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Public Private Partnerships and universal healthcare in Latin America – at what cost?

Executive summary

At the heart of the Sustainable Development Goals is an international commitment to Universal Health Coverage (UHC). This responds to the urgent need to address a crucial problem: at least half of the world's population still lacks access to essential health services, and affordability remains a key reason for that.

Public private partnerships (PPPs) are increasingly being promoted as a way to tackle these issues by financing the health sector, both at the global level and across Latin America. This is happening against a backdrop of health systems that were reformed as a result of neoliberal policies and the influence of international financial institutions including the World Bank.

This briefing takes a critical look at the rise of PPPs in the health sector in Latin America as a tool to achieve UHC, by drawing on the global evidence on PPPs in the health sector. The case of Peru is used to illustrate wider trends across the region with the aim of informing civil society debate on the issue in Latin America and globally.

We find that there is weak evidence that health PPPs are able to address the challenges that most Latin American countries face to deliver on UHC, including fragmentation and inequalities within the health system. In fact, the reliance on heath PPPs risks undermining progress on UHC altogether.

On the basis of the global evidence on PPPs in the health sector, this briefing raises three issues to be considered before promoting health PPPs further in Latin America:

1. **Health PPPs can be an expensive and risky business.**
2. **There is no empirical evidence to claim that health PPPs deliver positive development outcomes.**
3. **Health PPPs can have negative impacts on the wider health system and on democratic governance.**

We call on international financial institutions and their member governments to stop the ideologically driven promotion of PPPs in the health sector, in Latin America and globally. If they genuinely want to improve access to healthcare and its quality, the focus should be placed on national health systems, as they can be a tool for addressing social inequality and exclusion. An increasing role of the private sector in the provision of healthcare risks undermining social goals in favour of private profits.

As Latin America is one of the regions in the world with the highest levels of inequality, the ability of health PPPs to reduce inequalities needs to be carefully considered. Latin American governments should learn lessons from the international experience with health PPPs and avoid 'buying a model' that is questionable in its ability to deliver in the public interest. It is critical to identify alternatives to health PPPs: increasing public finance for health is key to making progress on UHC.

Introduction

In 2015, world leaders agreed on the Agenda 2030 for Sustainable Development at the United Nations,[1] which includes a commitment on health with Universal Health Coverage (UHC) at the core. According to the World Health Organization (WHO), this means making sure all individuals receive the quality health services they need without suffering financial hardship.[2] Delivering on UHC, therefore, means taking steps towards equality, development priorities and social inclusion.

The commitment on UHC refers to the urgent need to address a crucial problem: at least half of the world's population still lacks access to essential health services, and affordability remains a key reason for that.[3] However, it has further intensified different interpretations about how the provision of healthcare will be delivered and financed. The most dominant policy paradigm has placed private finance at the heart of financing for development, and includes public private partnerships (PPPs) as a key tool to deliver on the Sustainable Development Goals (SDGs), including SDG3 on health[4].

PPPs have been implemented in infrastructure and the health sector since the early 1990s. However, there is not a universally agreed definition of the term 'public private partnership'. The word *partnership* has become both a development buzzword, which speaks to "an agenda for transforming development's relationships", and a *fuzzword*, as it obfuscates the resource transfers that take place.[5] The acronym *PPP* is used to describe the engagement between public and private actors (for-profit as well as non-profit). It identifies very different types of arrangements, particularly in the health sector.

Box 1: Types of health PPPs

Generally, health PPPs involve three different types of arrangements:

1. **Multi-stakeholder initiatives** that are based on the pooling of different resources and skills of the different actors involved. An example is the Global Alliance for Vaccine and Immunization (Gavi, The Vaccine Alliance), which is committed to increasing access to immunisation in poor countries.
2. **Formal and long-term contractual arrangements** in which the private sector participates in the financing and supply of infrastructure assets and services, for instance, hospital and healthcare.
3. **Demand and supply-side health policies**, such as voucher and franchising schemes, which are designed either to stimulate demand for a specific health service or to organise for-profit health practitioners to provide socially beneficial services.

Although there is a need for a comprehensive analysis that includes all types of health PPPs, in this briefing we have chosen to analyse the 'contractual arrangement' PPP (number 2 in Box 1), as it connects the public sector with a private sector company through a long-term contract for the provision of a service or the delivery of an asset. In this case, this relates to services or assets that are key to guaranteeing the right to health, which has been recognised by the International Covenant on Economic, Social and Cultural Rights, among other human rights treaties.[6]

In the last decade there has been a dramatic upscaling of the global promotion of (contractual arrangement) health PPPs.[7] PPPs are supported, and in some cases directly promoted, by a wide range of actors, including the World Bank and key governments from the global north. This promotion has resulted in different platforms, donor facilities and initiatives to enable PPPs to flourish.[8] This is happening in spite of ambiguous (and often negative) evidence regarding the effectiveness, cost and equity implications of PPPs.[9]

Latin America has historically attracted a great deal of private investment. PPP projects have traditionally focused on physical infrastructure: transportation, telecommunications and energy. In the last decade, however, many countries in the region have started to use PPPs to address social infrastructure needs, including healthcare.[10] Most countries in the region have passed specific laws to regulate PPPs[11] and have included PPPs in national development and sectoral plans. In the health sector, the emerging role of PPPs has to be placed in the context of health systems that went through a reform process heavily influenced by the Washington Consensus, driven by international financial institutions – which emphasised the liberalisation of the health sector and the contraction of the public health system.[12]

This briefing takes a critical look at the rise of PPPs in the health sector in Latin America as a tool to achieve UHC, by drawing on the global evidence on PPPs. It focuses on the case of Peru as an example of wider trends across the region. In Peru, health PPPs are high up the national political agenda and the health system presents specific challenges in terms of achieving UHC.

The current briefing analyses the rise of PPPs through three steps. First, it analyses where health PPPs fit in Latin American health systems; second, it exposes the actors behind the promotion of health PPPs in Latin America; and third, it presents key issues relating to cost-effectiveness, equity and governance. The literature on health PPPs in Latin America is still emerging and has not been systematically analysed yet, which points to the need to stimulate the debate and to learn from global experiences.

We build on existing work by Eurodad and LATINDAD on PPPs, which includes collaboration with civil society organisations (CSOs) and scholars from both the global north and south, and the launch of a PPP *Campaign Manifesto* in October 2017.[13] A multi-stakeholder workshop on health PPPs took place in Lima, Peru, in early July 2019 where points raised in this briefing were discussed. The aim of this briefing is to inform a civil society debate on the issue in Latin America and globally.

The emerging role of PPPs in the health sector – both in Latin America and elsewhere – needs to be seen in the broader context of a changing landscape of development finance over the past two decades. Globalisation trends have resulted in increasing health service commercialisation, both within countries and in international markets. However, critics have repeatedly raised concerns in relation to the lack of evidence in support of the links between commercialisation and improved health outcomes.[14] Four key features are worth highlighting with regards to current trends in health. First, the health arena has become increasingly dominated by an emphasis on evidence-based medicine and the imperatives of health economics.[15] Second, there has been a shift from the public provision of social services to an increased reliance on the activities and resources of the private sector to deliver on healthcare. Third, different actors have increased their relevance in global health governance, including philanthropic foundations.[16] Fourth, in recent years new mechanisms to raise and disburse finance have emerged in the field of health, which has contributed to the financialisation of the health sector.[17]

Somewhat paradoxically, the financial and economic crisis of 2007-2008 resulted in an increased focus on private finance in development. This may be driven by the mass of wealth in the hands of investors seeking stable and profitable investment opportunities, including in the health sector.[18]

This report is organised as follows:

Chapter 2 presents a brief account of the key trends in health systems in Latin America, which is key to understanding the context in which PPPs have emerged in the region. In addition, it analyses the rise of health PPPs in Latin America, with a particular focus on the key players and driving forces.

Chapter 3 summarises the main challenges arising from health PPPs globally.

The final section raises key issues and presents some concrete policy recommendations.

An increased role of the private sector in the provision of healthcare risks undermining social goals in favour of private profits

2. Health systems in Latin America: from structural adjustment to the rise of PPPs

Following global trends in health, most Latin American health systems have experienced substantial changes with important impacts on health outcomes.[19] The emerging role of PPPs has to be placed in the context of health systems that went through a reform process emphasising the liberalisation of the health sector and the contraction of the public health system.[20] This section presents the recent trajectories of health systems in Latin America and looks at the problems that PPPs are supposed to solve. Even though Latin America is a very diverse region, the case of Peru – where health PPPs are high up on the political agenda – is used to illustrate wider trends identified across the continent.

2.1 Main features of Latin American health systems

In Latin America, most national health systems were transformed under the influence of the Washington Consensus, driven by international financial institutions.[21] The neoliberal policies implemented in the region through structural adjustment programmes provided by the International Monetary Fund (IMF) and World Bank (WB) entailed the reduction and privatisation of state social services and safety nets, the expansive opening of national economies to foreign trade and investment, and the overall promotion of the market and its logic over a state-based social contract.

In the health sector, neoliberal policies were promoted by international agencies and governments from the global north, with the active support or uncritical acceptance of developing country governments. They set in motion a process of reform that included the provision of health services through a 'mix' of public, private and voluntary providers; the contraction and decentralisation of healthcare services and programmes; an increased precariousness of health professionals' terms of labour; an emphasis on management efficiency; and the growing prominence of private insurance and other forms of public private partnerships.[22] In practice, these policies aggravated the commodification and privatisation of healthcare,[23] resulting in many families suffering from "catastrophic spending on health". According to the WB and WHO, this is defined as out-of-pocket spending (without reimbursement by a third party) exceeding a household's ability to pay.[24] According to a report published by the WB and WHO in 2017, Latin America was the region with the highest incidence of people with out-of-pocket expenditures exceeding 10 per cent of household total consumption or income (14.8 per cent), a rate that was double that of Europe during the same period (7.2 per cent).[25] Critics have also argued that the costs of structural adjustment policies in the health sector were high, resulting in the return of previously eradicated infectious diseases, such as cholera, and the spread of new diseases, including HIV, alongside an increase in chronic diseases including diabetes and hypertension.[26]

Although Latin America is a very diverse continent and different countries experienced structural adjustment policies in a different way,[27] the penetration of the neoliberal model was specifically facilitated by a series of regional factors. These include the debt crisis, the end of the region's post-war model of development of import substitution industrialisation, as well as a wave of military dictatorships in place across the region from the 1950s to the 1980s.[28] In addition, the presence of a large middle class has encouraged foreign investment in the social security systems that provided healthcare insurance.[29] Historically many of the health systems across the region have evolved out of a series of social security funds that were established for formal sector workers.[30] As a result, health systems in Latin America are characterised by segmentation and fragmentation – a combination that has important implications for its outcomes. According to the Pan American Health Organization (PAHO), both features "give rise to inequities and inefficiencies that compromise universal access, quality, and financing".[31]

Over subsequent decades, centre-left and left-wing parties came into power in most countries across the region with a platform that was opposed to neoliberal policies. Some of the new governments promoted a wave of health sector reforms with the objective of expanding access and coverage,[32] for instance, in Bolivia, Ecuador, Nicaragua, Uruguay and Venezuela. In addition, the continent experienced a decade of economic growth as a result of the high prices of commodities exported by countries from the region.[33] This resulted in an increase in public expenditure on health. Although the PAHO reports that there was "a slight increase in public expenditure, together with a slight decrease in out-of-pocket expenditure" [34] from 1995-2014, the inability to pay for health services still represents a significant challenge in Latin America, which undermines progress towards UHC. According to the PAHO, most Latin American countries still suffer from "lack of universality and equity in access to quality services and appropriate coverage, which entails a substantial social cost and impoverishes the more vulnerable population groups".[35] Indeed, in the case of Peru, research suggests that, in the absence of a fully functioning social insurance programme, low-income households can be hard hit by catastrophic healthcare spending. Over the longer term this may divert resources intended for education costs to cover the shortfall, thus raising concerns about inter-generational transfers of poverty.[36]

2.2 The rise of health PPPs in Latin America

PPPs allow for an increased role of private sector actors in the health sector. They are increasingly being promoted as a way of achieving UHC in Latin America, as they are portrayed as tools to repair, rehabilitate, build and manage priority health facilities. This is happening in a context where countries spend the bulk of their health budget on hospitals, and there is a deficit of public investment in healthcare. A wide range of actors – including multilateral and regional financial institutions, governments from the global north and corporate bodies – are supporting, and in some cases directly promoting, health PPPs in the region. These institutions have developed a narrative in support of health PPPs, and have played a leading role advising governments on how to reform their national health systems to allow for PPPs.

The World Bank Group (WBG) has played a very influential role in driving forward the PPP agenda in the health sector in Latin America (and globally), with other institutions like the Inter-American Development Bank (IADB) following the same path. This happens through the WBG's lending to public and private sector actors, the production of 'knowledge products' and diagnostic and benchmarking tools. Over the years the WB has published several working papers and strategies on health. The 1993 *World Development Report* (WDR) entitled 'Investing in Health'[37] was entirely dedicated to health, resulting in increased legitimacy of the institution in the health sector. However, the report has been extensively criticised "for lacking a strong evidence base, and for promoting privatisation" of healthcare.[38] The ideas included in the 1993 report are still present in the 2013 report *Global Health 2035: A World Converging within a Generation*,[39] published by the prestigious medical journal, *The Lancet*. The report was produced by the Lancet Commission on Investing in Health, created to build on the legacy of the WDR 1993, and led by two economists who had been actively involved in the work of the WB. This Commission advocated the importance of private finance to increase health coverage, yet no acknowledgement was given to the central role of the public sector in producing good health indicators.[40]

In 2017, the WBG launched two initiatives that might have significant implications for health policies in Latin America and globally. First, it launched the 'cascade' approach, now officially known as Maximising Finance for Development (MFD), which systematises WBG's efforts in support of the expansion of private finance in infrastructure, including in social sectors. According to the 'cascade' principles, the WB "first seeks to mobilise commercial finance" and "only where market solutions are not possible through sector reform and risk mitigation would official and public resources be applied".[41] This means that the WB pursues a "private finance first" approach to development finance, as it prioritises the use of private finance over public or concessional finance.

To implement this approach, the WBG will focus on "enabling policy and regulatory environments and on de-risking the private sector's entry into these environments",[42] which can have significant implications for the projects that are prioritised. According to the WB, the MFD "is currently focused on infrastructure but will be expanded to… education and health".[43] Importantly, the MFD is being supported by specific diagnostic tools, such as the Country Private Sector Diagnostic (CPSD), which "takes an investor perspective in reviewing all economic sectors to identify opportunities for action to spur private sector-led growth".[44] Second, the WB launched the Human Capital Project,[45] which quantifies how much governments are spending on human capital in a bid to spur government investments in health (and education). However, CSOs have raised concerns in relation to framing health funding as a capital investment, given that UHC is rooted in equitable access to health services, which calls for a human-rights based approach to health financing.[46]

In Latin America, the WBG has approved several loans to reform the health sector and has financed health PPP projects through its private sector arm, the International Finance Corporation (IFC), including in Brazil and Mexico. The IADB has recently increased its lending capacity to support health PPP projects, which follows its active engagement in physical infrastructure.[47] In Peru, the WB has approved several policy loans to reform the Peruvian health sector and PPP laws.[48] In 2015, the IADB approved a loan to strengthen the capacity of the country to implement health PPPs[49] (see Box 2).

In addition, over the years bilateral relations between Latin American countries and key governments from the global north have also contributed to expanding the business of healthcare through PPPs. In the case of the UK, a report from the Public Services International Research Unit (PSIRU) published in 2016 noted that Colombia, Mexico and Peru were on the list of "new markets" for Healthcare UK, which was created in 2013 as part of the Department of Health and Social Care and the Department for International Trade.[50] The focus on Latin America has continued and in a recent Healthcare UK annual review, Brazil, Chile, Mexico, Colombia and Peru are on the list of "priority markets" for the period April 2017 to March 2018.[51] To deliver on this goal, several business missions participated in events with the support of embassies in both the UK and in Latin America to showcase expertise and business opportunities.[52] This is happening in spite of increasing criticism of the UK's PPP,[53] including by the UK's National Audit Office,[54] and its formal abandonment in October 2018. On the other hand, a similar picture can be painted in the case of the Netherlands, which has been an active player in the promotion of health PPPs.[55]

The Netherlands has had a constant presence in Brazil and in Colombia with the support of Dutch embassies and the Netherlands Enterprise Agency.[56] Importantly, these are the same governments that hold significant power at the WBG – due to its shareholding structure. They have worked with their national development finance institutions – the UK's CDC and the Netherlands Development Finance Company (FMO) – to support private sector companies to engage in health PPP projects in Latin America and globally.[57] In practice, the promotion of health PPPs worldwide has laid the basis for UK and Dutch companies and consultancies to win contracts in developing countries.[58]

Official agencies have not been alone in the promotion of health PPPs. Global consultancy firms – such as PwC, Deloitte, KPMG and Ernst & Young – act as enablers and advisors for health PPPs in Latin America and globally. They have developed highly profitable lines of business, making profits through fees from legal and consultancy work commissioned by both public and private sector clients, and have actively shaped national policies in health through reviews of policies, legal frameworks and practices for PPPs rivalling the efforts of public bodies.[59] They have also produced several reports that highlight the market opportunities for healthcare across the developing world. A 2015 report by PwC focuses on the market for health PPPs in Latin America, with cases studies from Chile, Colombia, Honduras, Mexico and Peru.[60]

Box 2: The health system in Peru and the rise of PPPs

In 2013, the Peruvian government initiated a reform of the health system with the goal of recognising the right to health for all as set out in the Peruvian constitution. The reform led to an increase in population health coverage from 64 per cent to 73 per cent. Additionally, since 2015 newborns without access to any other protection mechanism, have been affiliated to the Integral Health Insurance (SIS, to use its Spanish acronym).[61] In addition, there has been an increase of health financing, although the country continues to be below the regional average in this respect.[62] However, the Peruvian health system has different features that undermine progress towards the government's commitment to achieving UHC by 2021.

Four key points characterise the Peruvian health system:

1. **It is segmented and fragmented**. The Ministry of Health (MINSA, to use its Spanish acronym) provides health services for 60 per cent of the population; EsSalud (Social Health Insurance) serves 30 per cent of the population and is obtained through formal employment; the Armed Forces (FFAA), National Police (PNP, to use its Spanish acronym) and the private sector together cover the remaining 10 per cent. The public system serves the poor and the social security systems serve the formal workers of the upper and middle classes.
2. **It is highly gendered and racialised** with poor, indigenous women primarily concentrated in the SIS, and mestizo and 'whiter' men located in the social security systems.[63]
3. **It suffers from high levels of inequality**, where gender, race, class, age and locality shape individual access to the system.[64] In addition, the lack of culturally appropriate healthcare services has resulted in the continued marginalisation of indigenous communities from healthcare services.[65] Many low-income users rely on out-of-pocket expenditure, buying medications directly from local pharmacies rather than using healthcare services.[66]
4. **It is characterised by lack of resources**, including human resources, limited equipment and significant urban-rural divide.[67] Public hospitals and health clinics are heavily concentrated in urban areas,[68] and rural services continue to experience a lack of financial investment, poor infrastructure and equipment, as well as providing poor quality care.[69]

PPPs have been used as a central tool to promote private investment in various sectors since the 1990s and are currently high up on the political agenda. In the last decade, the national regulatory framework has been reformed to enable PPPs,70 including in healthcare, with critics pointing to weak spots in terms of state capacity to evaluate the cost and benefits of projects, and to monitor its fiscal risks.[71]

In 2018, the Peruvian government announced a National Plan on Competitiveness and Productivity 2019-2030,[72] alongside a National Plan on Infrastructure for Competitiveness.[73] Both plans stress the need to increase social and economic infrastructure and to use health PPPs as a relevant tool. In addition, the Ministry of Health also released a Multiannual Report of Investment in PPPs in health 2019-2021, which includes seven hospitals and five healthcare specialised institutions to be managed and operated by the private sector.[74]

Interestingly, this coincides with calls included in a document entitled 'Country Agenda'[75] also released in 2018 by the National Confederation of Private Business Institutions (CONFIEP, to use its Spanish acronym), which seeks an enabling environment for doing business in the sector. These plans have been contested by a growing group of national CSOs, including ForoSalud and the National Group on Public Budget.

As of August 2019, two PPP hospitals are in operation;[76] both are run by EsSalud[77] (Hospital Alberto Leopoldo Barton Thompson and Hospital Guillermo Kaelin de la Fuente), and both involve the building and clinical operation of new hospitals. Additionally, according to ProInversión – the Peruvian Private Investment Promotion Agency – five further PPP hospitals are under negotiation and two other projects are in the pipeline.[78]

3. Can health PPPs deliver UHC in Latin America?

There is considerable controversy surrounding the perceived benefits and costs of health PPPs around the world. While advocates claim they offer finance, efficiency and innovation, a critical analysis of the empirical evidence reveals a different picture. This section presents the theoretical arguments in support of health PPPs and analyses the global evidence on PPPs in the health sector. Given the promotion of health PPPs in Latin America as a way of delivering UHC, it is important to assess whether the theoretical claims in support of PPPs have materialised, and to draw lessons for the still-emerging debate on health PPPs in Latin America. Although the term UHC is a contested term,[79] we argue that this is about expanding coverage by reaching the most vulnerable, and delivering quality health services without creating financial hardship.

3.1 Health PPPs in theory

The changing landscape of development and health finance has given rise to a particular narrative in support of health PPPs. The potential benefits of health PPPs refer to three main points. First, it is the ability of PPPs to raise finance that would help to fill the health financing gap, including by requiring less government resources to carry out pre-project studies. Second, it is the ability of PPPs to improve cost-effectiveness in public health systems, which are under pressure to expand access due to demographic changes. And third, it is the fact that PPPs increase efficiency through encouraging innovation.[80] In parallel, there are claims that emphasise the lack of capacity of the state to deliver healthcare in an efficient way, which are reinforced by austerity policies that have reduced public investment in social sectors, thus dismantling state capacity to deliver social services. In turn, this has further helped to support the belief that the private sector is more efficient in delivering services than the public sector, which does not translate to all contexts.[81] Efficiency claims also relate to managerial assumptions that emphasise private sector techniques and market competition.[82]

Interestingly, most of these arguments often replicate the points in favour of greater private participation in the provision of services, without considering the specific aspects of the health sector. There are several theoretical reasons why health PPPs are different from other PPPs.[83] For instance, hospital PPPs typically receive nearly all of their income from government in the form of scheduled payments during the lifespan of the contract; the outputs in healthcare cannot easily be measured or ascribed to the governance arrangements of provision; the variability of outputs over time as demographic and epidemiological features alter during the lifespan of a PPP contract; and the variability and unpredictability of technology and organisational configurations over time, including those of inpatient-outpatient mix or the necessary duration of stay for a particular medical intervention.

According to health specialists Montagu and Harding, these issues raise difficulties for contract specification, management and monitoring and imply that the "benefits to government that accrue from private participation in finance and facility provision are often less predictable in hospital PPPs than infrastructure PPPs".[84]

3.2 Health PPPs in practice

This section analyses the empirical literature on health PPPs around three main issues:

A. Cost-effectiveness and risky transfers in health PPPs

B. Development outcomes

C. Impacts of health PPPs on the wider health system and on democratic governance.

A. The costs and risks of health PPPs

The empirical literature on health PPPs across the globe warns against the high costs of PPPs to governments, and thus to citizens, and the fact that PPPs are a risky financing mechanism. While the literature on countries from the global north have clearly exposed these concerns,[85] there is little evidence available from countries in the global south, due to lack of data.

The evidence shows that health projects run as PPPs have been more expensive than they would have been if procured using traditional procurement methods. The costs of health PPPs come from at least three sources. First, research shows that the cost of financing a project (i.e. a hospital) is usually more expensive in PPPs than in public sector works, as national governments can usually borrow money at lower interest rates than private sector companies, because they are perceived to have a lower risk of defaulting on loans.[86] Second, private sector companies are generally expected to make a profit on their investment, which has to be added to the overall cost of the project. In the case of developing countries, the returns required by investors are higher than in developed countries, due to higher perceived risks. Third, there are high transaction costs associated with the negotiation of complex PPP contracts that benefit consultancy firms. For instance, as the *Financial Times* reported in 2011, "lawyers, financial and other consultants have earned a minimum of £2.8bn and more likely well over £4bn in fees over the past decade" to implement the 700 projects that successive governments acquired under the Private Finance Initiative (PFI) scheme – a form of PPP used in the UK.[87] Moreover, health PPP contracts can even include tax benefits for the private partner, thus contributing to a race to the bottom in tax rates.

Two recent cases have added to the pool of evidence: the Queen Mamohato PPP hospital in Lesotho and the Nya Karolinska Solna (NKS) hospital in Sweden. Both cases show how expensive and risky PPP hospitals can be. On the one hand, Oxfam's work on the Queen Mamohato PPP hospital in Lesotho – for which the government received support from the World Bank Group – has exposed how the initial cost of the project escalated, and ended up consuming more than half of the national health budget.[88] In that case, factors contributing to cost escalation included changes in output specification and poor forecasting. For instance, some costs were overlooked or underestimated, such as out-patient pharmacy, monitoring costs or patient referrals. Despite these problems, the PPP model is being heavily promoted across African countries as the relevant solution to the shortfall of resources (see, for instance, the case of Uganda[89]).

On the other hand, the work of journalists has been key in terms of exposing the problems of the NKS hospital in Sweden. The total construction cost of the NKS hospital increased from €1.4 billion to €2.4 billion. The main reason for the increase in costs is that the initial estimate did not include all the outsourced costs for vital services such as IT cables, lab and medical-technical equipment. As a recent academic paper on the NKS hospital states, "experience from research in different disciplines, as well as in construction and health-care practice, could have been used to scrutinise vague promises of innovation, quality and cost control put forward by private interest groups (as the consultants)".[90] These projects were implemented both in a low-income and a high-income country, thus the argument that these problems resulted from the lack of capacity of developing country governments to negotiate PPP contracts is not robust, and has to be understood as part of the structural problems of the PPP model.

Importantly, the International Monetary Fund (IMF) has also raised concerns regarding the fiscal risks of PPPs. A 2018 *How to Notes* published by the IMF's Fiscal Affairs Department (FAD) argues that "the fiscal risks from PPPs are sizeable". For instance, "a survey of 80 advanced and emerging market economies showed that the average fiscal cost of PPP-related contingent liabilities that crystallized during 1990–2014 was about 1.2 percent of GDP, while the maximum cost was 2 percent of GDP".[91] As such, the fiscal risks of PPPs can undermine the financial sustainability of the whole national budget.

Furthermore, the ability of PPPs to transfer risks from the public to the private sector is a key myth that needs to be exposed. Two crucial points make health PPPs a very risky business. First, when PPPs are used to deliver public services, an important question to consider is who bears the risk of the investment. While there is an assumption that the risk will be transferred to the private sector, this does not always prove to be the case. The state is always the residual risk-holder should the private sector company somehow fail. Moreover, terminating inflexible contracts and operating projects under unplanned public management can have significant financial implications for the state. If a project delivering an essential public service – as it is the case of healthcare – goes wrong then the government will be under pressure to bail it out to avoid political and social disruption. If a company fails spectacularly – for example, by running up big debts – and the government has to bail it out, then private debts will be transferred to the public sector.[92]

Second, the lack of flexibility and the complexity of health PPPs also make them a very risky business. The delivery of healthcare is changing rapidly, partly in response to (a) demographic and geographical changes in the population; (b) altered demands on healthcare systems, such as shifting patterns of disease; and (c) opportunities offered by new technology – for instance, in the last decade new treatments and new diagnostic techniques have made real, but at the same time, very expensive contributions to health. Against this backdrop, the quest to minimise the risk that the parties are exposed to has meant that the contracts are often specified in very great detail, with large penalties for introducing changes. According to health researchers, "the lack of flexibility has meant that the configuration of some hospitals has been out of date by the time they are opened. The problem is not unique to PPPs, but the rigidity of contracts makes the solution more complex."[93]

The Queen Mamohato PPP hospital in Lesotho exposed how a project's initial cost can escalate, in this case consuming more than half of the national health budget

The challenges of implementing a PPP have been greatest in the case of major teaching hospitals, as they accept a wide range of referrals and provide services for various types of patients. As a Chilean scholar argues, "the rigidities associated to the [PPP] contracts increase the risk instead of decreasing it, since it is not possible to introduce modifications, nor changes to the hospital management models, nor adjustments in the services based on demand or layout of the healthcare network".[94] Ultimately, as the empirical evidence shows, the unbalanced risk allocation undermines the financial sustainability of the project.[95]

Finally, it is also alarming that, in most countries, the costs and risks of PPPs are not disclosed in a transparent way, as they are kept off-balance sheets. While this applies to all PPP projects, it highlights how particularly risky health PPPs can be as a financing tool due to poor transparency and lack of parliamentarian and public oversight. In the case of Peru, this has raised concerns from academics, CSOs[96] and the IMF. The 2015 IMF *Fiscal Transparency Evaluation* states that "financial liabilities related to PPPs are likely underreported" and that "the government's reported commitments likely underestimate the underlying risks arising from PPPs". As a result, the IMF called on the government to "improve reporting of fiscal risks arising from PPPs",[97] a point that as of July 2018 – when the IMF released its last report on the country – is still a work in progress.[98]

This results in a perverse incentive in favour of PPPs, as governments select them to circumvent budget constraints rather than for efficiency reasons. According to IMF staff, "while in the short term, PPPs may appear cheaper than traditional public investment, over time they can turn out to be more expensive and undermine fiscal sustainability, particularly when governments ignore or are unaware of their deferred costs and associated fiscal risks".[99] As a result, academic research conducted on 38 audit reports on PPPs, including health PPP projects, published by 21 audit offices in 13 countries reveals findings that are not surprising. According to the authors, the vast majority of the reports studied are "highly critical of the financing and the cost aspects of PPP projects". The main problems identified are that: "both the costs and the risks are kept off balance sheets; cost calculations are not complete; alternative options are not examined on an equivalent basis; and the government still bears an excessive proportion of the risks involved and hence all too frequently ends up footing too much of the bill."[100]

B. Development outcomes and health PPPs

Over the years, many scholars and international organisations have produced evaluation reports and case studies to shed light on the impacts of health PPPs. However, an overarching concern relates to the lack of empirical evidence in relation to the extent to which health PPPs are the appropriate tool to enable positive development outcomes. In particular, this relates to the ability of PPPs to improve access by providing affordable services, generate quality services, reduce inequalities, including gender inequality, and promote decent work.

The evidence is not conclusive and large data gaps exist, which stands in stark contrast with the advocacy efforts that international organisations have put into promoting PPPs to achieve UHC. The lack of data is mentioned in several evaluations conducted by the WB's Independent Evaluation Group.[101] A report on the WBG's support to health services states that IFC's advisory services "are generally successful in bringing [PPP] transactions to commercial closure". However, there is insufficient information available to judge aspects of access (such as affordability), efficiency and sustainability of PPPs as projects lack a clear framework to measure long-term results.[102] In addition, an academic review, argues that the production of knowledge on health (and education) PPPs has been dominated by its main advocates, namely the World Bank and consultancy firms, among others, and there is still little evidence on whether marginalised groups, including women, benefit from PPPs.[103]

On the basis of the empirical evidence available, four key points are worth considering. First, health PPPs are often surrounded by weak claims of private sector efficiency. A 2014 report by a European Commission Expert Panel on health PPPs "did not find scientific evidence that PPPs are cost-effective compared with traditional forms of public financed and managed provision of health care".[104] This finding was also mentioned in the reviewed reports on PPPs by audit offices, as it points out that "the audits didn't show clear evidence that PPP projects are more efficient than the traditional forms of procurement". In a similar vein, a review published in 2015 concluded that "although PPPs have become a common approach to health care problems worldwide, there is no general agreement on their main benefits. In particular, doubts remain concerning their actual effectiveness, efficiency and convenience in the health care sector".[105]

This is also confirmed by a 2019 study that compares the performance of a PPP hospital in Spain (Alzira's PPP) with public hospitals over the period 2003-2015: although the PPP hospital "behaved as a benchmark in a number of indicators", the study concludes that "performance does not necessarily depend on the type of governance model".[106] At the same time, empirical findings suggest that, when efficiency gains are made, they often come at a cost – for example, as a result of lack of investment by the private sector partner to deliver services to an adequate standard, or by lowering costs as a result of flexibilising working conditions and cutting jobs, most of which are held by women. Several reports indicate that, to make real the potential efficiency gains of health PPPs and to translate them into benefits for users, it is key to have a regulatory framework that protects the public interest and allows for monitoring and accountability.

Second, whether health PPPs can be a tool to deliver quality services for patients and reduce inequalities, including gender inequality is still contested. A 2019 review of health PPPs concludes that "there is inconclusive evidence of the impact of PPPs on health service utilisation, the quality of services, patient satisfaction and health-related outcomes". In cases where high-quality clinical services have been reported, as in the Lesotho PPP hospital, there are still concerns about the equity implications of the project. Research published in 2019 highlights that "the effect of the [higher-than-expected] costs of project has been to channel resources towards hospital services in the capital [where the PPP hospital is located] and away from primary care settings in rural areas" where more than 60 per cent of the country's population live. This raises serious concerns in relation to the capacity of PPPs to serve the most vulnerable population as well as their impact on the wider health system (see point C below). Moreover, research on health PPPs also questions their ability to address gender inequalities effectively. Almost no attention has been given to the way ideas around gender inequalities are framed in the design of health PPP projects and there has been very limited acknowledgement of their gendered impacts.[107]

Even though some projects promote free healthcare services at the point of delivery – for example, when women receive pre-paid health vouchers to cover the cost of specific services – there are frequently additional costs to pay. These may be formal charges, such as the need to pay for hospital bedding, food, additional medication or transportation costs. Women are frequently expected to cover these costs themselves, and yet, as the case of Peru clearly demonstrates, many women are excluded from economic decision-making processes within the household and lack access to economic resources.[108]

Third, the inherent contradiction between the quest for profits and the need to deliver social goals is evident in the case of health PPPs. Currently, there is a strong focus on identifying 'bankable' projects, which limits the extent to which PPPs can proceed in areas that are at first not profitable. This has implications on public sector investment priorities: low priority projects may go ahead simply because they are commercially more attractive.[109] In the case of healthcare, this translates into a greater focus on secondary and tertiary healthcare (i.e. 'hospital care' and highly specialised care), while primary healthcare, prevention and community clinics and health centres are neglected (for instance, this has been the case in Colombia and Peru[110]). This goes against the emphasis on primary healthcare placed at the global level in the Alma-Ata declaration adopted in 1978 – a major milestone in the field of public health.[111]

In addition, in PPP hospitals, commercial imperatives are incorporated in the delivery of healthcare, which might undermine the right to health. According to researchers from King's College London, "healthcare professionals in corporately owned hospitals, for example, face overt and implicit incentives to increase revenue which manifest in many settings with over-testing, over-diagnosis and unnecessary treatments".[112] This trend is also in line with the high Caesarean section rate in Latin American private hospitals, due to monetary incentives for overuse.[113] Moreover, PPP hospitals might also favour a reduction in the average length of stay in hospitals, a metric used by the healthcare industry to measure efficiency. However, this measure does not necessarily mean better hospital practices and can disproportionately affect women as they are frequently responsible for looking after sick relatives at home (see for instance, the cases of Mexico, Ecuador and Peru).[114] This can also negatively impact on women's own health and well-being as they take on additional work loads.[115]

Finally, health PPPs have also been questioned about their ability to protect and promote decent work, especially for women. The evidence available from the global north suggests that health workers have been negatively impacted. For instance, the Alzira PPP hospital in Spain resulted in changes in labour contracts that worsened labour conditions, "with less job security, lower pay scales and longer working hours".[116] In the case of the NKS hospital in Sweden, hospital staff also voiced their discontent with management of the PPP project, and reported negative consequences for the patients and the professionals, including IT breakdowns, seriously threatening patient security; operating theatres not being adapted for operations; the risk of medicines being destroyed because of medicine rooms being too warm; and physicians having to carry administrative material in back packs because of the lack of space for administrative tasks, among others.[117] Similar concerns have been raised in the case of health PPP hospitals in Australia, the most recent being in the Northern Beaches Hospital, in Sydney.[118] In this context, it is fair to assume that this issue has disproportionally affected women, as there is a higher concentration of female workers in the delivery of healthcare services, compared with their share of employment in the economy as a whole.[119] In the case of Latin America, there is an empirical study that refer to performance gains through the flexibilisation of working conditions in Brazilian PPP hospitals,[120] but this is clearly an area that requires more empirical research.

C. The social contract, the wider health system and democratic governance

The private sector (both for-profit, and not-for profit) has historically played an active role in the provision of healthcare. However, the increased use of PPPs in the health sector raises specific issues regarding the relationship between public and private sector actors (or the social contract), the wider health system and democratic governance.

First, under the PPP model, the state commissions services, rather than being in charge of direct provision. There is an assumption that the state has the capacity to regulate in the public interest, which is not always the case. Moreover, the state plays an active role that entails the creation of a secured revenue stream for private sector companies in the context of healthcare, which contributes to commodification trends that undermine the right to health. All this has profound consequences for how or whether the state can attend to inequalities by ensuring provision for the most vulnerable and excluded groups in society, such as women, low-income groups, people with disabilities, ethnic minorities, etc.

Importantly, the increased reliance on the private sector to deliver healthcare has been contested by human rights advocates from around the world for many years,[121] and more recently, by the African Commission on Human and Peoples' Rights, which approved a landmark resolution on the obligations of states to regulate private actors involved in the provision of health (and education) services. This commission calls on African states "to consider carefully the risks for the realization of economic, social and cultural rights of PPPs and ensure that any potential arrangements for PPPS are in accordance with their substantive, procedural and operational human rights obligations".[122]

Second, all too often the negative impacts that health PPPs can have on the wider health system, and thus on public health, are neglected. The high costs associated with PPPs creates greater threats to the spending on public services,[123] including on rural healthcare and on services specifically targeting women, such as free reproductive healthcare services.[124] This can be exacerbated in a context where there are political demands to cut public spending, including through IMF programmes,[125] and has consequences for the public health system, where the most vulnerable people are treated.

Third, PPPs in the health sector have been challenged about the lack of transparency and procedures that allow for democratic accountability – a problem that is also present in PPPs in other sectors, but the issue is even more acute when it applies to a service that is so key to guaranteeing a human right. PPPs require significantly more complex due diligence than traditional public procurement projects in order to deliver services in an efficient manner, as holding the private sector to account throughout the lifespan of the contract is a challenging task. The empirical literature refers to the lack of informed public consultation, and the lack of public scrutiny, due mainly to commercial confidentially clauses that protect PPP contracts.[126] This adds to information asymmetry between the public and private sector that favours the latter, and undermines state capacity to monitor project implementation. In Latin America two additional points add further complexity to this picture: on the one hand, the fact that PPP projects can be initiated by the private sector – known as unsolicited PPPs – as they can increase the risk of national plans being driven by corporate priorities. On the other, the renegotiation of PPP projects, which is a common feature in the region – although figures refer mostly to physical infrastructure projects.

Renegotiation of PPP projects usually increases the cost of projects for the public sector, and thus for citizens, changing the initial cost-benefit analysis that underpinned the decision to go for a PPP project in the first place. They also imply limited competition and transparency problems linked with opportunistic behaviour.[127] In recent years, many Latin American countries have been shaken by corruption scandals, mostly in infrastructure projects but also in the health sector.[128] The most relevant one is associated with the Brazilian construction giant, Odebrecht, which paid bribes to government officials in a dozen countries throughout the whole continent. This case unveiled the spurious nexus between private and public sector actors, and revealed how PPPs have been used as vehicles for the benefit of private sector companies. These practices have increased the final costs of the projects,[129] and have further contributed to discredit the public sector and to deepen the process of a 'captured state'.[130]

The inherent contradiction between the quest for profits and the need to deliver social goals is evident in the case of health PPPs

4. Conclusion and recommendations

PPPs are currently being promoted as a way to finance health-related needs. The promotion of health PPPs is taking place at the global level and has permeated Latin American health systems. This has happened in a context of health systems that were reformed as a result of neoliberal policies and the influence of international financial institutions. The case of Peru is a relevant case in point. The emergence of health PPPs, both globally and in Latin America, needs to be placed in the context of the increased financialisation of healthcare.

The international commitment on UHC is responding to the urgent need to address a crucial problem: at least half of the world's population still lacks access to essential health services, and affordability remains a key reason for that. However, as this briefing shows, there is weak evidence that health PPPs are able to address the challenges that most Latin American countries face to deliver on UHC, including fragmentation and inequalities within the health system. On the contrary, all too often heath PPPs represent a transfer of public resources to the private sector and do not lead to any efficiencies, which means that they end up undermining progress on UHC.

On the basis of the global evidence on PPPs in the health sector, this briefing raises three main points to be considered before promoting health PPPs in Latin America further:

1. **Health PPPs can be an expensive and risky business.**
2. **There is no empirical evidence to claim that health PPPs deliver positive development outcomes.**
3. **Health PPPs can have negative impacts on the wider health system and on democratic governance.**

First, all too often health PPP projects are more expensive than they would have been if procured using traditional procurement. The costs of PPPs include the cost of capital, profit expectations by the private partners and transaction charges associated with the negotiation of complex PPP contracts. This can even include tax benefits for the private partner, which contributes to a race to the bottom in tax rates. Second, despite the extensive literature on health PPPs, the empirical evidence of their benefits – in terms of their ability to improve access, generate quality services, reduce inequalities, including gender inequality and promote decent work – is not conclusive, and large data gaps exist. This stands in stark contrast with the advocacy efforts that international organisations have put into promoting health PPPs. Furthermore, the evidence suggests that health PPPs are not 'gender neutral', which means that it is necessary to consider the specific risks that women face as a result of health PPPs. Third, all too often the negative impacts of health PPPs on the wider health system, and thus on public health, are neglected. Health PPPs can also undermine democratic governance, as lack of transparency and meaningful public participation prevails.

Given these findings, we are raising a red flag regarding the promotion of PPPs to deliver on UHC in Latin America. In cases like Peru, where inequalities are deeply embedded in the health system, questions must be asked about the implications of health PPPs for fiscal sustainability, equity and the wider health system. There is a risk that health PPPs exacerbate existing inequalities rather than reducing them. Until more evidence is available, this briefing argues that health PPPs should not be promoted as an effective way to achieve UHC.

We are calling on international financial institutions and their member governments to stop the ideologically driven promotion of PPPs in the health sector, in Latin America and globally. If these institutions genuinely want to improve access to and the quality of healthcare, the focus has to be placed on national health systems, as they can be a tool for addressing social inequality and exclusion. National states should adopt legislative and policy frameworks regulating private actors in healthcare delivery and should ensure that their involvement conforms with international human rights standards. An increasing role of the private sector in the provision of healthcare, without the necessary safeguards that guarantee human rights, risks undermining social goals in favour of private profits.

All too often heath PPPs represent a transfer of public resources to the private sector and do not lead to any efficiencies, which means that they end up undermining progress on UHC

Recommendations

Governments and international financial institutions should carry out the following recommendations in order to honour international commitments on health and to make sure that people around the world have access to affordable healthcare:

- **Evidence-based approach**: The financing mechanisms chosen to deliver healthcare should be assessed for their ability to ensure that they benefit citizens, and their ability to address inequalities. International financial institutions and governments should build the evidence base through human rights impact assessments that consider the impact on both the expansion of coverage (quantity) and on the affordability, accessibility and appropriateness (quality).
- **Domestic resource mobilisation**: To ensure governments have a genuine choice in finding the best financing mechanism for healthcare, donors should support the prioritisation of progressive taxation at the national and international level, and provide long-term concessional finance through soft loans.
- **Rigorous assessment**: International financial institutions should require thorough fiscal risks and human rights impact assessment analysis on the health PPP projects that they support, including a gender impact assessment, PPP contingent liabilities and the potential impacts on the wider health system and national budget.
- **Transparency and accountability**: For all health PPP projects, international financial institutions and governments must ensure that rigorous transparency standards are applied, particularly with regard to accounting of public funds, and disclosure of contracts and performance reports. International financial institutions and governments must also ensure broad civil society participation before and during project implementation. This should be done through informed consultations, including the input of local communities and women's rights organisations.

As Latin America is one of the regions in the world with the highest levels of inequality, the ability of health PPPs to reduce inequalities needs to be carefully considered. Latin American governments should take lessons from the international experience with health PPPs and avoid 'buying a model' that is questionable in terms of its ability to deliver in the public interest. It is critical to identify alternatives to health PPPs: increasing public finance for health is key to making progress on UHC.

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The European Network on Debt and Development (Eurodad) is a network of 50 civil society organisations (CSOs) from 20 European countries, which works for transformative yet specific changes to global and European policies, institutions, rules and structures to ensure a democratically controlled, environmentally sustainable financial and economic system that works to eradicate poverty and ensure human rights for all.

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The Latin American Network for Economic and Social Justice (LATINDADD) is made up of institutions, teams and campaigns from Latin American countries working to solve the problems arising from systemic crisis and to create conditions that enable the establishment of an economy that serves the people, in which economic, social and cultural rights are respected.