

RISKY BUSINESS

POSITION PAPER ON THE PROMOTION OF PUBLIC-PRIVATE PARTNERSHIPS IN HEALTHCARE

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EXECUTIVE SUMMARY

Public-Private Partnerships (PPPs) are increasingly promoted as an instrument to provide and finance healthcare in low- and middle-income countries. However, the available evidence does not show that PPPs fulfill the benefits for which they are promoted. In fact, most research points out that PPPs have an opposite, negative effect on achieving equal access to quality key health services for everyone (Universal Health Coverage).

As outlined in this paper, PPPs are often far more expensive for governments than public procurement, do not align with the most urgent medical needs and they seem to exacerbate access for poor populations. Wemos therefore strongly recommends global actors such as the World Bank and World Health Organization and country donors to stop promoting PPPs for healthcare provision and financing in low- and middle-income countries. Instead, they should focus on strengthening public healthcare provision and financing - in alignment with the current trend in high-income countries.

What is a PPP? A PPP is a long-term contract between a private party and a government entity, for providing a public asset or service, in which the private party bears significant risk and management responsibility, and remuneration is linked to performance (source: pppknowledgelab.com). In a typical a PPP, the project company raises finance from the investors, subcontracts other private companies to run the service, and the service is repaid by the government (through subsidies) and/or citizens (through user fees).

PROMOTION OF PUBLIC-PRIVATE PARTNERSHIPS IN HEALTHCARE

The use of PPPs for healthcare provision and financing is promoted in low- and middle-income countries by global actors such as the World Bank and by country donors such as the Netherlands. Such institutions use many arguments while promoting PPPs in healthcare, which we can summarize in these points:

- PPPs leverage financial resources from the private sector, thus relieving the public purse;
- PPPs allow for higher risk sharing, shifting the investment risk from the public to the private sector;
- PPPs leverage the expertise and skills of the private sector;
- PPPs provide better efficiency and Value for Money;
- PPPs increase access of poor populations to healthcare.

However, how valid are these arguments? In this position paper, we compare these arguments with available literature from academics and civil society. After doing so, we highlight the main concerns regarding PPPs.

MAIN CONCERNS ON PPPS IN HEALTHCARE

PPPs are often more expensive than traditional methods of public procurement. The profit margin for investors, as well as the use of private finance, make PPPs often very expensive. According to a [2019 systematic review](#), all academic articles that compared PPPs with traditional public provision in Europe, pointed out the higher cost of PPPs in healthcare. Because of their high costs, European countries that previously invested the most in PPPs (Spain, Portugal and the UK), are now abandoning them. Yet, healthcare PPPs are still strongly promoted in low- and middle-income countries.

PPPs allow private investors to set (wrong) priorities in healthcare financing. Investors are interested in investing in the most profitable areas, such as specialized care, even when more basic services are lacking. For example, an expensive PPP contract for the leasing of specialised medical equipment in Kenya was conducted without a proper assessment of the healthcare and capacity. According to a [report from 2020](#), this resulted in underutilization of the equipment, due to lack of personnel and supporting infrastructure in the health facilities.

PPP require complex contracts, which often are renegotiated, with escalating costs for the government. This is what makes PPP very risky, especially in low- and middle-income countries, where governments lack the technical capacity to carry out complex contracts and renegotiations. Renegotiations are very common, with [68% of PPP contracts](#) being renegotiated in Latin America. The cost of renegotiations can also be very high, as in the case of the [Queen Mamohato Hospital](#) in Lesotho, whose costs more than doubled after the renegotiations.

PPP may not improve the access of poor populations to healthcare. As private health investment is often not directed to areas where the poorest populations live, they fail to improve access to care for the poorest, as highlighted in a [recent report from ISER](#) on a PPP for maternal health services in Uganda. Moreover, PPPs can entail user fees, which increase inequality in the access to healthcare, as [documented in India](#).

RECOMMENDATIONS

Considering the serious risks and disadvantages in healthcare PPPs, as pointed out by available evidence, and considering the States' obligations in terms of the right to health, we developed the following recommendations. Development actors – including bilateral, regional and international providers of Official Development Assistance, multilateral, regional and national development banks, and United Nations institutions – should:

- Stop promoting PPPs in healthcare delivery and financing until more evidence on their impact on access, efficiency and fiscal risk is produced.
- Focus on overcoming the obstacles in strengthening public healthcare provision and financing, through technical and financial assistance.
- Promote public investment, especially when used to address the most pressing needs of the health system; strengthen the public purse through progressive fiscal revenue.

1. INTRODUCTION

Since the early 2000s, the use of Public-Private Partnerships (PPPs) for healthcare provision and financing has increased worldwide.¹ This trend is catalysed by global actors such as the World Bank (WB). In its Maximizing Finance For Development strategy,² the WB proposes a ‘private-first approach’, giving a central role to private finance and PPPs. Despite this growing interest, PPPs are a controversial instrument of healthcare provision and financing.

Although there is an increasing amount of literature on PPPs, evidence for their contribution to achieving Universal Health Coverage³ (UHC) remains inconclusive. Both academics and Civil Society Organisations (CSOs), especially in social sectors such as health, have criticised the use of PPPs. Moreover, the promotion of healthcare PPPs in low- and middle-income countries (LMICs) collates with an opposite tendency in high-income countries (HICs). In Europe, PPP investments had been growing until the 2008 financial crisis and are now decreasing, with the main countries that previously invested in PPPs shifting away from the PPP model.⁴

As a CSO involved in policy analysis and advocacy in health system strengthening, Wemos has been engaged in discussions around PPPs in healthcare in LMICs, collecting experiences from partner CSOs and health workers, conducting case studies, and critically assessing the promotion of PPPs.⁵ During our collaborative research on the [Dutch combined Aid and Trade agenda in health](#), local and global CSOs, stakeholders and advocacy partners expressed concerns regarding PPP promotion in health by development actors, such as donors and financial institutions.⁶ In this paper we outline our position on donor promotion of PPPs in healthcare as a development tool, and provide policy recommendations on how states can ensure the protection of *the Right to Health for All*, enshrined by international law, by regulating and monitoring private participants or actors in healthcare. In particular, states have an obligation to protect, respect and fulfil the right to health in their jurisdictions as well as through international cooperation and development. This also encompasses international financial institutions: “states parties which are members of international financial institutions, notably the International Monetary Fund, the World Bank, and regional development banks, should pay greater attention to the protection of the right to health in influencing the lending policies, credit agreements and international measures of these institutions⁷.” Private actors themselves have the responsibility, amongst others, to respect the right to health and not impede States’ efforts to respect, protect and fulfil access to healthcare.

¹ PwC (2017) PPPs in healthcare: Models, lessons and trends for the future [\[LINK\]](#)

² WB (2015). From billions to trillions: transforming development finance post-2015 financing for development [\[LINK\]](#)

³ UHC means that all people and communities can use the health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship [\[LINK\]](#). UHC is often misinterpreted as (mandatory) universal insurance coverage, which is only one of the ways to achieve UHC.

⁴ European Court of Auditors (2018), Public Private Partnerships in the EU: Widespread shortcomings and limited benefits [\[LINK\]](#)

⁵ See the [Joint CSO letter on WB’s promotion of PPPs](#), co-signed by Wemos, and [this reflection on Uganda’s fiscal space for health](#)

⁶ Wemos (2020) In the interest of health for all?

⁷ Committee on Economic, Social and Cultural Rights, General Comment No. 14, The Right to the Highest Attainable Standard of Health. UN Doc. E/C.12/2000/4 (2000), para. 39. [\[LINK\]](#)

WHAT A PPP IS: DEFINITION AND CHARACTERISTICS

DEFINITION

There is no internationally recognised definition of PPPs. As the WB is the largest promoter and supporter of PPPs (both in terms of financing and technical advice/implementation), we use the WB definition⁸ for this paper, which defines a PPP as:

A long-term contract between a private party and a government entity, for providing a public asset or service, in which the private party bears significant risk and management responsibility, and remuneration is linked to performance.

THE DEFINING CHARACTERISTICS OF A PPP

According to the WB,⁹ these are the 3 defining characteristics of PPPs.

1. Duration: a long-term contract. Most PPPs have a contractual term between 20 and 30 years, although others have shorter terms and a few last longer than 30 years.

2. Functions: a central characteristic of a PPP contract is that it **bundles together multiple project phases or functions**. Typical functions that can be bundled together include (but are not limited to) design, infrastructure build, finance, maintenance, and operation. Healthcare PPPs also include healthcare service delivery as a function. To give a concrete example, figure 1 shows the functions of WB-financed PPPs in healthcare. See box 1 for more examples.

PPP category	Common denominations	Explanation
Health Services only	Operating contract, performance-based contract (concession, lease)	A private operator is brought in to operate and deliver publicly funded health services in a public facility.
Facility Finance (accommodation)	Design, Build, Finance, Operate (DBFO); Build, Own, Operate, Transfer (BOOT); UK's private finance initiative ¹⁰	A public agency contracts a private operator to design, build, finance, and operate a health facility. Health services within the facility are (mostly) provided by the government.
Combined (accommodation and services)	Twin accommodation, clinical services joint venture/ Franchising, PFI+ ¹¹	A private operator builds or leases a facility and provides free (or subsidised) healthcare services to a defined population.

Figure 1 - Classification of the WB-funded PPPs in Healthcare. From: WB Independent Evaluation Group (2016). PPPs in Health

⁸ WB (2017). PPP Reference guide 3.0 – Introduction [\[LINK\]](#)

⁹ WB (2017). PPP Reference guide 3.0 – PPP Contract Types and Terminology [\[LINK\]](#)

¹⁰ The private finance initiative (PFI) was a UK procurement policy implemented between 1992 and 2018, where private firms were contracted to finance and manage public services.

¹¹ PFI+ was a second generation of PFI contracts for social infrastructure, implemented in Mexico by the IFC

3. Payment mechanism: the private company is remunerated for the services provided by **a) the government, b) user fees, or c) a mix of both. The payment is contingent on performance.** To our knowledge, under most healthcare PPPs, the private partners are either repaid by the government or by a mix of user fees and government payment.

Box 1: Examples of PPPs in health service delivery and/or financing

Examples of PPP agreements that fall within the scope of our paper: the following examples of PPPs for healthcare service delivery and financing fall within the WB definition which we used to limit the scope of our paper.

- Hospital PPPs. The Alzira Hospital in Spain and the Karolinska Institute in Sweden are well-known examples of PPPs in the Global North; the Queen Mamohato Hospital in Lesotho and the Inkosi Albert Luthuli hospital in South Africa are well-known PPP hospitals in the Global South.
- PPPs for the provision of healthcare services. For example, the Managed Equipment Services programme for leasing medical equipment in public health facilities in Kenya.
- Voucher schemes for essential health services. Although voucher schemes have a shorter duration than most PPPs, they are mostly considered and referred to as PPP, being characterised by performance-based repayment and the creation of a PPP agency - a Special Purpose Vehicle (SPV) - that contracts private companies.
- The UK's Private Finance Initiatives (PFI). The government signs a contract with a private sector consortium that funds the construction and the management of public infrastructures such as hospitals and, in some cases, the operation of the services in it.

THE FINANCIAL STRUCTURE OF A PPP¹²

In healthcare PPPs, a private company is contracted by the government to build infrastructure and/or provide a service. The private company contracted is usually a company specifically created for that purpose – a Special Purpose Vehicle (SPV). The SPV contracts (already existing) agencies to provide the service, construct infrastructure, do maintenance, etc. Figure 2 summarises the flow of payments occurring in a classic PPP. For the provision of the service

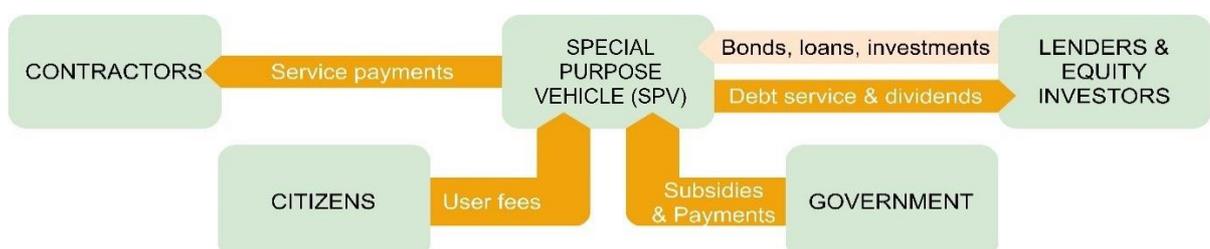


Figure 2 - Flow of payments in a PPP. Adapted from: WB (2017). PPP Reference Guide 3.0 - Finance Structures for PPP.

¹² WB (2017). PPP Reference guide 3.0 - Finance Structures for PPP [\[LINK\]](#)

and/or the infrastructure, the SPV is remunerated by the government, collects user fees, or a combination of both.

When upfront financing is needed, the SPV raises finance through a combination of equity (provided by the company's shareholders) and debt (provided by banks, or through bonds or other financial instruments). It is very common for multilateral development banks to lend the money necessary for implementing healthcare PPPs in LMICs. Additionally, development partners can finance the implementation of PPPs in LMICs: they usually do so through their development banks or other financial institutions such as the WB.

OTHER FORMS OF PRIVATE SECTOR ENGAGEMENT¹³

There are different forms of private sector engagement in healthcare. Below, we describe other types of contracts that involve the private sector, but that are not PPPs:

- **Public procurement** is the process of purchasing goods, services or work by the public sector from the private sector.
- **Design-build or turnkey contracts** include performance-based payment, just like PPPs. However, because they are shorter-term contracts and do not include maintenance or operation (and thus lack a long-term commitment from government and private counterparts), they are not considered PPPs.
- **Management contracts** do not have the long-term duration of PPPs nor, more importantly, their significant private capital investment, as they are financed by the government. As for PPPs, the payment in management contracts is based on performance.
- **Affermage and lease contracts** are contracts under which a government delegates management of a public service to a private company. Such contracts involve public (not private) financing and are completely repaid by user fees; because of this, they are not used in healthcare.

EXAMPLES OF PPPS THAT DO NOT FALL WITHIN THE SCOPE OF THE PAPER

Other partnerships that are commonly referred to as PPPs, but don't fall within this definition's scope, are Global Health Initiatives - such as Gavi, the Vaccine Alliance (GAVI), the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), and the Global Financing Facility (GFF). They have multiple stakeholders (governments, UN institutions, philanthropic organisations and private companies) and a global level governance structure next to national level governance structures.

Moreover, in this paper we do not consider PPPs involving Not-For-Profit organisations, as they often lack many characteristics of the partnerships with the For-Profit sector, such as the expected return on investment, the investment in 'marketable' areas, and the involvement of

¹³ WB (2017). PPP Reference guide 3.0 - What PPP is Not: Other Types of Private Involvement [\[LINK\]](#)

high levels of private finance. Neither will we consider PPPs with other scopes than service provision and facility building/management, such as PPPs for development and/or distribution of vaccines and treatments (see box 2 for examples). This limited focus should not be taken to suggest that it is undesirable to understand and apply human rights standards and principles to these PPPs.

Box 2: Examples of healthcare projects and initiatives that are commonly referred to as ‘PPP’, but do not fall within the scope of our paper

- Global Health PPPs. In Tanzania, a PPP for subsidising the provision of mosquito nets for malaria prevention (the Tanzania National Voucher Scheme) was established in 2004 with the support of the GFATM, USAID, and the UK Department for International Development. It also involved several actors from the commercial sector, non-governmental organisations (NGOs), development partners and the Tanzanian Ministry of Health.
- PPPs with Not-For-Profit Organisations. The Malawian government established a formal partnership with a faith-based organisation that delivered healthcare services in rural areas, because of its large presence in the country. According to a 2020 report by Equinet, this partnership led to an increase in healthcare access in rural areas and is the only functional healthcare PPP in Malawi to date. Because the partnership involves a Not-For-Profit organisation, we excluded this, and other similar PPPs from the scope of our paper.

THE NARRATIVE BEHIND PPPS: WHO PROMOTES THEM AND WHY?

Since publishing its *Investing in Health* World Development Report in 1993¹⁴, the WB has been the strongest proponent and financial supporter of PPPs in healthcare. Between 2004 and 2015, the WB approved 78 projects related to healthcare PPPs, partially through the International Finance Corporation (IFC), the private sector arm of the WB (53 projects) and partially through World Bank lending (25 projects). The WB provided development grants and loans to countries with weak enabling environments for PPPs, while also supporting the development of legal and regulatory frameworks. The IFC invested in countries with more conducive PPP environments.¹⁵

Since the creation of the Sustainable Development Goals (SDGs), the UN also promotes the use of PPPs for development. The use of PPPs as a development tool is encouraged by SDG 17.17, which calls for partnerships with the private sector. Moreover, some UN institutions, like the United Nations Economic Commission for Europe (UNECE)¹⁶, actively promote PPPs, mainly through technical support and guidelines. Finally, the Addis Ababa Action Agenda encourages the use of blended finance and PPPs in various sectors, including health.¹⁷

¹⁴ World Bank Group (1993). World Development Report 1993: Investing in Health [\[LINK\]](#)

¹⁵ Independent Evaluation Group of the World Bank (2016). PPPs in Health [\[LINK\]](#)

¹⁶ See the website of UNECE International PPP Centre of Excellence [\[LINK\]](#)

¹⁷ UN (2015). Addis Ababa Action Agenda of the Third International Conference on Financing for Development [\[LINK\]](#)

The European Union declared to support the use of PPPs for the provision of basic services in LMICs, including health.¹⁸ Often, PPPs are implemented in HICs, which then ‘export’ the same PPP model implemented in their own country to the Global South through e.g., promotion and/or financing.

In healthcare, the UK is the largest ‘exporter’ of PPPs.¹⁹ The Department for International Development, for example, has used UK aid money to fund the IFC’s health PPP advisory facility via the partnership ‘Harnessing non-state actors for better health for the poor’. The Dutch government has also been promoting PPP agreements in LMICs for over a decade²⁰, with healthcare being one of the main sectors. In 2019, the [Dutch Entrepreneurial Development Bank allocated EUR 1 million](#) from the Development Accelerator – a fund from the Dutch Ministry of Foreign Affairs managed by FMO – to a trust fund managed by the IFC for PPP implementation in water and healthcare. Dutch Official Developmental Assistance (ODA), together with FMO, also promote PPPs in health by providing grants to support preparations for specific PPP contracts, like in a [project for primary care in Kenya](#). And there are other country donors, development finance institutions and multilateral development partners promoting healthcare PPPs.

In the promotion of healthcare PPPs, the main arguments often used are:²¹

1. PPPs leverage resources from the private sector, thus relieving the public purse;
2. PPPs allow for higher sharing of risk, shifting the investment risk from the public to the private;
3. PPPs leverage the expertise and skills of the private sector;
4. PPPs provide better efficiency and Value for Money (VFM)²²;
5. PPPs increase access of poor populations to healthcare.

In this paper, we compare this narrative with the most recent academic literature, guidelines from official institutions and material published by CSOs. The appendix provides information as to our methodology and selection criteria for the academic literature.

¹⁸ European Commission (2014). A Stronger Role of the Private Sector in Achieving Inclusive and Sustainable Growth in Developing Countries [\[LINK\]](#)

¹⁹ Holden (2009). Exporting PPPs in healthcare: export strategy and policy transfer. *Policy Studies*, 30(3), 313-332.

²⁰ IOB Study (2013). Public-Private Partnerships in developing countries [\[LINK\]](#)

²¹ We presented the arguments used by the UN and the WB; however, the narrative is similar across all actors promoting PPPs in healthcare. For reference, see: UNECE (2012). A preliminary reflection on the best practice in PPP in healthcare sector: a review of different PPP case studies and experiences [\[LINK\]](#); and: PwC (2010). The Revolution of Healthcare PPPs [\[LINK\]](#).

²² VFM is defined as the optimum combination of whole life cost and quality to meet the user’s requirement

2. PPPS IN HEALTHCARE: THE NARRATIVE AND THE EVIDENCE

ARGUMENT #1: PPPS LEVERAGE FINANCIAL RESOURCES FROM THE PRIVATE SECTOR

A major incentive for using PPPs is the fact that they enable governments to shift the initial cost of infrastructure and services to the private sector, thus relieving the public purse in the short-term.²³ Due to insufficient fiscal revenue, economic treaties and fiscal rigor in national and international policies, governments in HICs and LMICs find themselves insufficiently able to invest in essential infrastructure and services.²⁴ This investment gap is filled by the private sector, that seeks investment opportunities in LMICs, also as a result of increasingly available global financial capital.²⁵ Private companies, attracted by an expected growth in health expenditure in LMICs, are willing to invest in healthcare.²⁶ PPPs attempt to create an enabling environment for the private sector to fill the gaps of the public sector, attract private investments and use them for health service provision, by [increasing access to capital](#).

This is also the source of a big misconception in the PPP narrative, according to which PPPs reduce the financial burden on the government. However, **rather than lifting the government from the cost of providing services, the private sector contributes to the initial investment, which is repaid over time (and with interest) by the government and the users, who bear the real cost.** In our opinion, this is problematic in at least two ways, which we outline below.

EXPOSURE OF COUNTRIES TO EXCESSIVE FISCAL RISK

The fact that healthcare PPPs rely on the government for the re-payment of services, poses a significant fiscal risk for the government. A report from the WB Independent Evaluation Group (WB IEG)²⁷ states that the fiscal implications of healthcare PPPs, even when bearing significant fiscal risk, are not consistently assessed.²⁸ PPP liabilities can thus accumulate as ‘hidden’ public debt that is not considered within the long-term public borrowing and debt limits, with a delayed but severe fiscal impact. For this reason, the International Monetary Fund (IMF) highlighted - already in 2004 - the large fiscal risks of PPPs, as they are used to move government spending off the budget records, and bypass spending controls.²⁹

²³ Michelitsch et al (2017), Evaluation of Public-Private Partnerships in Infrastructure: Executive Summary [\[LINK\]](#)

²⁴ OECD (2012) Public Governance of Public-Private Partnerships [\[LINK\]](#)

²⁵ Bayliss & Van Waeyenberge (2018). Unpacking the PPP revival. Journal of Development Studies, 54(4), 577-593. [\[LINK\]](#)

²⁶ UNECE (2012). A preliminary reflection on the best practice in PPP in healthcare sector: a review of different PPP case studies and experiences [\[LINK\]](#)

²⁷ The WB IEG [is a specialized unit within the WB](#) group that is charged with evaluating the activities of the WB, with the declared objective of helping the WB to achieve better development results.

²⁸ Independent Evaluation Group of the World Bank (2016). PPPs in Health [\[LINK\]](#)

²⁹ IMF (2004). Public-Private Partnerships [\[LINK\]](#)

According to the IMF, the fact that PPPs are privately financed and PPP investment is recorded as private, and not public, debt, allows government to bypass spending targets. This puts the sustainability of public debt at risk, because PPPs have a higher cost for governments over time. Therefore, the Organisation for Economic Co-operation and Development (OECD) and the IMF now recommend respecting the budgetary principle of unity, meaning that revenues and expenditures deriving from PPPs should be included in the government budget.³⁰ These recommendations are in stark contrast with how PPPs are still being [promoted by the WB itself](#) as “allowing off-balance sheet borrowing”.³¹

A poignant example of the consequences of this fiscal risk is the proliferation of PPP hospitals in Portugal, where healthcare PPPs represent the major PPP expenditure. PPPs were used to move infrastructure investments off-balance sheet, to delay their impact on public finance.³² According to the IMF,³³ this practice contributed to the Portuguese debt crisis: annual payments for PPPs from the public to the private sector were considerably above the investment cost, which burdened the country budget.³⁴ Moreover, the PPP model used in Portugal (based on the Spanish ‘Alzira’ model) was exported to LMICs such as Lesotho, with similarly negative fiscal consequences (see next subchapter).

PRIORITY SETTING

The second concern over shifting investments from the public to the private sector, is related to priority setting in healthcare financing. Although PPPs are paid by governments, they are largely dependent on the private sector’s willingness to invest, leading to the risk that investors’ needs and preferences determine the design and focus of the health system. As stated in an IFC report promoting healthcare PPPs: “providers are free to choose their location and facility, which market forces would dictate”.³⁵ Some researcher argued that LMICs, “rather than designing comprehensive public service provision plans, instead have lists of PPP pipeline projects that are up for sale internationally.”³⁶ Moreover, when engaging in PPPs, governments commit to a flow of payments over the years. This means that, when governments cut their healthcare expenditures in times of fiscal consolidation, this must occur in non-PPP areas.

The WB IEG states that “PPPs often address health needs that – given the deficiencies in a country’s health system – appear peripheral”, and also that “it may be unrealistic to expect that all PPPs address the most urgent health needs in a country.” Given the considerable fiscal risk and cost of PPPs (see Argument #2 and #4), the fact that they address minor health needs

³⁰ OECD (2012) Public Governance of Public-Private Partnerships [\[LINK\]](#)

³¹ Mohieldin (2018). SDGs and PPPs: What's the connection? From: blogs.worldbank.org

³² Cruz, & Marques (2011). Revisiting the Portuguese experience with public-private partnerships. African Journal of Business Management, 5(11), 4023-4032. [\[LINK\]](#)

³³ Independent Evaluation Group of the IMF (2016). The Portuguese Crisis and the IMF [\[LINK\]](#)

³⁴ Sarmiento, & Renneboog (2014). The Portuguese experience with public-private partnerships. [\[LINK\]](#)

³⁵ Handshake - IFC’s quarterly journal on public-private partnerships (2011). Health PPPs [\[LINK\]](#)

³⁶ Bayliss, & Van Waeyenberge (2018). Unpacking the PPP revival. Journal of Development Studies, 54(4), 577-593. [\[LINK\]](#)

is particularly problematic in LMICs, where budget constraints seriously hamper the development of the healthcare system as a whole.³⁷

These problems are exemplified by the case of the Queen Mamohato Hospital contract in Lesotho, which was initially regarded as a success by the WB.³⁸ This 18-year contract to develop, build, and operate the facility, led to an excessive diversion of government resources away from primary care towards specialist hospital care. In January 2020, after a decade of operation, the hospital consumed almost a third of the Kingdom's health budget. This case has been widely used in literature to highlight the danger of PPP agreements, and still serves as a warning for governments adopting healthcare PPPs.³⁹ The case of Lesotho is not isolated, and other countries are still engaging in similarly risky and large contracts. Although still under construction, the Lubowa Hospital in Uganda receives similar critiques by local CSOs and is strongly criticised by the local press.⁴⁰

ARGUMENT #2: PPPS SHIFT THE RISK OF INVESTMENT TO THE PRIVATE SECTOR

An argument for PPPs is that they shift the financial risk to the private partners who bear the cost of the initial investment, thus relieving the public sector from the investment risk. However, as healthcare provision is a human rights obligation of the government towards all its inhabitants, the risk of investment loss is often minimised for the private investor, with negative spill over effects on the governments.

NO REAL RISK FOR THE PRIVATE PARTNER

To attract investors in implementing PPPs, significant resources from development institutions and government funds are used to de-risk PPP investments. For example, minimum guarantees of payments, as well as subsidies, grants and financial agreements to lower the risk profile of the project are used to attract investors, who would otherwise consider it too risky to invest in LMICs.⁴¹ [According to the WB](#), de-risking practices cause additional transaction costs; such practices use public resources and development funds that could otherwise have been invested directly in service provision.⁴²

³⁷ Independent Evaluation Group of the World Bank (2016). PPPs in Health [\[LINK\]](#)

³⁸ Lesotho Health Network Public-Private Partnership (PPP). From: worldbank.org

³⁹ Oxfam (2014). A dangerous diversion [\[LINK\]](#); Bhekisisa Centre for Health Journalism (2020). Why one hospital takes up almost 30% of this country's entire health budget [\[LINK\]](#)

⁴⁰ Seatini, Oxfam, Uganda Debt Network and CSBAG (2019). Civil Society Statement on the International Specialized Hospital of Uganda (ISHU) at Lubowa [\[LINK\]](#); for articles from the local press, see [LINK](#) and [LINK](#)

⁴¹ Croce, Paula, & Laboul (2015). Infrastructure financing instruments and incentives. OECD [\[LINK\]](#)

⁴² Van Waeyenberge, Dimakou, Bayliss, Laskaridis, Bonizzi, & Farwa (2020). The use of development funds for de-risking private investment: how effective is it in delivering development results? European Parliament [\[LINK\]](#)

INCREASED RISKS FOR THE PUBLIC SECTOR

The IMF states that PPPs carry higher fiscal risks than traditional financing.⁴³ Governments have both the interest and the duty to ensure that healthcare PPPs work. When projects go wrong, the costs for governments often escalate through renegotiations or governments bailouts⁴⁴ of the projects. In these cases, taxpayer money, which might for example have been invested in the provision of public healthcare, is used to fix problems caused by private sector mismanagement or market fluctuations that increase investment costs, as stated by the WB.⁴⁵

The absence of real risk for investors in PPPs is more pronounced in the healthcare sector, as showed by the experience of hospital PPPs in Australia. Although it is uncommon, in Australia a few cases were documented where the private sector paid for miscalculating the risks of PPPs.⁴⁶ However, this never happens in the hospital sector: since the Australian government cannot just withdraw health services, it regularly buys back unsuccessful PPP hospitals and thus ends up paying for them.⁴⁷

In LMICs, the major risk for the public sector is renegotiation, which causes escalating costs that have negative consequences for governments' health budget.⁴⁸ According to a 2014 OECD study, 68% of PPPs in Latin America were renegotiated.⁴⁹ Renegotiations are also common in Africa. They are often motivated by opportunism and bear the risk of increases in user fees or more unfavourable terms for the government.⁵⁰

ARGUMENT #3: PPPS ALLOW TO LEVERAGE THE EXPERTISE AND SKILLS OF THE PRIVATE SECTOR

Another argument often used for promoting PPPs is that the private sector has access to a wider range of resources and skills, and PPPs allow governments to leverage these for health system development. As modern healthcare is technology intensive, PPPs can improve the quality of the service. This narrative seems to be confirmed by the fact that the perceived

⁴³ IMF (2015). Making public investment more efficient [\[LINK\]](#)

⁴⁴ Acerete, Stafford, & Stapleton (2011). Spanish healthcare public private partnerships: The 'Alzira model'. *Critical Perspectives on Accounting*, 22(6), 533-549 [\[LINK\]](#)

⁴⁵ World Bank Blog (2009). Is it a good idea to bail out privately financed infrastructure projects? [\[LINK\]](#)

⁴⁶ PwC (2017). Reimagining Public Private Partnerships [\[LINK\]](#)

⁴⁷ To the knowledge of the Author, this was the case at least for the Northern Beaches Hospital [\[LINK\]](#); the Robina Hospital [\[LINK\]](#); the Victoria's La Trobe Regional Hospital [\[LINK\]](#); the Port Macquarie Hospital [\[LINK\]](#); the Modbury Hospital [\[LINK\]](#). The lack of real risk for private investors in Australia is highly criticized by the press [\[LINK\]](#).

⁴⁸ Asian Development Bank, Inter-American Development Bank, World Bank, Public-Private Infrastructure Advisory Facility, (2014). *Public-Private Partnerships Reference Guide. Version 2.0.* [\[LINK\]](#)

⁴⁹ Guasch et al. (2014), "The Renegotiation of PPP Contracts: An Overview of its Recent Evolution in Latin America", *International Transport Forum Discussion Papers, 2014/18*, OECD Publishing, Paris. [\[LINK\]](#)

⁵⁰ Wamwere (2016). *Infrastructure in Africa: Overcoming the Legal and Commercial Challenges to Successful PPPs* [\[LINK\]](#).

quality of care in PPP hospitals is often higher than in their public counterparts, as documented in a study in India.⁵¹

We concur that PPPs can transfer technical resources and knowledge which allow to increase the quality of specialised care and services to the public sector. However, PPPs can come at the expense of other – more basic and more needed – services, as in the discussed case of Lesotho (see Argument #1). To give another example, a study from Spain highlighted how PPP hospitals in Valencia focused on the more profitable specialised services, while referring patients which needed less profitable services (such as care for HIV and chronic diseases) to other hospitals.⁵²

We must consider that, in many LMICs, the use of technologically intensive and specialised care does not necessarily align with the local public health priorities. Hospitals and health centres in LMICs often face more basic challenges than the need of advanced technology, such as being understaffed or lacking essential medicines and basic equipment.

This is clearly illustrated by the case of a PPP contract in Kenya for the leasing of specialised medical equipment for primary healthcare centres, documented as a success by the WB.⁵³ According to an extensive report from the Institute of Economic Affairs, the project, which required a significant investment of the government's health budget, was implemented without a proper assessment of the healthcare needs and capacity.⁵⁴ This resulted in underutilisation (and even non-utilisation) of the equipment, due to lack of personnel and supporting infrastructure in the health facilities. Moreover, these kinds of PPP agreements often involve multinational companies (the PPP in Kenya, for example, involved five multinational companies as the private counterparts), not benefitting the local economy. While investing in basic equipment and human resources can have a direct, positive impact on the local economy, on the capacity of the local healthcare system and on local (private) health companies.

ARGUMENT #4: PPPS PROVIDE BETTER EFFICIENCY AND VALUE FOR MONEY

It is often assumed that the private sector is more cost-effective and provides better Value for Money (VFM) than the public sector. The use of PPPs, which allow a private actor to finance, build and operationalise the health facility and/or the service, would therefore create greater VFM compared to the public option.

⁵¹ Baliga, Ravikiran, Rao, Coutinho & Jain (2016). Public–private partnership in health care: a comparative cross-sectional study of perceived quality of care among parents of children admitted in two government district-hospitals, Southern India. *Journal of Clinical and Diagnostic Research: JCDR*, 10(2), SC05. [\[LINK\]](#)

⁵² Benedito (2010). La experiencia valenciana de las concesiones administrativas en al sanidad pública. In *¿Por nuestra salud?: La rehabilitación de los servicios sanitarios* (pp. 97-106). *Traficantes de Sueños*.

⁵³ Monish Patolawala (2017). Transforming Kenya's healthcare system: a PPP success story. [\[LINK\]](#)

⁵⁴ Institute of Economic Affairs (2020). Leasing of Medical Equipment Project in Kenya: Value for Money Assessment

Contrary to the prevailing assumption, the available evidence from the literature shows that public healthcare provision tends to be more cost-effective than private provision, at least in HICs.⁵⁵ In LMICs settings, although less research has been done, the available literature shows similar results. A literature review from 2012 which analysed 102 articles comparing private and public healthcare provision in LMICs found that “the private sector appeared to have lower efficiency than the public sector, resulting from higher drug costs, perverse incentives for unnecessary testing and treatment, greater risks of complications, and weak regulation”.⁵⁶

Regarding PPP’s VFM, the evidence is still inconclusive, and often biased. According to the IMF,⁵⁷ the practice of moving PPP expenditure off-balance sheet favours PPPs in cost assessments. Moreover, cost assessments often do not consider the use of public expenditure to de-risk PPP investments.⁵⁸ An academic paper from 2015 analysed the methodologies for conducting VFM appraisals on PPP in nine countries, from both the Global South and the Global North, and explained how the methodologies for conducting VFM appraisals are often biased in favour of PPPs.⁵⁹

In the specific case of healthcare PPPs, the evidence is also inconclusive. Although PPP’s efficiency is at the core of the WB narrative, the WB PPP guidance states that healthcare PPPs are not necessarily less costly than public provision.⁶⁰ Successful and unsuccessful examples of PPPs can be easily found in the literature. However, to objectively assess PPP’s ability to deliver VFM, we must consider literature reviews that collect evidence from a significant number of studies. In all the reviews on healthcare PPPs we identified during our literature survey (see the Methodological notes), the evidence on cost-effectiveness was either lacking or inconclusive.

EVIDENCE FROM EUROPE

In HICs, the high cost of healthcare PPPs when compared to the public option is resulting in a progressive abandonment of the PPP model. A literature review from 2019⁶¹ noted how, among 30 articles which compared the cost of PPPs with other procurement methods, 24 articles determined that PPPs were more expensive, three were inconclusive, and only three stated that PPPs had a lower cost. Among the articles analysed, all those related specifically to healthcare PPP pointed out their higher costs.

⁵⁵ Kruse, Stadhouders, Adang, Groenewoud, & Jeurissen (2018). Do private hospitals outperform public hospitals regarding efficiency, accessibility, and quality of care in the European Union? A literature review. *The International journal of health planning and management*, 33(2), e434-e453. [\[LINK\]](#); Tynkkynen & Vrangbæk (2018). Comparing public and private providers: a scoping review of hospital services in Europe. *BMC health services research*, 18(1), 141. [\[LINK\]](#)

⁵⁶ Basu, Andrews, Kishore, Panjabi, & Stuckler (2012). Comparative performance of private and public healthcare systems in low-and middle-income countries: a systematic review. *PLoS med*, 9(6), e1001244. [\[LINK\]](#)

⁵⁷ IMF (2015). Making public investment more efficient [\[LINK\]](#)

⁵⁸ Bayliss, & Van Waeyenberge (2018). Unpacking the PPP revival. *Journal of Development Studies*, 54(4), 577-593. [\[LINK\]](#)

⁵⁹ Boardman & Hellowell (2017) A Comparative Analysis and Evaluation of Specialist PPP Units’ Methodologies for Conducting Value for Money Appraisals, *Journal of Comparative Policy Analysis: Research and Practice*, 19:3, 191-206 [\[LINK\]](#)

⁶⁰ WB (2017). PPP Reference guide 3.0 – Health [\[LINK\]](#)

⁶¹ Cepparulo, Eusepi, & Giuriato (2019). Public Private Partnership and fiscal illusion: A systematic review. *Journal of Infrastructure, Policy and Development*, 3(2), 288-309. [\[LINK\]](#)

The shortcomings of PPPs in terms of VFM have been highlighted in Portugal⁶², Spain,⁶³ and the UK,⁶⁴ the countries in Europe with the highest PPP expenditure. Such countries are now shifting away from PPPs in healthcare. The UK, the largest spender in PPPs, abandoned this model in 2018. In the same year, Spain initiated a programme to revert the process of PPP implementation agreements in healthcare initiated in 1999 with the Alzira model.⁶⁵ In Portugal, the extensive use of PPPs in many sectors (including health) has been related to the debt crisis by the IMF,⁶⁶ and public opinion is strongly turning against PPPs.

Already in 2013, the European Commission suggested that healthcare PPPs should be implemented only when offering better VFM than the public option.⁶⁷ A 2018 extensive report of the European Court of Auditors (which included healthcare), strongly criticised PPPs, and advised against promotion until (among other issues) the problem of VFM is addressed.⁶⁸ Yet, donors and financial institutions based in HICs are still promoting PPPs as a development tool.

EVIDENCE FROM LMICS

Less evidence regarding the VFM of PPPs is available in LMICs, as PPPs are more recent in those countries. In our survey, we found that some of the literature shows a more optimistic standpoint,⁶⁹ while other a more critical one.⁷⁰ However, all the reviews conclude that there is no ground in the literature to assess whether PPPs provide better VFM.

EVIDENCE FROM WB-SUPPORTED PROJECTS

The Independent Evaluation Group of the World Bank, in its 2016 report on healthcare PPPs, examined the 78 projects supported by the WB from 2004 to 2015.⁷¹ In these projects, indicators for efficiency show mixed results, and the Monitoring & Evaluation system to assess the efficiency of healthcare PPPs was deemed insufficient. The assessment of efficiency of

⁶² Pereira, Ferreira, & Marques (2020). A critical look at the Portuguese public–private partnerships in healthcare. *The International Journal of Health Planning and Management*. [\[LINK\]](#)

⁶³ Acerete, Stafford, & Stapleton (2011). Spanish healthcare public private partnerships: The ‘Alzira model’. *Critical Perspectives on Accounting*, 22(6), 533-549. [\[LINK\]](#);

⁶⁴ Santandrea, Bailey, & Giorgino (2016). Value for money in UK healthcare public–private partnerships: A fragility perspective. *Public Policy and Administration*, 31(3), 260-279. [\[LINK\]](#); Hellowell, M. and Pollock, A. (2009) *The Private Financing of NHS Hospitals: Politics, Policy and Practice*. *Journal of the Institute of Economic Affairs*, 29:1 pp13–19 [\[LINK\]](#)

⁶⁵ Comendeiro-Maaløe, Ridaio-López, Gorgemans, & Bernal-Delgado (2019). Public-private partnerships in the Spanish National Health System: The reversion of the Alzira model. *Health policy*, 123(4), 408-411. [\[LINK\]](#)

⁶⁶ Independent Evaluation Group of the IMF (2016). *The Portuguese Crisis and the IMF* [\[LINK\]](#)

⁶⁷ European Commission (2013). *Health and Economics Analysis for an evaluation of the Public Private Partnerships in health care delivery across EU* [\[LINK\]](#)

⁶⁸ European Court of Auditors (2018), *Public Private Partnerships in the EU: Widespread shortcomings and limited benefits* [\[LINK\]](#)

⁶⁹ Kostyak, Shaw, Elger, & Annaheim (2017). A means of improving public health in low- and middle-income countries? Benefits and challenges of international public-private partnerships. *Public health*, 149, 120–129. [\[LINK\]](#)

⁷⁰ Languille (2017). Public Private partnerships in education and health in the global South: a literature review. *Journal of International and Comparative Social Policy*, 33(2), 142-165. [\[LINK\]](#)

⁷¹ Independent Evaluation Group of the World Bank (2016). *PPPs in Health* [\[LINK\]](#)

health-related PPPs must be done in comparison with the alternatives, the main one being the public option. However, this is never done, and the VFM of a PPP is evaluated only on whether or not the PPP can respect the terms of the contract. The report goes as far as to state that this lack of assessment “poses a reputational risk for the Bank”.

CRITICS FROM CSO ABOUT PPPS IN LMICS

Although it is not academic literature, CSOs have been producing an increasing number of reports that challenge the narrative of PPP’s alleged VFM. In Africa, this is the case in [Kenya](#), [Lesotho](#) and [Uganda](#), among others. In Latin America, the numerous problems of PPPs in healthcare (including VFM) have recently been highlighted by Latindadd.⁷²

REASONS FOR HIGH PPP COST

There are at least two practical reasons that limit the VFM of healthcare PPPs when compared to the public options: the cost of investment and the required return on investment of the private sector. In normal conditions, governments can borrow money at lower interest rates than private companies. This makes the cost for investing in PPPs higher than public investment, and more subjected to changes in interest rates.⁷³ Secondly, in PPPs, governments typically agree to build in profit margins to induce private sector involvement. This profit margin is greater in poorer countries, where the investment risk is higher.⁷⁴

One of the arguments for the use of healthcare PPPs is that the competition in the bidding process for the PPP contract generates long-term savings.⁷⁵ However, being long-term contracts, the cost-saving effect of competition for PPPs occurs only during the initial bidding, whereas other forms of financing allow for competition at various stages of the construction process and/or service provision.⁷⁶ Moreover, the OECD noted how the complexity of PPP contracts may lead to limited participation in the tender, especially for small and medium enterprises, favouring anticompetitive agreements among a few multinational companies.⁷⁷ A clear example is the Karolinska PPP Hospital in Sweden, known as the most expensive hospital in the world; the tender had only one competitor, due to the size and complexity of the project.⁷⁸

Finally, one of the major issues of PPPs are the renegotiations. The OECD noted that the renegotiations are linked to the aggressive character of the bids: during the bidding process, companies place competitive bids, offering good conditions for the government; only to renegotiate them shortly after, causing the costs to escalate. Thus, the winner of the bidding

⁷² Latindadd (2019) Public Private Partnerships and universal healthcare in Latin America – at what cost? [\[LINK\]](#)

⁷³ AMPG PPP certification Program. Financial costs [\[LINK\]](#); Jin, H., & Rial, I. (2016). Regulating local government financing vehicles and public-private partnerships in China. IMF Working Paper [\[LINK\]](#)

⁷⁴ WB (2017). PPP Reference guide 3.0 - Finance Structures for PPP [\[LINK\]](#)

⁷⁵ PwC Health Research Institute (2010). Build and Beyond: The revolution of Healthcare PPPs (PwC) [\[LINK\]](#)

⁷⁶ Jubilee Debt Campaign UK (2017). Double Standards [\[LINK\]](#)

⁷⁷ OECD (2014), Competition Issues in Public-Private Partnerships [\[LINK\]](#)

⁷⁸ Waluszewski, Hakansson, & Snehota (2019). The public-private partnership (PPP) disaster of a new hospital—expected political and existing business interaction patterns. Journal of business & industrial marketing. [\[LINK\]](#)

processes of PPPs is often not the most efficient competitor, but rather the one with more expertise on renegotiation.⁷⁹

To avoid an escalation of the PPP costs, with potentially negative effect on the government budgets, the literature suggest that it is essential for governments to have the institutional capacity to deal with the renegotiating process.⁸⁰ However, for many LMICs in which PPPs are implemented this is not the case. According to the WB IEG, a higher share of health PPP projects goes to countries with less developed PPP frameworks and a very limited record of using PPPs.⁸¹ This can increase the risk of unfavourable renegotiations with dangerous consequences for a country's healthcare budget, as in the case of the Lesotho hospital.⁸²

ARGUMENT #5: PPPS INCREASE ACCESS TO HEALTHCARE FOR POOR POPULATIONS

By increasing the coverage of health infrastructure and services, PPPs are said to improve access to high-quality healthcare for poor populations. A report from the PricewaterhouseCoopers Health Research Institute⁸³ (which was also published on the WB webpage on PPPs)⁸⁴ stated that PPPs are “challenging the notion that private healthcare is for the rich, and public healthcare is for the poor. Rather than creating or exacerbating inequities in care, PPPs can equalize care to all populations.”

Although PPPs can increase the offer of healthcare services for a part of the population, we must consider that the private healthcare investment tends to be unequally distributed across a country. Private investors are attracted to invest in areas that are easiest to serve and where there is largest demand. Thus, private investment is directed towards richer areas, leaving the government to provide services in remote, poorer areas that cannot afford private healthcare.⁸⁵ That is why PPPs often serve areas with less urgent healthcare needs, failing to reach the poor socioeconomic classes, where healthcare investment is needed the most. A report from Public Services International noted how “PPPs in Africa finance high-tech hospitals in a few urban centres where there are enough wealthy people to support private medicine, but not the universal networks of clinics or the salaries of staff needed to provide

⁷⁹ Guasch, J., et al. (2014), "The Renegotiation of PPP Contracts: An Overview of its Recent Evolution in Latin America", International Transport Forum Discussion Papers, No. 2014/18, OECD Publishing, Paris [\[LINK\]](#)

⁸⁰ Trebilcock & Rosenstock (2015). Infrastructure public-private partnerships in the developing world: Lessons from recent experience. The Journal of Development Studies, 51(4), 335-354. [\[LINK\]](#)

⁸¹ Independent Evaluation Group of the World Bank (2016). PPPs in Health [\[LINK\]](#)

⁸² Hellowell, (2019). Are public-private partnerships the future of healthcare delivery in sub-Saharan Africa? Lessons from Lesotho. BMJ global health, 4(2). [\[LINK\]](#)

⁸³ PwC Health Research Institute (2010). Build and Beyond: The revolution of Healthcare PPPs (PwC) [\[LINK\]](#)

⁸⁴ PPP in Health. From: ppp.worldbank.org

⁸⁵ Languille (2017). Public Private partnerships in education and health in the global South: a literature review. Journal of International and Comparative Social Policy, 33(2), 142-165. [\[LINK\]](#); Romero & Ellmers (2018). The Financial and Social Cost of Public-Private Partnerships. In Sovereign Debt and Human Rights: Oxford University Press.

healthcare for the poor.”⁸⁶ Although healthcare PPPs have now become more widespread also in non-urban areas, more recent evidence still questions their ability to reach the poorest.⁸⁷

For example, a WB financed PPP in Uganda for Reproductive Health Vouchers aimed to provide subsidised maternal services from private clinics through a voucher system. The project had an explicit pro-poor focus and was regarded as a success from the WB’s point of view.⁸⁸ A 2020 report from the Initiative for Social and Economic Rights (ISER), however, highlighted how the project failed to reach the poorest areas of the regions, as there were no private facilities where women could use the voucher. Moreover, the scheme entailed user fees that were hardly affordable for the poorest and that facilitated the commercialisation of the services.⁸⁹

The available literature also presents other cases in which PPPs introduced user fees, excluding poor populations. In India, where the increasing cost of care is the second cause of rural indebtedness, a PPP introduced user fees in primary healthcare, producing an exclusionary effect.⁹⁰ In some other cases, when PPP services do not entail user fees, they can affect accessibility by restricting the range of services provided, increasing side-expenditures, or to select uncomplicated cases, while diverting severe cases to public hospitals, as in the case of India.⁹¹ In the Indian region of Gujarat, a PPP scheme was designed to take advantage of the large presence of the private health sector in the area, by providing vouchers for maternal care to women living below the poverty line. This, however, created differences between patients within the facilities, where the beneficiaries of the vouchers were charged more for medicines.⁹²

The 2016 report from the WB IEG⁹³ does not confirm nor exclude an improved access for the poor in WB-supported PPPs. A third of the evaluated projects explicitly mentions access for the poor in their design, and 68% of the project were implemented in areas “where poor people lived”, thus assuming that poor populations would benefit from the service. However, according to the same report, projects lacked the necessary suitable indicators, baselines and targets to assess whether the poor were able to access the services.

⁸⁶ Hall (2015). Why Public-Private Partnerships don’t work - The many advantages of the public alternative. Page 10 [\[LINK\]](#)

⁸⁷ Fabre & Straub (2019). The Economic Impact of public private partnerships (PPPs) in Infrastructure, Health and Education: A Review. Toulouse School of Economics [\[LINK\]](#)

⁸⁸ Uganda Reproductive Health Voucher Project. From: projects.worldbank.org

⁸⁹ ISER (2020). Failing to reach the poor? Assessment of the WB funded Uganda reproductive health voucher project [\[LINK\]](#)

⁹⁰ Roy & Gupta (2011). Public-Private Partnership and User fees in healthcare: evidence from West Bengal. *Econ Polit Wkly*, 46(38), 74-78. [\[LINK\]](#); Fabre & Straub (2019). The Economic Impact of public private partnerships (PPPs) in Infrastructure, Health and Education: A Review. Toulouse School of Economics [\[LINK\]](#)

⁹¹ Thadani (2014). Public private partnership in the health sector: Boon or bane. *Procedia-Social and Behavioral Sciences*, 157, 307-316. [\[LINK\]](#);

⁹² Bhat, Mavalankar, Singh, & Singh (2009). Maternal healthcare financing: Gujarat's Chiranjeevi Scheme and its beneficiaries. *Journal of health, population, and nutrition*, 27(2), 249. [\[LINK\]](#); Mohanan, Bauhoff, La Forgia, Babiartz, Singh, and Miller (2014). Effect of Chiranjeevi Yojana on institutional deliveries and neonatal and maternal outcomes in Gujarat, India: a difference-in-differences analysis. *Bulletin of the WHO* [\[LINK\]](#)

⁹³ Independent Evaluation Group of the World Bank (2016). PPPs in Health [\[LINK\]](#)

Overall, the evidence on increased access to healthcare services is rather fragmented, with various examples of PPPs that failed to reach the poorest. This is rather concerning, if we consider that PPPs often draw significant government resources (see Argument#4). There is consensus that assessments of the impact on poor populations are often lacking, making it hard to evaluate PPPs in that regard.⁹⁴

⁹⁴ Romero & Ellmers (2018). The Financial and Social Cost of Public–Private Partnerships. In *Sovereign Debt and Human Rights*: Oxford University Press.

3. THE PPP MODEL, THE PUBLIC OPTION, AND THE ROLE OF PRIVATE SECTOR

The promotion of PPPs was built around the promise of more resource allocation in health, less investment risk for governments, technical improvements, better VFM, and increased access to healthcare. In our analysis we observed how PPPs represent a risky and often inefficient health financing mechanism whereas the evidence on their benefits is inconclusive. Moreover, PPPs contribute to the fragmentation of health systems and lead to private investors' interests affecting priority setting in resource allocation.

On the other hand, it is often noted how public provision of healthcare services has been plagued by underinvestment, inefficiency, and corruption, especially in Africa.⁹⁵ On this basis, some see PPPs as a way to ensure that healthcare is delivered, and to avoid that tax-payer money and development finance are used to support a corrupt and inefficient public system.⁹⁶

Nevertheless, the track record of healthcare PPPs is also not short of examples of inefficiency, corruption and lack of transparency.⁹⁷ A recent academic article even argued that the PPP financing model is intrinsically more vulnerable to corruption.⁹⁸ One point on which the analysed literature seems to agree, is that PPPs tend to work well only when good governance is in place.⁹⁹ Thus, it is unlikely that PPPs would represent a solution for poor public sector governance, as both options are equally dependent on good governance to be successful. In the end, both promotion and critique of healthcare PPPs appears to be at least partly driven by ideology, rather than being based on evidence of effectiveness and efficiency.¹⁰⁰

Often PPPs and the use of blended finance are promoted using the argument that private resources are needed to fill the SDG funding gap. However, they do not appear to result in additional resources. Moreover, in a 2007 multi-country study, the WHO Commission on the Social Determinants of Health noted how even countries with relatively limited health budgets can make significant progress towards UHC, when relying primarily on public finance and execution.¹⁰¹ This requires elimination of user fees, progressive revenue raising and health financing arrangements that redistribute resources towards poorer groups, with a complementary role for the private sector. As Oxfam noted in 2009,¹⁰² government provision of healthcare services for the majority of the population, has been a key factor in achieving

⁹⁵ Hutchinson, Balabanova, & McKee (2019). We need to talk about corruption in health systems. *International Journal of Health Policy and Management*, 8(4), 191.

⁹⁶ From the WB blog: [LINK](#); also, from the Inter-American Development Bank: [LINK](#)

⁹⁷ Transparency International (2019). Corruption and unsolicited proposals [LINK](#); see also: [LINK](#)

⁹⁸ Schomaker (2020). Conceptualizing Corruption in Public Private Partnerships. *Public Organization Review*, 1-14. [LINK](#)

⁹⁹ Trebilcock, M., & Rosenstock, M. (2015). Infrastructure public-private partnerships in the developing world: Lessons from recent experience. *The Journal of Development Studies*, 51(4), 335-354. [LINK](#)

¹⁰⁰ Languille (2017). Public Private partnerships in education and health in the global South: a literature review. *Journal of International and Comparative Social Policy*, 33(2), 142-165. [LINK](#)

¹⁰¹ WHO Commission on The Social Determinants of Health (2007). Challenging inequity through health systems [LINK](#)

¹⁰² Oxfam (2009). Blind optimism - Challenging the myths about private health care in poor countries [LINK](#)

UHC in HICs and also in many LMICs. To ensure available, accessible, acceptable and quality health services everywhere, as States are legally obligated to do, public healthcare is the preferred option – if the WHO guidelines on the building blocks of health systems are followed, especially with regards to sufficient health financing¹⁰³ and good governance.¹⁰⁴

THE ROLE OF THE PRIVATE SECTOR

As we specified in the introduction, PPPs are not the only type of private sector contracting in healthcare. In many countries, the private sector has an important role in the construction of infrastructure, in the development and provision of equipment, medicines and vaccines, and in healthcare service provision. The aim of this paper is not to deny the importance of private sector actors in healthcare, but to highlight the risks of PPP contracts for healthcare provision and/or financing as described in chapter 2.

As described in the private-first approach promoted by the WB, the PPP model puts private investment at the centre of financing and provision of healthcare services. Many of the concerns around PPPs seem to be related to this use of private finance. We can summarise three main concerns within this issue:

- The important role of private finance influences priority setting in healthcare, directing healthcare investments towards areas that are more promising for the investors, rather than those where health needs are highest;
- The need for profit margins for investors, and thus the investment in specialised and technologically intensive care (which are more profitable) often makes PPPs very expensive, draining (already limited) public resources;
- The complex contracts required when using private financing, which the government is often not sufficiently prepared to handle, expose the government to greater fiscal risk.

Among other institutions, the UNECE developed guidelines (see box 3), to contain fiscal risks, to improve the VFM and the alignment of healthcare PPPs to country priorities. However, [CSOs criticised](#) such guidelines because they were developed without the participation of civil society, and outside of global, democratic and inclusive intergovernmental settings. Moreover, even with such standards in place, we question whether a financing model built around the needs of investors is suited to meet the urgent need of investment in healthcare, especially in poor and underserved areas.

Other existing models of contracting the private sector may bring some of the benefits ascribed to PPPs, without carrying the same risks. Based on currently available evidence, we conclude that PPPs represent a less adequate strategy for healthcare financing and service provision and are not likely to solve existing problems with public health care, nor ensure States' compliance with their individual and collective obligation to ensure affordable access to quality healthcare for everyone within the maximum of their available resources.

¹⁰³ For health financing objectives, we refer to [the twin targets](#) of committing at least 5% of GDP and 86 USD per capita in government health expenditure.

¹⁰⁴ WHO (2010). Monitoring the building blocks of health systems: a handbook of indicators and measurement strategies [\[LINK\]](#)

Box 3: Relevant guidelines for healthcare PPPs

To address some concerns around PPPs – also in healthcare – and to promote PPP implementation, various guidelines have been produced, such as:

1. **The PPP reference guide:** developed, among others, by the WB and the OECD. It is the most comprehensive and most referenced set of guidelines on PPP implementation.
2. **The PFRAM PPP Fiscal Risk Assessment Model:** developed by the WB and the IMF. It aims to address the fiscal risks of PPPs through a fiscal risk assessment model.
3. **The UNECE guidelines for People’s First PPPs:** the UNECE developed several guidelines for implementing PPPs, aimed at increasing access to essential services, equity and efficiency, and being replicable everywhere. The explicit purpose of these standards is to scale up and promote PPP implementation in a wide range of sectors, including healthcare.
4. **The UNECE standard on Public-Private Partnerships in Healthcare Policy:** was intended to be one of the guidelines of the People’s-first PPP project, and developed a set of standards for countries wishing to engage in healthcare PPPs. **The draft paper** is available since 2015 but was never published.
5. The **OECD Principles for Public Governance of PPP:** a set of twelve guiding principles for PPP implementation.

PPPS IN TIMES OF COVID-19

The COVID-19 pandemic strongly reinforced the need for responsive and resilient health systems. The current narrative around blended finance asserts that investment in PPPs will be crucial in the medium- and long-term response to the pandemic, to foster reconstruction and improve pandemic resilience. As the WB notes, the pandemic will lead to severe losses for private investors in PPPs, which will need to be addressed by the governments; to do that, renegotiations, buybacks and capital injections will likely be necessary.¹⁰⁵

On the other hand, empirical evidence and economic literature show that an effective way to counter economic crises is to use public investment.¹⁰⁶ The current crisis brings home the importance of the public option for health system development, and to promote public investment in the social sectors. The OECD called for a massive plan of government investment in healthcare, through central bank support and financial regulation, with a “vision akin to that of the New Deal, but now at the global level.”¹⁰⁷ This, however, requires that donor and recipient governments, as well as multilateral institutions, agree to overcome the current narrative, and address the problems that surround public provision of health care services in many places. This pandemic poses us in front of a conundrum: should we continue with the same narrative, or even reinforce it, to try to achieve UHC? Or should we change the paradigm, and make governments and public institutions accountable for available, accessible, acceptable, and quality health services?

¹⁰⁵ How the World Bank is looking at COVID-19 and PPPs, right now and post-crisis. From: blogs.worldbank.org

¹⁰⁶ Mazzucato, M., & Kattel, R. (2020). COVID-19 and public-sector capacity. Oxford Review of Economic Policy [\[LINK\]](#)

¹⁰⁷ OECD (2020). Coronavirus (COVID-19): Joint actions to win the war [\[LINK\]](#)

4. CONCLUSIONS

Overall, the evidence around healthcare PPPs is fragmented and their outcomes are contested. The literature does not produce convincing evidence that PPPs fulfil the promises around which they are promoted, nor that they represent a noticeably better way of healthcare service financing and provision.

On the other hand, the available literature points out serious risks and disadvantages. Indeed most, and the best documented, research pointing at such risks is from HICs. This is unsurprising, considering that many HICs are moving away from the PPP model. It is thus all the more surprising that the PPP model is being promoted in LMICs by the World Bank Group, and by other institutions based in HICs. In fact, the risks related to healthcare PPPs may be expected to be higher in LMICs, where health system development is constrained much more by insufficient budget, and where governance challenges are bigger.

Despite its objective to serve both, it appears that the PPP financing model puts investors' needs before citizens' healthcare needs. With the PPP model, investment in healthcare is guided by the assessment whether projects are 'marketable' for private investors. This new model for healthcare financing, rather than offering a solution to failing health systems, comes with new problems for healthcare provision. In fact, the UN Department of Economic and Social Affairs reflects that PPPs are less suited for the health sector, where access and equity are major concerns.¹⁰⁸

To assess the impact of healthcare PPPs, one cannot ignore the wider political and economic framework in which they are promoted. In the current system, LMICs governments face budget constraints that are caused by a combination of national and international problems – including high debt burdens, a small tax base and insufficient revenue-raising capacity, volatile international financial flows and international corporate tax-reduction competition. At the same time, low corporate tax rates increase the availability of financial capital looking for a return on investment, which is now looked at to fill the gap left by the public sector.¹⁰⁹ There are other – more progressive and equitable ways – to finance healthcare services and fill the SDG funding gap.¹¹⁰

Ultimately, the aim of the SDGs and of the concept of UHC is to leave no one behind. States are bound to obligations in terms of international human rights law to ensure affordable access to quality healthcare for all persons without discrimination. To move towards these goals and legal obligations, it is paramount to leave ideology behind and look at successes and failures – well documented and analysed – in public and private provision and financing of health care services, and to learn from these.

¹⁰⁸ Jomo, Chowdhury, Sharma, & Platz (2016). PPPs and the 2030 Agenda for Sustainable Development: fit for purpose? [\[LINK\]](#)

¹⁰⁹ Bayliss & Van Waeyenberge (2018). Unpacking the PPP revival. *Journal of Development Studies*, 54(4), 577-593. [\[LINK\]](#)

¹¹⁰ Ortiz, Cummins, & Karunaneth (2015). Fiscal space for social protection - A Handbook for Assessing Financing Options. ILO and UN Women publication [\[LINK\]](#)

5. WEMOS' RECOMMENDATIONS

Considering the serious risks and disadvantages in healthcare PPPs, as pointed out by available evidence, and considering the States' obligations in terms of the right to health, we developed the following recommendations:

Development actors – including bilateral, regional and international providers of ODA, multilateral, regional and national development banks – should:

1. Stop promoting PPPs in healthcare delivery and financing through financial or technical support, as long as convincing evidence in support of the acclaimed relative advantages is missing;
2. Focus on overcoming the obstacles in strengthening public healthcare provision and financing, through technical and financial assistance, in a harmonised way and free from vested interests. When private contracting is used, avoid using PPP contracts, and rather focus on arms' length private contracting;
3. Promote public investment, especially when used to address the most pressing needs in health system development, through progressive fiscal revenue – rather than finding a solution for lack of government budget in the use of private finance. As noted by global health experts, to reach UHC, governments should commit to spend at least 5% of gross domestic product on health and move progressively towards this target, and ensure government health expenditures per capita of at least USD 86 whenever possible.¹¹¹

The UN and UN agencies – particularly the WHO – should:

4. Avoid promoting the implementation of healthcare PPPs in official guidance for healthcare financing, highlight the risks related to PPPs, and underpin the fact that PPPs are less suited in the health sector, until more evidence on their impact on access, efficiency and fiscal risk is produced;
5. Advise on increasing the budget for public healthcare, because of its potential to reach UHC even with limited resources. PPPs do not represent a solution for lack of public health budget;
6. Define clear targets of government health expenditure, such as the ones defined by the Working Group on Health Financing at the Chatham House Centre on Global Health Security (see recommendation #3), to promote public investment in healthcare.

¹¹¹ The twin targets were defined [in this 2014 document](#) by the Working Group on Health Financing at the Chatham House Centre on Global Health Security: "Shared Responsibilities for Health: A Coherent Global Framework for Health Financing". Please note: the minimum amount of absolute spending (86\$) varies according to the sources. For example, the WHO refers to an average government spending of 112\$ per capita. More in depth explanation regarding the twin targets of health financing can be found in [this 2018 publication from Wemos: Public finance targets for UHC](#)

All global actors (including GF, GAVI, GFF, GAP) should:

7. Promote domestic resource mobilisation to increase the public health budgets (see recommendation #3). At a global level, promote measures that facilitate tax justice (e.g. by taxing cross border financial transactions), to collect sufficient revenue for healthcare provision.

APPENDIX: METHODOLOGICAL NOTES

LITERATURE REVIEWS

To gain a general overview regarding PPPs and their outcomes in terms of efficiency, efficacy, healthcare accessibility and VFM, we searched for literature reviews on PPPs. Such literature reviews were identified using the search engines *PubMed*, *Scopus* and *Google Scholar*. Our literature survey was conducted between June and November 2020.

A search through *PubMed* using the keyword 'Public Private Partnerships', applying the filters 'systematic reviews', 'reviews' and 'meta-analyses' for the years 2010-onwards delivered 449 results. Based on title and abstract, we identified 6 articles.

Through *Google Scholar*, we performed several searches using different combinations of the keywords 'literature review', 'review', 'PPP', 'public private partnership', 'health', 'healthcare'. 3 further articles were identified.

A search through *Scopus* using the keywords 'public private partnership healthcare', and the filter 'reviews' gave 131 results. Although several overlaps were found, no additional article was identified.

The articles were selected based on:

- The methodology of the article (literature reviews);
- The date of publication (2010-onwards);
- The topic (Public-Private Partnership for healthcare service provision and/or infrastructure);
- The setting of the study (articles referring to single country experiences were excluded).

The following are the literature reviews on healthcare PPPs we identified:

Document reference	Setting
Barlow, J., Roehrich, J., & Wright, S. (2013). Europe sees mixed results from public-private partnerships for building and managing health care facilities and services. <i>Health Affairs</i> , 32(1), 146-154.	Europe
Fabre, A., & Straub, S. (2019). The Economic Impact of public private partnerships (PPPs) in Infrastructure, Health and Education: A Review.	Global
Fanelli, S., Salvatore, F. P., De Pascale, G., & Faccilongo, N. (2020). Insights for the future of health system partnerships in low- and middle-income countries: a systematic literature review. <i>BMC health services research</i> , 20(1), 571.	LMICs
Jensen, J. (2016, June). A review of public–private partnership activities in health system strengthening. In <i>The role of public-private partnerships in health systems strengthening: workshop summary</i> . National Academies Press (US).	Global
Kostyak, L., Shaw, D. M., Elger, B., & Annaheim, B. (2017). A means of improving public health in low- and middle-income countries? Benefits and challenges of international public-private partnerships. <i>Public health</i> , 149, 120–129.	LMICs
Languille, S. (2017). Public Private partnerships in education and health in the global South: a literature review. <i>Journal of International and Comparative Social Policy</i> , 33(2), 142-165.	LMICs
Roehrich, J. K., Lewis, M. A., & George, G. (2014). Are public–private partnerships a healthy option? A systematic literature review. <i>Social science & medicine</i> , 113, 110-119.	Global
Torchia, M., Calabrò, A., & Morner, M. (2015). Public–private partnerships in the health care sector: a systematic review of the literature. <i>Public Management Review</i> , 17(2), 236-261.	Global
Whyle, E. B., & Olivier, J. (2016). Models of public-private engagement for health services delivery and financing in Southern Africa: a systematic review. <i>Health policy and planning</i> , 31(10), 1515–1529.	Southern Africa

REPORTS AND PUBLICATIONS FROM OFFICIAL INSTITUTIONS

Other relevant literature about PPPs in healthcare and public services has been produced by official institutions such as the UN, the EU, the WB and the OECD, which was used for the paper. Such literature is the following:

Document reference	Name of institution
European Commission (2013). Health and Economics Analysis for an evaluation of the Public Private Partnerships in health care delivery across EU	EU
European Commission (2014). A Stronger Role of the Private Sector in Achieving Inclusive and Sustainable Growth in Developing Countries	EU

European Court of Auditors (2018), Public Private Partnerships in the EU: Widespread shortcomings and limited benefits	EU
Van Waeyenberge, Dimakou, Bayliss, Laskaridis, Bonizzi, & Farwa (2020). The use of development funds for de-risking private investment: how effective is it in delivering development results? European Parliament	EU
Jin, H., & Rial, I. (2016). Regulating local government financing vehicles and public-private partnerships in China. IMF Working Paper	IMF
IMF (2004). Public-Private Partnerships	IMF
IMF (2015). Making public investment more efficient	IMF
IMF (2015). Making public investment more efficient	IMF
Independent Evaluation Group of the IMF (2016). The Portuguese Crisis and the IMF	IMF
OECD (2012) Public Governance of Public-Private Partnerships	OECD
OECD (2014), Competition Issues in Public-Private Partnerships	OECD
OECD (2020). Coronavirus (COVID-19): Joint actions to win the war	OECD
Croce, Paula, & Laboul (2015). Infrastructure financing instruments and incentives. OECD	OECD
Burger & Hawkesworth (2011). How to attain value for money: comparing PPP and traditional infrastructure public procurement. OECD Journal on Budgeting, 11(1), 91-146	OECD
Ortiz, Cummins, & Karunaneth (2015). Fiscal space for social protection - A Handbook for Assessing Financing Options. ILO and UN Women publication	UN
UNECE (2012). A preliminary reflection on the best practice in PPP in healthcare sector: a review of different PPP case studies and experiences	UN
Jomo, Chowdhury, Sharma, & Platz (2016). Public-private partnerships and the 2030 Agenda for Sustainable Development: fit for purpose? UN Department of Economic and Social Affairs	UN
WHO (2010). Monitoring the building blocks of health systems: a handbook of indicators and measurement strategies	UN
Asian Development Bank, Inter-American Development Bank, World Bank, Public-Private Infrastructure Advisory Facility, (2014). Public-Private Partnerships Reference Guide. Version 2.0.	WB
WB (2015). From billions to trillions: transforming development finance post-2015 financing for development: multilateral development finance	WB
WB (2017). PPP Reference guide 3.0	WB
Independent Evaluation Group of the World Bank (2016). PPPs in Health	WB

OTHER RELEVANT ACADEMIC LITERATURE

During the scoping reviews, and using of snowball sampling and internet research, we found additional literature regarding infrastructural PPPs, PPPs for social services, and private sector involvement in healthcare, which was deemed relevant for the scope of the paper. Such literature is the following:

Document reference
Bayliss & Van Waeyenberge (2018). Unpacking the PPP revival. <i>Journal of Development Studies</i> , 54(4), 577-593.
Boardman & Hellowell (2017) A Comparative Analysis and Evaluation of Specialist PPP Units' Methodologies for Conducting Value for Money Appraisals, <i>Journal of Comparative Policy Analysis: Research and Practice</i> , 19:3, 191-206
Burger & Hawkesworth (2011). How to attain value for money: comparing PPP and traditional infrastructure public procurement. <i>OECD Journal on Budgeting</i> , 11(1), 91-146
Cepparulo, Eusepi, & Giuriato (2019). Public Private Partnership and fiscal illusion: A systematic review. <i>Journal of Infrastructure, Policy and Development</i> , 3(2), 288-309.
Marks (2019). <i>The Perils of Partnership, Industry Influence, Institutional Integrity, and Public Health</i> . Oxford University Press.
Romero & Ellmers (2018). <i>The Financial and Social Cost of Public–Private Partnerships</i> . In <i>Sovereign Debt and Human Rights</i> : Oxford University Press.
Schomaker (2020). Conceptualizing Corruption in Public Private Partnerships. <i>Public Organization Review</i> , 1-14.
Thadani (2014). Public private partnership in the health sector: Boon or bane. <i>Procedia-Social and Behavioral Sciences</i> , 157, 307-316.
Trebilcock, M., & Rosenstock, M. (2015). Infrastructure public–private partnerships in the developing world: Lessons from recent experience. <i>The Journal of Development Studies</i> , 51(4), 335-354.

CASE STUDIES

To provide examples and illustrate and case studies regarding PPPs in healthcare, we used several sources, including academic literature, reports from NGOs and advocacy organisations, as well as official documentation from development banks. Such literature was identified using several search engines (Google, Google Scholar, Scopus), using different combinations of the keywords 'literature review', 'review', 'PPP', 'public private partnership', 'health', 'healthcare', as well as snowball sampling. The literature regarding the case studies (which is also referenced throughout the text) is the following:

Document reference	Type of document
Acerete, Stafford, & Stapleton (2011). Spanish healthcare public private partnerships: The 'Alzira model'. <i>Critical Perspectives on Accounting</i> , 22(6), 533-549	Academic paper
Bhat, Mavalankar, Singh, & Singh (2009). Maternal healthcare financing: Gujarat's Chiranjeevi Scheme and its beneficiaries. <i>Journal of health, population, and nutrition</i> , 27(2), 249.	Academic paper
Comendeiro-Maaløe, Ridaio-López, Gorgemans, & Bernal-Delgado (2019). Public-private partnerships in the Spanish National Health System: The reversion of the Alzira model. <i>Health policy</i> , 123(4), 408-411.	Academic paper
Cruz, & Marques (2011). Revisiting the Portuguese experience with public-private partnerships. <i>African Journal of Business Management</i> , 5(11), 4023-4032.	Academic paper
Demi Chung, 'Developing an Analytical Framework for Analysing and Assessing Public-Private Partnerships: A Hospital Case Study,' <i>Economic and Labour Relations Review</i> 19, no. 2 (2009): 69–90.	Academic paper
Guasch et al. (2014), "The Renegotiation of PPP Contracts: An Overview of its Recent Evolution in Latin America", <i>International Transport Forum Discussion Papers</i> , 2014/18, OECD Publishing, Paris.	Academic paper
Guasch, J., et al. (2014), "The Renegotiation of PPP Contracts: An Overview of its Recent Evolution in Latin America", <i>International Transport Forum Discussion Papers</i> , No. 2014/18, OECD Publishing, Paris	Academic paper
Hellowell, M. and Pollock, A. (2009) <i>The Private Financing of NHS Hospitals: Politics, Policy and Practice</i> . <i>Journal of the Institute of Economic Affairs</i> , 29:1 pp13–19	Academic paper
Hellowell, Mark. "Are public–private partnerships the future of healthcare delivery in sub-Saharan Africa? Lessons from Lesotho." <i>BMJ global health</i> 4.2 (2019): e001217	Academic paper
Mohanani, Bauhoff, La Forgia, Babiarz, Singh, and Miller (2014). Effect of Chiranjeevi Yojana on institutional deliveries and neonatal and maternal outcomes in Gujarat, India: a difference-in-differences analysis. <i>Bulletin of the WHO</i>	Academic paper
Pereira, Ferreira, & Marques (2020). A critical look at the Portuguese public–private partnerships in healthcare. <i>The International Journal of Health Planning and Management</i> .	Academic paper
Roy & Gupta (2011). Public-Private Partnership and User fees in healthcare: evidence from West Bengal. <i>Econ Polit Wkly</i> , 46(38), 74-78. ;	Academic paper
Santandrea, Bailey, & Giorgino (2016). Value for money in UK healthcare public–private partnerships: A fragility perspective. <i>Public Policy and Administration</i> , 31(3), 260-279.	Academic paper
Sarmiento, & Renneboog (2014). The Portuguese experience with public-private partnerships. <i>CentER Discussion Paper Series No. 2014-005</i>	Academic paper

Waluszewski, Hakansson, & Snehota (2019). The public-private partnership (PPP) disaster of a new hospital—expected political and existing business interaction patterns. <i>Journal of business & industrial marketing</i> .	Academic paper
Michelitsch et al (2017), Evaluation of Public–Private Partnerships in Infrastructure: Executive Summary. Inter-American Development Bank (IADB) Report	IADB report
Seatini, Oxfam, Uganda Debt Network and CSBAG (2019). Civil Society Statement on the International Specialized Hospital of Uganda (ISHU) at Lubowa	NGO open letter
Benedito (2010). La experiencia valenciana de las concesiones administrativas en al sanidad pública. In ¿Por nuestra salud?: La rehabilitación de los servicios sanitarios (pp. 97-106). <i>Traficantes de Sueños</i> .	NGO report
Eurodad (2018) History RePPPeated - How public-private partnerships are failing	NGO report
Hall (2015). Why Public-Private Partnerships don't work - The many advantages of the public alternative	NGO report
Institute of Economic Affairs (2020). Leasing of Medical Equipment Project in Kenya: Value for Money Assessment	NGO report
ISER (2020). Failing to reach the poor? Assessment of the WB funded Uganda reproductive health voucher project	NGO report
Jubilee Debt Campaign UK (2017). Double Standards	NGO report
Latindadd (2019) Public Private Partnerships and universal healthcare in Latin America – at what cost?	NGO report
Oxfam (2009). Blind optimism - Challenging the myths about private health care in poor countries	NGO report
Oxfam (2014). A dangerous diversion; Bhekisisa Centre for Health Journalism (2020). Why one hospital takes up almost 30% of this country's entire health budget	NGO report
Transparency International (2019). Corruption and unsolicited proposals	NGO report
Lesotho Health Network Public-Private Partnership (PPP).	Web article (WB blog)
Monish Patolawala (2017). Transforming Kenya's healthcare system: a PPP success story.	Web article (WB blog)
Uganda Reproductive Health Voucher Project. From: projects.worldbank.org	Web article (WB blog)