governments, and international organizations. The changed paradigm also aimed to change the state-business relationship, suggesting or sometimes forcing developing countries to adopt more pro-market but socially expanded policies. Thus, the increasing role of the private sector in health and the expansionist tendencies of the states operate together under the concerned global social policy paradigm.

Washington Consensus organizations have been the implementers of this policy paradigm. WB, IMF, and WTO interventions and indirect impacts concerning health policy outcomes have had mixed results in developing countries. WB, for example, directly proposed a policy approach for developing countries starting in the 1990s. Its focus was on the effectiveness of financing schemes, public-private partnerships, and monitoring the outcomes in the countries receiving WB loans. The IMF's intervention has usually been associated with its adverse effects on governments' health spending because of its fiscal restrictions. The WTO also directed negative consequences for developing countries by initiating trade agreements and patents to benefit transnational pharmaceutical, insurance, and service companies. In sum, the paradigm shift in social

policy and international organizations has changed the state's role in health care services to a more regulatory role and made social policy formation a market-based process. As a result of economic liberalization reforms, the private sector has become a more prominent actor in health systems. Public-private partnerships have become an alternative way to provide health care services.

One common observation in the literature focusing on the transformation in developing countries is that governments and political actors have actively directed reform processes to facilitate the pro-market health system's growth and maintain popular support for themselves. After rethinking the state-capital relationship in this context, I have concluded that there are limitations to understanding state policies only through actors. The need to integrate the legitimacy concerns of governments with the impacts of organized political, economic, and civil society actors in the policy formation scene is one of the most important outputs of the critical literature review I have attempted to undertake for a comprehensive political economy analysis. This implies that case studies should inevitably focus on case-specific developments after examining the effects of policy paradigms and marketization trends.

The need for reform in health services in Turkey has been a matter of debate since the 1990s due to fundamental problems such as the low coverage of health insurance in Turkey and the quantitative and qualitative inadequacy of health services. These discussions and the neoliberal transformation were followed by a transformation in

Turkey, as in many countries, that necessarily overlapped with the international social policy paradigm. The historical trajectory of the changes in Turkey's health care system shows that Turkey followed an internationally orchestrated plan with specific differences in the process of legislative changes and implementations. The most prominent characteristic of the Turkish case has been the uninterrupted phase of the transformation with AKP governments since 2002. Although there was state involvement until WW2 in Turkey that dealt with preventative care, it was insufficient in terms of both institutional and human needs. Until the 1980s, there were efforts to expand this capacity, but health policies remained labor-market attached. After 1980, the Turkish state took quick action to harmonize the laws with the new policy paradigm. The projects that were tried to be carried forward with Washington Consensus organizations, especially the WB, started after 1990. However, these projects could not be sustained consistently due to political crises. With the 2001 economic crisis, the continuation of these projects became even more difficult. In this conjuncture, the AKP government and its rapid intervention in health transformation came. With the Health Transformation Project (HTP), which the government prepared following the Washington Consensus, the necessary institutional changes were implemented much more quickly.

The implementation of HTP has produced outputs that allow us to reach conclusions about the political and economic conjuncture progressed in the process. The first phase of HTP was studied more intensely by scholars interested in Turkey regarding legal changes and political motivations. In the literature where AKP is defined as a prominent actor, health policies have been examined "as a state response to structural needs," "as a set of

populist policies," and "as a sector to implement market-based policies." However, there have been very few evaluations analyzing HTP with its second phase of PPP hospitals. I think it is vital to evaluate how the outputs of the first phase provided a base for the PPP hospitals. By taking a closer look at the official statistics in this literature, I tried to conduct a more detailed analysis of private sector involvement in HTP and the process leading to PPP hospitals, the second phase of HTP. With the same goals, I tried to enrich the evaluations of the outputs of the process with the reports and statements of TÜSİAD, TOBB, and OHSAD, which represent the capitalist class. Thus, I had the opportunity to evaluate the attitude of the capitalist class, which is one of my research questions, during these changes.

According to the expenditure data, the expansion in public social and health expenditures (as a proportion of GDP) in Turkey, seen together with certain developing countries, almost stops after 2008. Although public expenditure has preserved its weight, private sector expenditure, which was decreasing, has started to increase again. It is evident that the increase in public expenditure has reached a level that cannot proceed further and that the spending rates were stabilized. It is also clear that the private sector representatives were satisfied with the first period of the transformation in their evaluations of HTP. However, they started to express conflict points frequently in the later periods. One should acknowledge that it is impossible and not expected that the private sector has always been satisfied with the transformation. TÜSİAD, for example, was unhappy with the absence of an opt-out option in the general health insurance scheme, as it does not provide as much opportunity for private health insurance companies. Another capitalist

group, private hospital owners, showed their unhappiness with the PPP hospital project because these public hospitals reduced their chances to expand more in the health care delivery sector. However, the whole story shows us that business people were optimistic about the transformation, especially in the first years, for their own interest in general, as the most significant contribution of the AKP government was to accelerate the internationally orchestrated process politically and legally in the first phase. The populist character and electoral base of the AKP facilitated all pro-market transformations.

However, the state's hand on spending is slightly weaker than before, as the statistical data show. The more optimistic capitalist circles are starting to voice some "concerns" that the expansion lost its momentum at the beginning of the 2010s. When we consider the fact that the most visible move in terms of health policies after 2010 is PPP hospitals, we can conclude that trying to continue the expansion that has lost momentum for the AKP government in a different direction and the possibility of opening a new investment area in terms of the capital class puts the PPP option forward for both sides. The first phase of the HTP accomplished almost universal coverage, which was advantageous for the private sector in health except for private insurance firms. Particularly for the private hospitals included in SSI coverage, patients covered by the state meant non-risky income. Although the hospitals started to complain about low prices set by the government after a few years, the HTP policies let them expand their shares in the private hospitals market. AKP has not taken significant steps back in order not to harm the universal coverage. It also did not provide substantial opportunities for the private sector in health not to damage public appeal. But it had to continue with the expansion in other ways mainly

because it has to maintain, if not expand, the public approval it created with the first phase. At the same time, the government had to address the increasing complaints of the private sector. Therefore, the initiation of PPP hospitals as the second phase of HTP in terms of timing and differentiation of dominant activity was a recovery option. The projects seemed to promise some possible opportunities to the private sector in health initially, but the opportunity was presented to construction firms that were never actually involved in HTP at the end of the projects. Although it is evident that the complaints of the private sector in health could not be addressed, we see that the sector has not developed any more serious complaints about it later.

Looking at the PPPs in health care in general, we see that although PPP hospitals were established in other countries between 2004 and 2007 and negative consequences were observed, the AKP government insisted on initiating similar projects since the early 2010s. This situation was an opportunity for a new move for both the government and slowing marketization policies. While the HTP has brought substantial changes to the dynamics of the relationship between public and private actors, the public-private partnerships, known as "city hospitals" in Turkey, have further shifted these dynamics. The transformation brought about by the HTP was utilized politically by the AKP government. However, the PPP hospitals turned out to be not cost-efficient projects for the government, and that the private sector had been securitized against all possible risks. In other words, the government was revealed to be subsidizing the private sector of construction companies while dressing the project as a necessary component of health transformation.

Although the PPP hospital project started as an idea that the government first put forward in its first years in power, it became a major part of the transformation in health in the 2010s. PPP projects have been the most visible projects showing the relation between the private sector and the government. The first essential characteristic of this partnership in Turkey is AKP's insistence on concealing the contract agreements, and therefore the terms of the agreements, from the public. This confidential information was revealed to a certain extent due to the legal efforts of the TTB during the first years of the project tenders. However, the revealing of details over time about the first few hospitals set the stage for the government to deny access to similar information for later projects. With the advantage of the one-party government, AKP could overcome any legal challenges. This power also allowed the government to construct the legal basis it needed to move forward in some situations and ignore the opposition in others. The AKP governments actively encouraged the capitalist class to be involved in the projects throughout the legal processes. The government's most crucial trump card was its legislative power and state guarantees in the agreements. Fed by its political ambition, the AKP government raised its offers in legislative changes that became unconstitutional over time and in its guarantees. Turkey became the first country to provide treasury guarantees to relieve the contractors' debt.

Furthermore, in various ways, such as an agenda item in the news, parliamentary debates, or propaganda platforms in the openings, PPP hospitals have become a serious political propaganda tool for AKP. The government appropriated many parts of the projects as

part of a war to fight against all political opposition against the AKP and was proved to be partially successful in bypassing the opponents that argued hospitals are against public interest and do not benefit public health. However, the AKP government widened the use of hospital projects as an agenda to use as a card in its policy debate against the opposition in general. Beyond being a propaganda tool for health policies, hospitals have been a substantial addition to AKP's list of megaprojects in economic development along with highways, bridges, airports, and investments in the energy sector. AKP's agenda to respond to opposition circles has been determined by the presumption that anti-government politics focused on undermining the rapid economic growth brought by AKP. In this sense, the PPP hospital projects were challenged by legitimacy concerns in terms of health policies and related reforms. Still, they survived because they were a government plan to serve as a tool to consolidate the power of Erdoğan and the AKP in general.

When we look at capitalist class involvement, we see that the PPP hospitals do not contradict AKP's prioritization of construction investment in economic growth. However, the party did not realize these projects with the businessmen it has close connections to. The AKP government, which initially established direct relations with the pro-Islamist fraction without turning its back on the large and established capitalist segment, nurtured a pro-AKP capitalist fraction after the 2010s. These pro-AKP capitalists pioneered in construction sector, in the infrastructure and real estate sectors, which also fulfill the economic strategy of the AKP government. However, we see that these politically important PPP projects were not specifically awarded to the pro-Islamist fraction. The

fact that TÜSİAD and MÜSİAD did not make any particular statements about PPP hospitals shows that the particular development of the projects made AKP's focus to remain entirely on enhancing its own power in these projects, not on its partisanship. At the same time, the size of these projects could not open any space for the medium-sized MÜSİAD capital in the health sector. The weight of CCN and Rönesans Holding in hospital projects shows that TÜSİAD was also involved in these projects.

It is unclear if the AKP government sought to open up new accumulation areas for health firms with the PPP projects. It had to continue the projects with construction capital, and this fit into the overall picture. For the private sector, the fact that the projects were nonstandard in terms of medical needs and that the facilities were unnecessarily large led the largest private hospital owners to withdraw from the competition. After that, all projects fell into the hands of the construction firms, with the only criterion of importance for the actors being to find financing. It is understood that those who completed the projects saved themselves from further financial risks of the projects compared to those who could not deliver the projects to the MoH yet. The most outstanding comfort for construction capital, the builder of all these complex and controversial public health projects, was that they were not concerned with health issues.

As a result of my examination, it does not seem possible to confirm that the AKP government necessarily gained strategic political support with these projects. Although users' dissatisfaction with the distance of the hospitals and the employees' dissatisfaction

with the working conditions have been cited in some studies, the criticism that the state has to pay "rent" for a long time and thus mortgage the state budget for decades has been generally accepted. This made the projects suspect in public. Moreover, the fact that the AKP government decided to abandon PPP hospital projects before they could complete all of them is an indication that the projects no longer had potential benefits or that they had lost their legitimacy in the eyes of the public. On the other hand, while the health sector businessmen remained almost neutral about the projects, their usual private sector partners in the construction sector did not receive any contracts. In this sense, the government did not gain a particularly significant advantage in working with specific construction sector actors. The fact that some of the large hospitals have not yet been opened and the tenders of many of them have been canceled shows that potential investors do not see the projects as a good accumulation opportunity. In fact, it is known that the financial crisis and thus the possibility of turning into a loss-making project for its investors continues. Therefore, it is plausible to conclude that PPP hospital projects have become a sign of eroding power for the AKP because they did not produce more public support or fulfill the promises made to the capitalist class.

As a result of this study, I tried to make realistic evaluations, especially considering the different pressures of the PPP hospital process in Turkey. The biggest shortcoming in these evaluations is that I could not evaluate the different cases of PPPs in health care and perform a comparative analysis. This is one of the limitations of this analysis had. However, this limitation also offers an idea for further studies. It seems possible and necessary to produce larger-scale analyses and results in this area by applying a political-

economic perspective to PPP hospitals in other country cases. Inevitably, more detailed evaluations of the financial, political, and social results should be made, especially considering that the projects are no longer implemented. The dimensions of the crisis that emerged with these partnership projects and the methods by which these crises might be overcome are issues that are worth following and studying on in the future.

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