Original Article

Received/Accepted Dates

27.04.2025/11.05.2025

DOI 10.52096/usbd.9.41.07

International Journal of Social Sciences

IJSS

Uluslararası Sosyal Bilimler Dergisi

www.sobider.net e-ISSN: 2548-0685

Cost-Oriented Healthcare Policies From A Political Legitimacy Perspective: A Conceptual Discussion

Lecturer Dr. Mehmet DUYAR

Aydın Adnan Menderes University, Söke Vocational School, mehmet.duyar@adu.edu.tr, ORCID NO: 0000-0001-6699-3920

Lecturer Dr. Burçak ÖNDER

Aydın Adnan Menderes University, Söke Vocational School, burcak.onder@adu.edu.tr, ORCID NO: 0000-0002-4029-095X

Abstract

This study analyzes the structural tension between the pursuit of efficiency and the need for democratic legitimacy in contemporary health policies. Since the neoliberal reforms of the 1980s, health services have been restructured under the logic of New Public Management and market-oriented governance, emphasizing performance, cost-effectiveness, and measurable outputs. However, such reforms have not only reduced health policies to a purely technical domain but also undermined the core components of democratic legitimacy. The study adopts a conceptual analysis approach, drawing on Weber's concept of legal-rational authority, Beetham's three-dimensional model of legitimacy, and Habermas's theory of communicative action to evaluate the political implications of cost-based reforms. The findings reveal that decisions justified solely by cost analyses and performance indicators reduce citizen participation to a symbolic level, complicate accountability chains, and produce a narrow understanding of legitimacy based solely on "output success." In conclusion, the structural conflict between cost-efficiency and democratic legitimacy poses a critical risk to the sustainability of health policies. The study emphasizes the need for new governance models that maintain cost-effectiveness while deepening citizen participation, strengthening accountability, and grounding legitimacy not only in performance but also in normative values.

Keywords: Democratic legitimacy, New Public Management, Governance, Health policies, Cost management

Siyasal Meşruiyet Perspektifinden Maliyet Odaklı Sağlık Politikaları: Kavramsal Bir Tartışma

Özet

Bu çalışma, maliyet odaklı sağlık politikalarının demokratik sistemlerde yarattığı temel gerilimi analiz etmektedir. 1980 sonrası neoliberal reformlarla birlikte sağlık hizmetleri Yeni Kamu İşletmeciliği ve piyasa mantığı çerçevesinde yeniden yapılandırılmış, performans, maliyet etkinliği ve çıktı odaklı yönetim modelleri yaygınlaşmıştır. Ancak bu yönelimler, sağlık hizmetlerini yalnızca teknik bir yönetim alanına indirgemekle kalmamış, aynı zamanda demokratik meşruiyetin kurucu unsurlarını zayıflatmıştır. Çalışma, kavramsal analiz yöntemine dayanmaktadır ve Weber'in yasal-ussal otorite kavrayışı, Beetham'ın üç düzeyli meşruiyet modeli ve Habermas'ın iletişimsel eylem kuramı üzerinden maliyet-temelli reformların siyasal sonuçlarını değerlendirmektedir. Bulgular, sağlık alanında kararların maliyet analizleri ve performans göstergeleriyle gerekçelendirilmesinin vatandaş katılımını simgesel düzeye indirdiğini, hesap verebilirliği karmaşıklaştırdığını ve meşruiyeti yalnızca "çıktı başarısıyla" tanımlayan dar bir anlayış ürettiğini

göstermektedir. Sonuç olarak maliyet-etkinliği arayışı ile demokratik meşruiyet ihtiyacı arasındaki yapısal gerilim, sağlık politikalarının sürdürülebilirliği açısından kritik bir risk üretmektedir. Çalışma, maliyet-etkinliğini korurken yurttaş katılımını derinleştiren, hesap verebilirliği güçlendiren ve meşruiyeti yalnızca performansa değil normatif değerlere de dayandıran yeni yönetişim yaklaşımlarına ihtiyaç olduğunu vurgulamaktadır.

Anahtar Kelimeler: Demokratik meşruiyet, Yeni kamu işletmeciliği, Yönetişim, Sağlık politikaları, Maliyet yönetimi

Introduction

In recent years, the administrative transformation observed in public healthcare services has demonstrated that cost-efficiency and performance-based management approaches have become central to public policy1. This trend not only reshapes the organizational structure of healthcare delivery but also redefines the political meaning of these services and the citizen–state relationship. The rise of cost-oriented reforms in such a fundamental public domain as healthcare necessitates a reconsideration of the relationship between public administration and democratic legitimacy.

Following the crisis of the welfare state model after the 1980s, neoliberal reform strategies sought to align healthcare services with market principles, with the discourse of efficiency, accountability, and sustainability serving as the primary justifying mechanisms for these transformations (Saltman & Figueras, 2004; Navarro, 2007). Within the framework of New Public Management (NPM), performance-based payment models, output-oriented evaluation methods, and institutional structures based on public–private partnerships became widespread (Hood, 1991; Dunleavy & Hood, 1994). However, the political and normative consequences of these technical reforms were often treated as secondary concerns. While cost management was emphasized, the inherently political nature of decision-making processes was largely overlooked.

Yet healthcare policy is not limited to technical and administrative preferences; it also encompasses ethical, social, and political values. Questions such as how and to whom healthcare services are provided, and according to what criteria resources are allocated, are inherently political decisions. The literature on the legitimacy of such decisions typically clusters around two tendencies: on the one hand, structural and technocratic approaches emphasize the managerial efficiency of health

[1] OECD and WHO reports indicate that in recent years, the rise in healthcare expenditures and the pressure for financial sustainability have led to the widespread adoption of performance-oriented reforms in many countries (Saltman & Figueras, 2004).

systems (Gauld, 2009; Saltman et al., 2011), while on the other hand, critical studies question the extent to which these processes align with democratic norms (Flinders, 2002; Beetham, 1991).

This study aligns with the second line of literature and aims to analyze the effects of cost-based healthcare policies on political legitimacy within a theoretical framework. Cost-orientation in health systems is considered not merely a tool to enhance efficiency but also a managerial style that technocratizes decision-making processes and restricts citizen participation. In this regard, Weber's typology of authority and differentiation of rationality, Beetham's three-dimensional model of legitimacy, and Habermas's theory of communicative action provide tools for analyzing the problem of legitimacy in healthcare policy at different levels.

Therefore, technical instruments such as cost management must be evaluated not only as mechanisms for financial efficiency but also as forces that shape political decision-making processes. Strategic planning, budget discipline, and resource allocation mechanisms, while ostensibly designed to control costs, can have a weakening effect on the public character of services, the political agency of citizens, and opportunities for democratic oversight. Cost management must thus be understood not merely as a process of technical optimization but also as an issue of political representation and legitimacy.

The central research question of this study is: How do cost-oriented healthcare policies transform political legitimacy? Addressing this question involves both establishing a theoretical framework and opening the democratic compatibility of healthcare policies to critical discussion. Methodologically, this study employs a conceptual analysis approach, a systematic method used in the social sciences to ensure theoretical clarity, define the content and boundaries of key concepts, and achieve analytical precision. Sartori (1970) emphasized the importance of conceptual sensitivity by addressing the phenomenon of conceptual stretching when concepts are transferred across different contexts. This approach was further developed by Collier and Mahon (1993), who stressed the necessity of using concepts consistently in comparative analyses.

Accordingly, this study examines structural concepts such as governance, performance orientation, and cost-efficiency alongside normative concepts such as political legitimacy, public reasoning, and participation. Conceptual analysis does not only define these concepts but also analytically reveals their interrelationships. This method systematically opens up the central assumption of this study: cost-oriented healthcare policies transform the political legitimacy of public services.

1. The Rise of Cost-Oriented Approaches in Healthcare Policy

Healthcare services occupy a privileged position within public policy because they are non-deferrable, non-substitutable, and cannot be fully commodified (Tengilimoğlu et al., 2018). Demographic shifts, population aging, increasing service demand, and technological advancements have significantly expanded the financial burden of healthcare systems in recent years. Many countries now allocate growing proportions of their GDP to healthcare, placing the search for sustainable financing and efficiency concerns at the center of public policy debates (Ağırbaş, 1999; Bakırer, 2025).

In contemporary health systems, cost management has gone beyond being a mere technical control tool and has become a fundamental element of governance that reshapes institutional structures. Tracking unit costs, output-based evaluation systems, performance-based payment models, and activity-based costing approaches not only influence how healthcare services are delivered but also to whom and under what conditions they are provided (Ağırbaş, 2014; Gizer & Atış, 2022). This transformation moves healthcare policy beyond the boundaries of technical-administrative preferences and constitutes a structural change that directly affects political legitimacy.

Since the second half of the 20th century, the welfare state model has been increasingly questioned, triggering a significant paradigm shift in public policy. Economic recessions, rising public debt, and global competitive pressures fostered the rise of a new managerial paradigm in public administration, emphasizing fiscal discipline, resource efficiency, and accountability. This shift directly affected highly complex and costly service areas such as healthcare, moving public health services away from a social rights-based understanding toward a cost- and performance-centered structure (Saltman & Figueras, 2004:103).

By the 1980s, this transformation became institutionalized through neoliberal reform strategies. Healthcare services were integrated into market mechanisms and managed through measurable outputs. Within this new framework, healthcare ceased to be framed primarily as a social right and was redefined as a service offered to consumers. Service provision was organized through contractual arrangements, co-payment mechanisms, and cost-control measures. The NPM approach accelerated the adoption of private-sector principles—such as performance, outputs, and competition—within the public sector. In healthcare, this shift led to the widespread adoption of

management models prioritizing measurability and cost reduction (Hood, 1991; Dunleavy & Hood, 1994).

While these structures increased technical efficiency, they also obscured the political dimension of healthcare. The success of healthcare services was no longer evaluated in terms of improving population health or reducing inequalities but rather through indicators such as increasing service volume and lowering unit costs (Miller & Rose, 2008:29). As a result, the role of social values and public consent in decision-making diminished, and legitimacy was increasingly substituted by technical performance.

In Turkey, this trend was institutionalized with the Health Transformation Program launched in 2003. Under this program, public hospitals were restructured along managerial lines, co-payments under the General Health Insurance system were increased, and performance-based payment systems were expanded (Atun et al., 2013:72). Particularly, the city hospital model, constructed through public-private partnerships, exemplifies how healthcare services were planned primarily on the basis of cost-effectiveness, while falling short of meeting principles such as transparency, accountability, and democratic oversight (Yeşiltaş, 2020:23). In this framework, the citizen is no longer positioned as a rights-holder but rather reduced to a "service user."

In conclusion, the rise of cost-oriented approaches in healthcare policy represents not just a technical reform process but a transformation of the very political nature of public services. Through seemingly neutral concepts such as efficiency, effectiveness, and performance, legitimacy is being redefined, while democratic participation, representation, and social justice are increasingly marginalized. For this reason, cost management in healthcare should not be understood solely as a financial instrument but must also be approached as a deeply political issue.

2. Governance Approach and Public Health

Since the 1980s, a paradigmatic shift has taken place in the field of public administration, replacing the traditional understanding of public services with a governance model that is multi-actor, flexible, and aligned with market mechanisms. This approach argues that governance is not confined to state-centered structures but is embedded in a broader network in which private sector actors, civil society, and international organizations also play an active role in decision-making

processes (Rhodes, 1997:51). Governance thus legitimizes this multi-actor structure not merely as institutional diversity but by linking it with the ideals of efficiency, effectiveness, and participation associated with New Public Management.

Accelerated by globalization, this transformation has also reshaped the nature of relationships between the state, society, and individuals. Citizens' expectations from the state have increased, along with a growing demand for more active participation in decision-making processes (Ökmen et al., 2004; Çukurçayır, 2003). In this context, governance is defined as a model that approaches administrative activities not solely as the unilateral domain of public authority but as a process of co-regulation, co-production, and co-monitoring involving multiple actors.

Healthcare policies have been directly affected by this administrative transformation. Rising cost pressures, technological advancements, and increasing service expectations have laid the groundwork for a more flexible, multi-actor, and market-oriented governance structure in the health sector. Public-private partnerships, performance-based financing mechanisms, contracted service providers, and digital health management systems have emerged as concrete manifestations of this transformation (Kickbusch & Gleicher, 2012:29–30).

However, this structural transformation has not necessarily enhanced participation and accountability; instead, it has often led to the diffusion of political responsibility, the narrowing of decision-making processes to technical expertise, and the weakening of democratic oversight (Flinders, 2002:296–298). Governance discourse tends to frame political choices as technical necessities, reducing decisions on resource allocation, priority setting, and service planning—matters inherently embedded with public values—into managerial and technical problems (Bevir, 2012:86). Consequently, citizens are removed from being subjects of decision-making and reduced to "service users."

This process reflects what Habermas describes as the decoupling between the "lifeworld" and the "system."[2] In health policies, this disconnection becomes evident as governance frameworks prioritize technical rationality over communicative rationality (Habermas, 1996:320). Healthcare services are reconstructed based on performance indicators and cost calculations, thereby

[2]According to Habermas, the lifeworld is the sphere in which social relations are built upon shared meanings and values, whereas the system refers to a structure dominated by bureaucratic processes and based on technical and economic rationality. The separation between these two spheres can be seen as weakening democratic legitimacy.

redefining political legitimacy not in terms of public consent or normative values but primarily through output performance and cost-effectiveness.

In Turkey, this governance logic became institutionalized through the Health Transformation Program implemented in 2003. The family medicine model, performance-based payment systems, the digital health information infrastructure, and city hospitals illustrate how the Turkish healthcare system has been restructured through governance mechanisms. While the Ministry of Health retains a central role, secondary and tertiary healthcare services are provided through a rational division of labor among public agencies, private sector actors, and voluntary organizations (Yolcu & Erençin, 2008). However, this structure has not fully realized the governance principles frequently emphasized in the literature—namely transparency, accountability, and meaningful participation.

The city hospital model is one of the most prominent examples of this transformation. As the private sector's role in financing and service delivery increased, public oversight weakened, decision-making processes narrowed, and citizens' access to services became more uncertain. Contrary to the democratic deepening promised by governance, legitimacy became increasingly reduced to performance indicators. In this regard, governance has brought about not only an administrative but also a normative rupture in the health sector.

In conclusion, governance has produced a deep transformation in healthcare, both structurally and discursively. The technocratization of political decision-making processes, the formalization rather than deepening of citizen participation, and the substitution of democratic legitimacy with performance-based measurement systems have raised serious concerns about the erosion of democratic values. Therefore, governance is not merely a management model but also a paradigm that redefines the boundaries of political legitimacy.

3. Conceptual Foundations of Political Legitimacy

Political legitimacy goes beyond a government's mere capacity to remain in power; it concerns the normative, social, and communicative foundations upon which that power is constructed. In democratic systems, legitimacy derives not only from legal conformity but also from public acceptance and the establishment of governance in a manner open to scrutiny. Thus, the theoretical

framework of legitimacy is critical both for understanding the nature of authority relations and for questioning how closely public policies align with democratic values.

Max Weber's classic approach explains political legitimacy through three ideal types of authority: traditional, charismatic, and legal-rational. Modern states rely primarily on legal-rational authority, meaning that governance is considered legitimate as long as it operates within rational rules and a legal framework (Weber, 1978:217). However, Weber's approach prioritizes the formal logic of authority over active citizen consent and participation. This makes it insufficient to address the growing demands for accountability and inclusion in contemporary democracies. In complex and multi-actor policy domains such as healthcare, Weberian legitimacy often emphasizes technical necessities and legal frameworks while relegating the formation of social consent to a secondary issue.

David Beetham (1991:20–21) sought to address this gap by conceptualizing legitimacy as a three-dimensional structure:

Normative validity (conformity with laws and shared values),

Justifiability of power (whether governance is morally acceptable and justifiable), and

Expressed consent (observable public support for authority).

This model frames legitimacy as a multi-layered phenomenon constructed not only through legal-rational mechanisms but also through social perceptions, value systems, and political practices. For instance, achieving cost-efficiency in healthcare policy may satisfy normative validity, but if citizens' explicit consent and perceptions of justice are absent, legitimacy can break down in Beetham's second and third dimensions.

Jürgen Habermas (1996:320), however, relocates the discussion to a different plane by grounding legitimacy in communicative reasoning and public deliberation. For Habermas, democratic legitimacy is not secured by the success of governance or the passive consent of citizens but rather by decisions being subjected to open, reasoned public debate. His theory of communicative action treats legitimacy not as the product of governance but as an outcome of the public reasoning process itself. This perspective directly challenges closed and technicalized decision-making processes by centering citizens' critical participation. Dryzek (2000:22–23) expands Habermas's

argument, emphasizing that democratic deliberation must extend beyond representative institutions into governance networks; otherwise, governance risks being reduced to a purely technocratic mode of administration.

These three theoretical approaches converge on the view that legitimacy must be assessed not merely by the existence of authority but also by how it is established, the normative framework within which it operates, and the type of relationship it fosters with the public. However, they differ in the dimensions they prioritize: Weber focuses on formal structures, Beetham highlights social consent and value alignment, while Habermas emphasizes communicative processes. This distinction implies that evaluating the legitimacy of public policies requires looking beyond legal frameworks or outputs to also consider the process and the role of citizens.

These theoretical distinctions become particularly visible in healthcare policy. Cost-oriented and performance-based policies are often justified through technical requirements and rational planning narratives, aligning with a Weberian understanding of legitimacy. However, if such policies fail to resonate with citizens or conflict with shared values, they risk breaking down Beetham's layers of legitimacy. More importantly, when decision-making is confined to narrow technical frameworks and citizen participation is reduced to a symbolic level, Habermas's principle of legitimacy based on public reasoning and deliberation is undermined.

Papadopoulos (2010:1040) notes that in multi-level governance models, while participation may formally increase, genuine accountability and democratic representation tend to decline—a phenomenon that is particularly pronounced in technocratic structures dominating healthcare policy.

Thus, no single theoretical model alone is sufficient to evaluate the legitimacy of healthcare policy. Focusing exclusively on performance or legal conformity is inadequate to capture the democratic quality of governance processes. Instead, legitimacy must be assessed through a combination of criteria, including normative alignment, genuine citizen participation, and communicative legitimacy. Only by doing so can we form a comprehensive understanding of how cost-oriented governance models align—or fail to align—with democratic principles.

4. The Impact of Cost-Oriented Policies on Legitimacy

Cost-orientation in healthcare policy represents not merely an administrative trend but a structural transformation that reshapes its political nature. Reconfiguring service delivery around the goals of efficiency, effectiveness, and cost reduction technocratizes decision-making, producing multi-layered effects on the democratic legitimacy of public services (Saltman & Figueras, 2004:35; Clarke, 2004:30). Governance discourse frames healthcare decisions as technical necessities, reducing inherently political choices—such as resource allocation and priority setting—into managerial problems, thereby narrowing the democratic space for debate (Bevir, 2012:75).

First, cost-oriented healthcare policies overshadow normative demands for quality and equity. Performance-based management models assess success primarily in terms of outputs, while indicators like equitable distribution, accessibility, or patient satisfaction become secondary. Navarro (2007:18) argues that neoliberal healthcare reforms have worsened care quality for disadvantaged groups and deepened health inequalities. For example, performance systems that reward physicians for seeing higher numbers of patients reduce the time available for qualitative care, disproportionately harming the elderly, chronically ill, and rural populations. This directly contradicts Beetham's assertion that legitimacy depends not only on outputs but also on alignment with shared values and public consent (Beetham, 1991:22).

Second, these policies diminish the substantive quality of citizen participation. As healthcare decisions increasingly shift into the realm of technical expertise and cost analysis, societal demands are filtered out rather than incorporated. Papadopoulos (2010:1040) highlights that in multi-level governance models, participation may formally increase, yet genuine accountability often declines. A similar dynamic is evident in healthcare: in Turkey, many reforms—such as the city hospital model under the Health Transformation Program—were implemented based on technical feasibility and investment projections without broad public deliberation. This reduces citizens to mere "users" of services and erodes their role as political subjects.

Third, cost-based systems transform decision-making into a technocratic exercise, reducing political responsibility to bureaucratic accountability. Bevir (2012:80) notes that governance structures reliant on technicalized decision-making obscure political debate and blur chains of responsibility. In healthcare, marketization creates multi-actor governance arrangements that complicate accountability mechanisms. For instance, in public-private partnership projects, when

service delivery fails, citizens often find that their complaints cannot be directed to public authorities but instead must be addressed to private contractors. This undermines classical models of political representation and distances legitimacy from Habermas's (1996:320) notion of communicative publicness.

Fourth, cost-orientation narrows the definition of political legitimacy, reducing it to performance and output success. In democratic systems, legitimacy should include participatory processes, transparency, and alignment with normative values. In cost-centered approaches, however, legitimacy becomes tied to whether services "function" and "become cheaper" (Dryzek, 2000:23). For example, increases in co-payment fees—justified as necessary for financial sustainability—have sparked public backlash, with citizens perceiving such measures as unjust and exclusionary (Türk Tabipler Birliği, 2024). As Habermas's distinction between the system and the lifeworld suggests, when healthcare is dominated by technical rationality, the space for social values and normative discourse becomes constrained.

In sum, cost-oriented healthcare policies have the potential to undermine democratic legitimacy in multiple ways. Legitimacy is not built solely through service delivery but also through how those services are provided, who makes the decisions, and whose interests they serve. When these questions are excluded from the political sphere, even if service efficiency improves, its democratic quality deteriorates. Therefore, evaluating healthcare policies requires looking beyond financial indicators to the multi-layered structure of political legitimacy.

5. Conclusion: The Tension Between Efficiency and Legitimacy

The success of cost-focused health policies is critical in terms of sustainability and effectiveness. These policies aim to increase the accessibility of health services and keep costs under control by ensuring the effective use of resources. However, it should be essential not to compromise on service quality while reducing costs. Therefore, cost-effectiveness analyzes and resource efficiency strategies should be developed and balanced solutions, both economically and socially, should be put forward. In addition, while reducing costs through innovation and technological developments, equal and fair access to society should be observed.

The ethical and social dimensions of cost-oriented policies should not be ignored. Organizing it in line with the principles of public health, equality and access makes it easier for projects to be accepted and ensure their sustainability. Digital health technologies and sustainability principles come to the fore in future predictions. These approaches provide the opportunity to expand access to quality healthcare while reducing costs. The long-term success of cost-focused health policies is possible with effective collaboration, comprehensive data analysis and well-designed policy mechanisms. Steps to be taken within this framework will contribute to the resilience of health systems by maximizing both economic and human benefits.

Cost-orientation in contemporary healthcare policies extends beyond a managerial approach; it profoundly reshapes the very structure of political legitimacy. Reforms developed within the framework of New Public Management and market logic aim to rationalize service delivery, reduce costs, and enhance system efficiency. Yet these same reforms can simultaneously narrow democratic decision-making processes and weaken citizens' political agency (Clarke, 2004:30; Saltman & Figueras, 2004:35). When healthcare services are evaluated solely through measurable outputs such as performance, efficiency, and cost, the fundamental questions of how and on whose behalf these services are designed are pushed to the background. Consequently, the core components of legitimacy—public consent, normative values, and citizen participation—are weakened.

The central tension thus emerges as a structural conflict between the principle of efficiency and the principle of democratic legitimacy. Decision-making in health systems increasingly relies on cost analyses, performance indicators, and technical feasibility studies, aligning with Weber's legal-rational conception of authority (Weber, 1978:217–219). However, Weber's formal understanding of legitimacy falls short in explaining citizens' value judgments, social consent, and normative expectations.

Beetham's (1991:20–22) three-dimensional model of legitimacy offers a more comprehensive lens, highlighting that legitimacy requires not only compliance with rules but also moral justification and explicit public consent. When these dimensions are ignored, the question of how services are provided becomes ambiguous, and citizen participation is reduced to a symbolic form (Papadopoulos, 2010:1040).

Habermas (1996:320) provides further insight by emphasizing that the legitimacy of public policies depends not only on their performance but also on whether decisions are subjected to open, reasoned public deliberation. Cost-based policies, however, marginalize public debate, pulling healthcare into a technocratic domain and reducing citizens to mere "service users" rather than active political subjects (Dryzek, 2000:22). As a result, governance becomes less transparent, accountability becomes dispersed, and the chain of responsibility becomes obscured (Bevir, 2012:77).

This structural trend ultimately transforms the very content of political legitimacy. It becomes defined primarily by whether services "function" rather than whether they are just, participatory, and publicly acceptable. Such a shift poses serious risks for the sustainability of democratic regimes. Legitimacy must not be reduced solely to managerial efficiency but must remain rooted in legal conformity, social acceptance, and open public discourse.

Therefore, aligning healthcare policies with democratic values requires an approach that balances cost-effectiveness with public legitimacy. This necessitates three structural shifts:

Opening policy design to deliberation: The formulation of healthcare policies should not be confined to technical expertise but must include deliberative mechanisms that enable meaningful participation by social actors. Rational planning should be complemented by collectively defined social priorities.

Reconceptualizing accountability: Accountability should not be viewed solely in terms of financial discipline but also in ways that strengthen political representation. In corporatized service models, citizens' access to governance and complaint mechanisms must be guaranteed.

Expanding the criteria of success: Legitimacy in healthcare should be measured not only by outputs but also by the extent to which processes are participatory, fair, and publicly oriented. "Success" must be understood through both economic indicators and citizens' perceptions of justice and consent.

In conclusion, the efficiency–legitimacy tension in healthcare policy is not merely a technical dilemma but a deeply political conflict. Resolving this conflict requires governance approaches that do not exclude either dimension but allow both to be discussed on the same plane. Only when cost-effectiveness is preserved while deepening citizen participation can healthcare policies

remain sustainable without drifting away from democratic legitimacy. Such an approach would not only improve the quality of services but also strengthen public consent and political stability. Future research should further explore the empirical dimensions of this tension, using comparative analyses across different countries to identify the conditions under which legitimacy can be strengthened.

References

Ağırbaş, İ. (1999). *Sağlık hizmetlerinde ekonomik değerlendirme teknikleri ve TCDD Ankara hastanesinde prostat vakalarının incelenmesi yoluyla maliyet etkililik analizi uygulaması*. Doktora tezi, Hacettepe Üniversitesi Sağlık Bilimleri Enstitüsü, Ankara.

Ağırbaş, İ. (2014). *Sağlık Kurumlarında Finansal Yönetim ve Maliyet Analizi*. Siyasal Kitabevi, Ankara.

Atun, R., Aydın, S., Chakraborty, S., Sumer, S., Aran, M., Gürol, I., … & Akdağ, R. (2013). Universal health coverage in Turkey: Enhancement of equity. *The Lancet*, 382, 65–99. http://dx.doi.org/10.1016/S0140-6736(13)61051-X

Beetham, D. (1991). *The legitimation of power*. London: Macmillan.

Bevir, M. (2012). *Governance: A very short introduction*. Oxford: Oxford University Press.

Clarke, J. (2004). Dissolving the public realm? The logics and limits of neo-liberalism. *Journal of Social Policy*, 33(1), 27–48. https://doi.org/10.1017/S0047279403007244

Collier, D., & Mahon, J. (1993). Conceptual "stretching" revisited: Adapting categories in comparative analysis. *American Political Science Review*, 87(4), 845–855. https://doi.org/10.2307/2938818

Çukurçayır, M. (2003). *Bölgesel Kalkınma ve Bölgesel Yönetişim*. Çizgi Kitabevi, 617-643

Dryzek, J. S. (2002). *Deliberative democracy and beyond: Liberals, critics, contestations*. Oxford: Oxford University Press.

Dunleavy, P., & Hood, C. (1994). From old public administration to new public management. *Public Money & Management*, 14(3), 9–16. http://dx.doi.org/10.1080/09540969409387823

Erençin A. & Yolcu Y. (2008), *Türkiye'de Sağlık Hizmetlerinin Dönüşümü ve Yerinden Yönetimi, Memleket*. Siyaset, Yönetim, 118-136

Flinders, M. (2002). Governance in Whitehall. *Public Administration*, 80(2), 301–322.

Gauld, R. (2009). *The New Health Policy*. Maidenhead: Open University Press.

Gizer, M., & Atış, E. (2022). Sağlık İşletmeciliğinde Maliyet ve Yönetim Muhasebesi Sisteminin Oluşturulması: Bir Hastane Uygulaması. *Akdeniz İİBF Dergisi*, 22 (1), 84-101.

Habermas, J. (1996). *Between facts and norms: Contributions to a discourse theory of law and democracy*. Cambridge, MA: MIT Press.

Hood, C. (1991). A public management for all seasons? *Public Administration*, 69(1),3-19. https://doi.org/10.1111/j.1467-9299.1991.tb00779.x

Kickbusch, I., & Gleicher, D. (2012*). Governance for health in the 21st century*. Copenhagen: WHO Regional Office for Europe.

Miller, P., & Rose, N. (2008). *Governing the present: Administering economic, social and personal life*. Cambridge: Polity Press.

Navarro, V. (2007). *Neoliberalism, globalization and inequalities: Consequences for health and quality of life.* Amityville, NY: Baywood Publishing.

Ökmen, M., vd. (2004). *Kamu Hizmetinde Yeni Yaklaşımlar ve Yönetişim Faktörü Olarak Yerel Yönetimler*. Gazi Kitabevi, Ankara

Papadopoulos, Y. (2010). Accountability and multi-level governance: More accountability, less democracy? *West European Politics*, 33(5), 1030–1049. http://dx.doi.org/10.1080/01402382.2010.486126

Rhodes, R. A. W. (1997). *Understanding governance: Policy networks, governance, reflexivity and accountability*. Buckingham: Open University Press.

Saltman, R. B., & Figueras, J. (2004). *The future of public health care systems*. Copenhagen: WHO Regional Office for Europe.

Saltman, R. B., Busse, R., & Figueras, J. (2011). *Social health insurance systems in western Europe*. Maidenhead: Open University Press.

Sartori, G. (1970). Concept misformation in comparative politics. *American Political Science Review*, 64(4), 1033–1053.

Tengilimoğlu, D., Akbolat, M., Işık, O. (2018). *Sağlık İşletmeleri Yönetimi*. Nobel Akademik Yayıncılık, Ankara.

Türk Tabipleri Birliği. (2024, Şubat). *TTB'nin açıklaması sonrası SGK'nin muayene katılım paylarına yaptığı zam oranları kısmen düşürüldü.* Erişim adresi: https://www.ttb.org.tr/haber_goster.php?Guid=188ba48c-f28d-11ef-bf77-918e15bc730a

Weber, M. (1978). *Economy and society: An outline of interpretive sociology*. Berkeley: University of California Press.

Yeşiltaş, A. (2020). Sağlık sektöründe kamu özel ortaklığı: Şehir hastaneleri üzerine bir değerlendirme. *Uluslararası Sağlık Yönetimi ve Stratejileri Dergisi*, 6(1), 15-28.