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Health PPPs in Latin America

A Review

Maria Jose Romero and Jasmine Gideon

Introduction

In 2015 world leaders agreed on the Agenda 2030 for Sustainable Development at the United Nations (United Nations, 2015), including a commitment on health with universal health coverage at its core. This commitment has further intensified different interpretations about how the provision of healthcare will be delivered and financed. The most dominant policy paradigm has placed the private sector at the heart of financing for development. Public Private Partnerships (PPPs) are part and parcel of this private turn in development finance (Bayliss and Van Waeyenberge, 2018). They are promoted as a key financing and policy tool and symbol of how to deliver on the Sustainable Development Goals (SDGs), including on health. This chapter addresses the rise of PPPs in Latin American health sectors, with a focus on Peru where health PPPs are high on the political agenda. It presents a literature review mapping the main debates over health PPPs, with a primary focus on hospital PPPs, including whether PPPs can deliver on the SDGs.

Since 2010 there has been a dramatic upscaling of global advocacy efforts in favour of PPPs (Bayliss and Van Waeyenberge, 2018). PPPs are fostered through different tools by a wide range of transnational actors, including specific departments of United Nations agencies, the Group of 20 (G20), the World Bank Group (WBG), bilateral development agencies, key donor governments, global consultancy firms, business associations, and philanthropic organisations. This promotion has resulted in different platforms, donor facilities, and initiatives to enable PPPs to flourish (Hall, 2015; Lethbridge, 2016; Romero, 2015; Shaoul, 2009). In healthcare, global PPPs – or multi-stakeholder partnerships – have proliferated and a market for healthcare PPPs has developed despite ambiguous (and often negative) evidence regarding their effectiveness, cost, and equity implications (Gideon and Unterhalter, 2017; Hall, 2015; KS et al., 2016; Languille, 2017; Romero, 2015; Trebilcock and Rosenstock, 2015).

The emerging role of health PPPs can be located in the broader context of a changing landscape of development and health finance over the past two decades, which has been marked by

significant changes in social policy across the global South. This reflects changing moments and forms of neoliberalism, underpinned and driven by financialisation, although these processes have proceeded unevenly (Lavinas, 2018). These changes are associated, firstly, with 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 and education. Secondly, there has been a greater focus on 'rationality' in social policy, in areas such as healthcare. There is a growing emphasis on the imperatives of health economics with a stress on hierarchies with regard to particular forms of research evidence and research methods (Adams, 2013). Philanthropic foundations have increased influence on health policy and are associated with new mechanisms to raise and disburse finance (Buse, Hein, and Drager, 2009; Hunter and Murray, 2019). Somewhat paradoxically and perversely, the financial and economic crisis of 2007–8 resulted in an increased focus on the private sector in development, underpinned by reliance upon, and promotion of, private finance. This trend may be driven by the mass of wealth in the hands of institutional investors seeking stable and profitable investment opportunities (Bayliss and Van Waeyenberge, 2018). According to Fine and Saad-Filho (2017, p. 687), the rise of financialisation, 'defined as the intensive and extensive accumulation of interest-bearing capital, has transformed profoundly the organisation of economic and social reproduction' (see also Fine, this volume). The privatisation of public utilities and, more recently, the role of PPPs in the provision of economic and social infrastructure has been central to this process. Furthermore, this changing landscape has given rise to a particular narrative in support of PPPs, which takes different forms and emphases across regions and countries. These include a focus on the ability of private finance to bridge the so-called financing gap in infrastructure and social sectors, which has been fuelled by austerity policies that have undermined the ability of the public sector to deliver healthcare.

Historically, private investment and PPP projects in Latin America and the Caribbean focused on physical infrastructure, especially transportation, telecommunications, and energy (WBG, 2019). In the last decade, however, much of the region has started to use PPPs to address social infrastructure, including healthcare, with countries like Brazil, Chile, Colombia, Mexico, and Peru in the lead (IDB, 2017; Llumpo et al., 2015; Vassallo, 2019). Across the region, PPP laws have been passed and PPPs have been included in national development and sectoral plans (Economic Intelligence Unit, 2019).

Although the private sector (both for-profit, and not-for-profit) has historically played an active role in the provision of healthcare, the increased use and promotion of PPPs raise specific

issues. These include the reconfiguration of public and private sector relations (Languille, 2017), and for strategies of universalisation of health provision based on social citizenship. Reconfiguring the role of the state to enable PPPs includes its reorientation towards the commissioning of services, rather than overseeing direct provision, and often, the creation by the state of a secured revenue stream for private sector companies in the context of essential services provision. This has profound consequences for how far the state can attend to inequalities by ensuring provision for the most marginalised groups in society (Hunter and Murray, 2019). Yet, the presumed global consensus on the need for universal coverage masks considerable divergence around the principles and politics of what constitutes 'universality' (Birn and Nervi, 2019). Moreover, since the 2007–8 global economic crisis attention has been diverted away from addressing the social determinants of health and delivering preventative primary care in favour of expanding private provision and an emphasis on the cost effectiveness of treatments (Benatar, Gill and Bakker, 2011; Vasquez, Perez-Brumer, and Parker, 2019). Several countries in the region, notably Bolivia and Ecuador prioritised the development of curative and hospital-based care, thereby diverting resources and attention away from addressing the social determinants of health (Hartmann, 2016).[1]

While there are a range of analyses of social and health policies in Latin America, including Peru (cf. Ewig, 2011; Haggard and Kaufman, 2008; Mesa Lago, 2008), the literature on health PPPs in this region is still emerging. In reviewing these studies, we draw lessons from the international experience with health PPPs to inform our analysis. The chapter starts with a brief discussion of the definition of PPPs before presenting an overview of the key features of Latin American health systems, with a special focus on Peru. It then analyses the emergence of health PPPs in Latin America, focussing on the key players and policy drivers setting these in the context key debates. The case of Peru is used throughout the chapter to illustrate the emergence of PPPs in a country facing particular health challenges.

Defining PPPs

PPPs have been a feature of social policy implementation since the early 1990s, although there is no universally agreed definition of the term PPP (see Romero and Van Waeyenberge, this volume). The word 'partnership' has become a development buzzword (Cornwall, 2007, p. 475), which speaks to 'an agenda for transforming development's relationships', with popularity that has 'as much to do with their feel-good factor as with what they promised to deliver'. According to Miraftab (2004, p. 92), the loose terminology surrounding PPPs serves a deliberate purpose, fostering 'convenient ambiguities in defining the roles and expectations

of each partner'. Many countries have developed their own definitions of PPPs in national laws and policies, which presents challenges for conducting comparative analysis.

Different typologies have been developed to categorise PPPs in the health sector. These include a widely used typology of hospital PPPs (Montagu and Harding, 2012), the distinction between demand-side health policies, such as voucher schemes, and supply-side health policies, such as franchising, and a typology of global PPPs for development on the basis of the goals that they pursue (Buse and Walt, 2000). However, following Romero and Van Waeyenberge (this volume), we argue that these typologies draw attention away from the underlying shared features of PPP arrangements, which become obfuscated as differences in concrete arrangements are emphasised. These shared features include that PPPs imply state support (domestically and internationally) for the transformation of public services into private assets – with the exception of partnerships with not-for-profit organisations. This shift is to the detriment of alternative practices and notions of public services and public goods framed by the imperatives of access and quality for all.

Latin American health systems

During the 1980s and 1990s Latin American health systems were transformed under the influence of the Washington Consensus, driven by the international financial institutions (Molyneux, 2008), with profound consequences for their health systems and their outcomes. Neoliberal policies implemented in the region entailed the reduction and privatisation of state social services and safety nets, the opening of national economies to foreign trade and investment, and promotion of a market logic over a state-based social contract. Within the health sector, the contraction and decentralisation of health care services and programmes took place, accompanied by increasingly precarious conditions of work for health professionals. There was a stress on management efficiency, and private insurance (Birn, Nervi, and Siqueira, 2016; Cueto, Palmer, and Palmer, 2015; Vasquez, Perez-Brumer, and Parker, 2019). This converted 'Latin America into a living laboratory of neoliberal macroeconomic reform' (Laurell, 2000, quoted in Vasquez, Perez-Brumer, and Parker, 2019, p. 780). Critics have argued that the costs of these neoliberal reforms for public health 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 (Cueto, Palmer, and Palmer, 2015; Yon, 2016).

Although different countries experienced this process differentially (Bustamante and Méndez, 2014; Haggard and Kaufman, 2009), the diffusion of the neoliberal model was facilitated by a series of regional factors. These include, an end to the region's post-war model of development associated with the debt crisis which dealt a blow to the region's history of internally driven economic development, import substitution and industrialisation. The military dictatorships which took power across the region from the 1950s to the 1980s also spurred on processes linked with neoliberalism (Birn, Nervi, and Siqueira, 2016). A large middle class has encouraged foreign investment in the social security systems that provided health care insurance (Birn, Nervi, and Siqueira, 2016). Historically many Latin American health systems evolved out of a series of social security funds that were established for formal sector workers (Mesa-Lago, 2008). As a result, health systems in the region are characterised by 'segmentation and fragmentation' – a combination that according to the Pan American Health Organisation (PAHO) 'give rise to inequities and inefficiencies that compromise universal access, quality, and financing' (PAHO, 2017, p. 1). In addition, 'weak health system regulatory capacity, excessive verticality in some public health programs, lack of integrated service delivery, and, occasionally, union pressure to protect privileges and lack of political will to make the necessary changes exacerbate and perpetuate this problem' (PAHO, 2017, p. 1).

From the late 1990s centre-left and left-wing parties came to power in most countries of the region, under what has been referred to as the 'pink tide', opposed to neoliberal policies (Riggirozzi and Grugel, 2012). These governments promoted a wave of health sector reforms that expanded access and coverage (Huber and Stephens, 2012; Vasquez, Perez-Brumer, and Parker, 2019). Peru, however, remained 'an outlier' to the pink tide (Crabtree and Durand, 2017). Here, 'despite significant popular reaction to the policies associated with neoliberalism, left-wing parties conspicuously failed to mount a convincing political challenge to the hegemony of the Washington Consensus, both during the Fujimori years and thereafter' (Crabtree and Durand, 2017, p. 173).[2]

During the 2000s Latin America experienced a decade of economic growth as a result of the 'commodity boom' (Ocampo, 2015). This allowed for an increase in health expenditure. However, most countries in the region continue to 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' (PAHO, 2017, p. 1). Despite constitutional changes in Bolivia, Ecuador, and Venezuela to define health as a state-guaranteed social right (Hartmann, 2016), the private sector remains prominent in health

sectors across the region. In Chile, Colombia, and Peru constitutions provide a legal framework for the participation of private actors in public services, such as health. Yet evidence highlights the ways in which existing regulatory mechanisms which encourage private actors' engagement in social development fail to protect public interests. In Chile private health insurance companies (ISAPRES) have circumvented regulations imposed on them (Martinez-Gutierrez and Cuadrado, 2017), particularly in relation to the pricing of health care plans for women (Gideon and Alvarez, 2018).

Although to date the extent to which domestic actors such as the business sector, politicians, and technocrats have advocated the use of PPPs in the health sector has not been centre stage in the literature, attention has been given to the part played by national actors in the design and implementation of previous neoliberal health reforms (Weyland, 2006). Research on Chile and Colombia has emphasised the importance of the business sector and technocrats in pushing forward neoliberal reforms that promoted the privatisation of health care services and increased the political influence of the private sector in health (Bustamante and Méndez, 2014; Ewig and Kay, 2011). Studies from Peru emphasise the importance of business groups in the reform process (Arroyo Laguna, 2001; Ewig, 2011), which 'organised themselves in an extremely effective manner in capturing the state' (Crabtree and Durand, 2017, p. 181). While the World Bank and other IFIs have exerted some influence in the direction of the reforms, Dargent (2012, p. 141) argues that:

> Peruvian experts were not just following orders from IFIs. Experts agreed with IFIs on many of the proposed solutions to the economic crisis, but Peruvian experts in the state were already committed to market reforms and had an ambitious reform agenda of their own.

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Similar conclusions are drawn by other authors (Ewig, 2011; Vreeland, 2003). Ewig (2011) argues that IFI interest in the reform process provided more space for Peruvian policy makers to implement the kinds of reforms they wanted to as they were able to pitch donors against one another forcing them to compromise. Nevertheless, the influence of business elites in the region is undeniable. As Homedes and Ugalde (2005) argue, the main beneficiaries of neoliberal health reforms across Latin America have been transnational corporations, consultant firms, and World Bank staff. In the Chilean case ISAPRES made profits of around US$60 million in 2015, while profits for the past decade surpassed US$860 million (Rotarou and Sakellariou,

2017, p. 500). We look now at some of these processes in detail as they have played out in Peru.

The Peruvian case

Peru has a mixed health system. Much of the health care needs of the population (60 percent) are covered by the Ministry of Health (Ministerio de Salud – MINSA); 30 per cent is covered by social health insurance – EsSalud; the rest of the population is covered by the Armed Forces, National Police, and the private sector. The health care needs of low-income groups are covered by MINSA's Comprehensive Health Insurance programme – Seguro Integral de Salud or SIS as it is commonly known, first introduced in 2002. However, unlike EsSalud and the other health insurance schemes, which provide full coverage for all health necessities, SIS only covers a list of prioritised conditions and interventions (Flores-Flores et al., 2018; Francke, 2013).

In 2013 the government initiated a health reform process that aimed at recognising the right to health for all as established in the Peruvian constitution. By 2015 health coverage had increased from 64 per cent of the population to 73 per cent and was accompanied by a three-fold increase of the SIS budget (Velásquez, Suarez, and Nepo-Linares, 2016). Despite the government's commitment to achieving universal health coverage (UHC) by 2021, the historical legacy associated with the development of the health system poses a number of challenges, some of which have been exacerbated by the reform (Eibenschutz et al., 2014). The dual system through which the public system serves the poor and the social security systems serve upper- and middle-class workers in the formal economy, has led to segmentation and fragmentation. The system is highly gendered and racialised with poor, indigenous women concentrated in the public system and mestizo and 'whiter' men located in the social security systems (Nagels, 2018). This is unsurprising given that 'social security health systems were an essentially male privilege and the public health systems were feminised' because 'one of its major premises was to control women's biological reproduction' (Ewig, 2011, p. 32). The gendered and racialised historical legacy of civil conflict in Peru is evident in health and the health system (Ewig, 2011; Grimard and Laszlo, 2014; Nagels, 2018). Several studies highlight significant inequalities within the Peruvian health system highlighting how social identity, particularly gender, race, class, age, and locality, shape individuals' access to, and experience of, the health system (Ewig, 2011; Flores-Flores et al., 2018). Research points to a significant gender pay gap among those working in the Peruvian health sector (Rosas et al., 2019). The lack of culturally appropriate health care services has exacerbated marginalisation of indigenous communities

from health care services (Gianella et al., 2016; Valenzuela-Oré et al., 2018; Yon, 2016). Studies suggest that many low-income users continue to rely on out-of-pocket expenditure, buying medication directly from local pharmacies rather than utilising health care services (Ypanaqué-Luyo and Martins, 2015).

MINSA health services are distributed nationally via Primary Health Centres (PHCs), but the public health system is characterised by lack of resources and significant urban-rural divides despite the increased coverage of the SIS (Yon, 2016). In contrast, the FFAA, PNP, EsSalud, and private health facilities have greater resources spread across fewer locations (Flores-Flores et al., 2018). Ninety per cent of public hospitals and health clinics are located in urban areas, seven per cent in marginal urban zones and only three per cent in rural areas (Nagels, 2018). Rural provision of services continues to experience a lack of financial investment, poor infrastructure and equipment, poor quality care, and lack of attention from staff. There is weak regulation (Defensoría del Pueblo 2013, cited in Yon, 2016). Studies identify a lack of political will as one of the main impediments to improving health systems so that Peru would be able to meet SDG targets of ensuring UHC (Cardenas, Miranda, and Beran, 2016). The public system has a significant shortage of human resources including doctors, nurses, and midwives, despite high numbers of graduates being trained (Jimenez et al., 2017). In 2016 an assessment of practising medical specialists across the country, noted the majority focused on maternity and infant health (Cardenas, Miranda, and Beran, 2016), reflecting government efforts to expand health coverage by concentrating on the needs of poor mothers and children (Noy, 2018). As the next section of the chapter highlights, in the context of under-funded public health systems the rise of PPPs has also been inextricably linked with the push to expand health care coverage in Peru and the rest of the region.

Latin American health systems and the rise of PPPs

Latin American discussions of the private sector in health have tended to look at mercantilisation and privatisation processes associated with social policy and health systems (Eibenschutz, 1996; Noy, 2017). Literature on health PPPs in the region is still sparse, possibly reflecting the health PPP market in Latin America is at an early stage of development. Knowledge production on PPPs has been dominated by its advocates, notably the World Bank, philanthropic organisations, and consultancy firms (Languille, 2017). Given this limited literature our discussion of health PPPs draws primarily on the wider literature and draws lessons from the international experience with health PPPs for Peru and the region. Clearly addressing the lack of detailed literature is a pressing future task.

The rise of health PPPs

Over the last three decades global health governance has experienced substantial changes with important impacts on the rise of health PPPs. While the World Bank initiated a leadership role in reforms of the health systems – through its lending capacity and the use of its 'knowledge products' – the relevance of the World Health Organization (WHO) diminished (Brown, Cueto, and Fee, 2006). This shift was associated with competing visions of health, articulated by distinctive epistemic communities. Health was portrayed as human capital supporting economic growth (a view mobilised by the World Bank). Alternatively, it was discussed through a basic human rights approach operating as a means for achieving further rights (a view associated with UN agencies) (Gideon, 2014). Over time, UN agencies have reshaped their strategic vision of the role of the private sector in achieving the right to health (Buse and Waxman, 2001), as evidenced in 2000 when the WHO corporate strategy emphasised the need to increase the effectiveness of its work through 'collective action and partnerships' (WHO, 2000).

In 1993 the World Bank laid out its neoliberal vision for the health sector with the publication of the World Development Report (WDR), 'Investing in Health' (World Bank, 1993). This was the first World Bank report entirely dedicated to health, resulting in increased legitimacy of the institution in the health sector. Reflecting on the key message of the WDR Cueto and colleagues argue that 'private and public investments in scientifically sound treatment and preventive programs could become main factors in the economic growth of countries' (Cueto, Palmer, and Palmer, 2015, p. 243). The call for private investment was reiterated in 2013 with the publication in the prestigious medical journal, the Lancet, of the report 'Global Health 2035: A World Converging within a Generation'. The report was produced by the Lancet Commission led by two economists previously involved in the 1993 WDR who were invited to build on its legacy (Jamison et al., 2013, cited in Birn, Nervi, and Siqueira, 2016). The Commission advocated the importance of private finance in 'reducing the worldwide burden of infectious disease and reproductive, maternal, new born and child health disorders in line with rates found in Chile, China, Costa Rica, and Cuba' (Birn, Nervi, and Siqueira, 2016, p. 744) (all countries with good indicators). Yet, no acknowledgement was given in this discussion to the central role of the public sector in producing the good health indicators found in the three Latin American countries, nor the specific histories of the three countries in the first phase of welfare state development in twentieth century Latin America (Birn, Nervi, and Siqueira, 2016).

Alongside official agencies an important set of private agents acted as enablers, advisors, providers, and financiers of PPPs globally, and at the regional and national levels. These included the 'big four' global consultancy firms – PwC, Deloitte, KPMG, and Ernst & Young – and others, like Mott MacDonald. These often act as key advisors to governments and private sector companies with regard to PPPs. These firms have developed highly profitable lines of business, through fees from legal and consultancy work commissioned by both public and private sector clients. Through this work they actively shape national policies in health and education. They also conduct worldwide reviews of policies, legal frameworks, and practices for PPPs rivalling the efforts of public bodies (Hall, 2015; Shaoul, 2009). Business associations also play an important role in the promotion of PPPs. The World Economic Forum (WEF), which provides a platform for the world's leading companies, is a key player in the field of global health. The WEF uses its convening power to gather numerous business, government, and civil society leaders annually in Davos with the objective of shaping global, regional, and industry agendas. Private sector companies, acting as providers, have been key actors in the rise of health PPPs and have gained influence in global (and national) health policy formation. They operate on a transnational level, and most are party to both global PPPs and national PPP arrangements. In some cases, private sector companies have established philanthropic activities to increase their legitimacy in the field. There has been a concentration of pharmaceutical companies around health PPP initiatives, for instance, a few companies – including GlaxoSmithKline, Johnson & Johnson, Merck/Merck, and Pfizer – are collectively represented in over half of total (global) health PPPs (Winters, 2017). Philanthropic organisations, which act as enablers and often as financial supporters of PPP projects, are also influential actors in health global policy networks. Although the involvement of philanthropists in social sectors is not new (Birn, 2014), several characteristics of the current trend mark a new phase of this process (Languille, 2017). These include the scale of philanthropic foundations' involvement, especially in health. The Bill and Melinda Gates Foundation, for example, constitutes one of the largest single sources of financial support for global health initiatives. In the current phase we also see a shift away from the popular conception of philanthropy, as altruistic private initiatives serving the public good, and the emergence of what has been termed 'philantrocapitalism' (Bishop and Green, 2010). This seeks to capture an alleged win-win situation associated with the idea that 'business thinking and market methods will save the world – and make some of us a fortune along the way' (Edwards, 2008, pp. 22–23). This differs from former phases of activity. They often have a pragmatic and active involvement in the

operations and running of the organisations they support by participating on the boards of global PPPs (McGoey, 2014).

In the last decade, health PPPs have emerged in many Latin American countries. Multilateral development banks, such as the WBG and the Inter-American Development Bank (IDB), have enabled and financially supported PPPs in Latin America. The majority of these projects have been implemented in Brazil, Mexico, and Colombia, and in energy and transport, but recently support has been provided to other sectors, including renewable energy and social sectors (IDB, 2017). In Peru, the World Bank has approved several loans to reform its health sector, and in 2015 the IDB approved a loan to strengthen the capacity of the country to implement PPPs in the health sector.[3] In Peru, health PPPs have been on the agenda since 2008, when the Investment Committee of the Ministry of Health was created, and a new law allowed EsSalud the right to enter into long-term contracts, including PPP contracts, without obtaining prior federal approval (Zevallos, Salas, and Robles, 2014). By August 2019, two PPP hospitals were in operation – both at the federal level, carried out by EsSalud, and located within the greater Lima metropolitan area, Hospital Alberto Leopoldo Barton Thompson and Hospital Guillermo Kaelin de la Fuente. Both projects involved the building and clinical operation of new hospitals, each with corresponding primary and urgent care centres. Additionally, according to ProInversión – the Peruvian Private Investment Promotion Agency – five PPP hospitals are under negotiation and two other projects are in the pipeline.[4] Given the deeply embedded inequalities within the Peruvian health system, questions must be asked about the promotion of PPPs and its implications for democratic governance and equity considerations.

The rise of PPPs: theory and practice

The conventional rationale underpinning the global promotion of health PPPs refers to the ability of PPPs to raise finance, including the requirement for fewer government resources to carry out pre-project studies, improve cost-effectiveness in public health systems, which are under pressure to expand access due to demographic changes (demand pressure), and increase efficiency through encouraging innovation (European Commission, 2014; Llumpo et al., 2015). Interestingly, all these arguments often replicate those in favour of greater private participation in service provision, without considering the specifics of the health sector. Montagu and Harding (2012) present several reasons as to why health PPPs have to be analysed differently to infrastructure PPPs. These include: that hospital PPPs typically receive most of their income from government in the form of scheduled payments during the lifespan of the

contract; that healthcare outputs 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. 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' (Montagu and Harding, 2012, pp. 16–17).

Richter (2003, p. 7) argues that the PPP policy paradigm is based on three controversial assumptions: (a) PPPs are a 'win-win' situation; (b) the interactions with business actors are built on the basis of 'trust' and 'mutual benefits'; and (c) this policy paradigm is an 'unavoidable necessity'. Additionally, the changing landscape of development (and health) finance has given rise to a narrative in support of PPPs. This includes a focus on the ability of private finance to bridge the so-called financing gap in infrastructure and social sectors, and arguments that emphasise the lack of capacity of the state to deliver healthcare in an efficient way. The latter is reinforced by the (controversial) belief that the private sector is more efficient in delivering services than the public sector (Hall, 2015; Miraftab, 2004). Behind these assumptions there is also an ideological bias against state provision, on the basis of poor decision-making and corrupt practices (Bayliss and Van Waeyenberge, 2018). Importantly, neoliberal policies that have reduced public investment in social sectors have further dismantled state capacity to deliver social services (Ortiz and Cummins, 2019).

Critiques of health PPPs discussion have focused on the extent to which they are able to produce positive development outcomes, including their ability to improve access, generate quality services, promote decent work, and reduce (gender) inequalities, (Hall, 2015; KS et al., 2016; Languille, 2017; Romero, 2015). In addition, there are also concerns in relation to the understandings of health that underpin the use of PPPs (Gideon and Unterhalter, 2017). Yet the evidence of their benefits is ambiguous, and large data gaps exist (Languille, 2017). This stands in stark contrast with the unambiguously positive advocacy efforts that international organisations have sought to promote. Several evaluations conducted by the World Bank's Independent Evaluation Group acknowledge the lack of data (IEG, 2018; 2014). For instance, a report on the WBG's support to health services states that the International Finance Corporation's advisory services 'are generally successful in bringing [PPP] transactions to

commercial closure', but 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 (IEG, 2018, p. 184). Moreover, in a review of PPPs in health, education, and infrastructure, Fabre and Straub (2019) consider the effectiveness of PPPs, and the implications for coverage and affordability. They point to the 'inconclusive evidence of the impact of PPPs on health service utilisation, the quality of services, patient satisfaction and health-related outcomes' (Fabre and Straub, 2019, pp. 2–3).

In light of available research, critics have questioned the ability of PPPs to effectively benefit vulnerable communities (Languille, 2017; Hellowell, 2019). These concerns have been explored in relation to gender inequalities, and analysis points to the lack of consideration of, or attention to, gender issues within health-related PPPs (Gideon, Hunter, and Murray, 2017; Hawkes, Buse, and Kapilashrami, 2017). Although women's health has been at the heart of many global PPPs, these initiatives tend to focus on a narrow and managerial perspective of women's health, which structure projects around measurable outcomes, i.e. number of people vaccinated (Gideon and Porter, 2016). This limits broader understandings of the structural factors shaping women's health, including power, economic inequality, and gender relations (Languille, 2017). Another concern is the lack of evidence on working conditions within PPP-managed health facilities (Acerete, Stafford, and Stapleton, 2011; Waluszewski, Hakansson, and Snehota, 2019). Ultimately, these issues relate to what success in PPPs means – an area of research contestation depending on whether the focus is on short-term outputs or systemic change (Hodge, Greve, and Biygautane, 2018).

Several case studies have pointed to the high costs and risks associated with health PPPs but the focus has been on high-income countries (Acerete, Stafford, and Stapleton, 2011; Chung, 2009), while little evidence is available – due to lack of ex post data – from the global South. However, in 2014 the issue gained wide public attention as a result of an Oxfam report on a PPP hospital in Lesotho, for which the government received support from the World Bank. It exposed how the initial cost of the project escalated and ended up consuming more than half of the national health budget (Marriott, 2014). Chilean research also raises concerns about the financial sustainability of PPP hospitals, demonstrating how this is ultimately undermined by the unbalanced risk allocation and so the financial sustainability of the project (Bachelet, 2014).

The assumed efficiency gains of PPPs have also been challenged. 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' (European Commission, 2014, p. 6). Similarly, Torchia, Calabrò, and Morner (2015, p. 238) conclude 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.

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The fiscal implications and the lack of evidence to assess the impact of PPPs on efficiency in the health (and education) sectors – including by the UK's National Account Office (HM Treasury, 2018) – led the UK government, one of the most active promoters of PPPs, to announce in October 2018 that it would give up on this modality for new infrastructure investments.[5]

Finally, the implications of PPP hospitals for the rest of the health system must be considered. The high costs associated with the existence of PPPs creates greater threats to the spending on public services (Shaoul, Stafford, and Stapleton, 2008), including on rural health care and on services specifically targeting women, such as domestic violence refuges and free reproductive healthcare services (Romero, 2019). The threat to public services posed by health PPPs can be exacerbated in a context where there are political demands to cut public spending, including through IMF programmes. Moreover, concerns have been raised in relation to the potential brain drain that results from private hospitals, including PPP hospitals. As Fabre and Straub (2019, p. 50) warn, 'the multiplication of these private facilities might deteriorate even more the quality of public services as they are likely to attract the most skilled health workers'. In a Latin American context, where many health systems are fragmented and suffer from significant urban-rural divides, these issues raise considerable concern (Romero and Gideon, 2019).

Concluding remarks

PPPs are currently being promoted as a way to finance health-related needs. Advocacy efforts supporting health PPPs take place at the global level and have also permeated Latin American health systems. This has happened in a context of health systems that were reformed under neoliberal policies influenced by international financial institutions. However, the emergence of health PPPs has not been free of controversies. This literature review indicates there is very

little evidence that PPPs can address the challenges that countries face in delivering UHC and the SDGs, including fragmentation and inequalities within health systems. Concerns have been raised by critics that health PPPs in fact further entrench existing inequalities.

This review exposes several limitations of the existing scholarship on health PPPs in Latin America that future research needs to address. First, the literature does not provide data on the outcomes of health PPPs in Latin America, particularly for equity, gender, and labour considerations. Different research methodologies are needed to deepen the understanding of global health PPPs in Latin America, demand-side type of PPPs and their impact in Latin American countries and the experience with hospital PPPs. Second, the literature does not provide detailed accounts of the relations between the state and domestic and international capital. In relation to this, there is a need to unpack the economics of health PPPs, to understand from where the capital comes, how the relation between capital and labour is being transformed under such arrangements, and how the state facilitates PPPs (Languille, 2017). Third, there is scarcity of data on the corporate sector, its contributions, and interests when engaging in health PPPs in Latin America. Finally, as Languille (2017, p. 157) argues, there is a need to explore the voices of the 'beneficiaries', understood in a broad sense: state officials, health frontline agents, and patients, to 'open the black box between the intervention[s] and [their] outcomes'. In view of achieving the SDGs, a broader evidence-based approach is needed to support an informed and inclusive debate that targets the design of social policies that serve people's needs.

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[1] It is worth noting that hospital care accounts for about 50 percent of total health care expenditure in the majority of countries (Levaggi and Levaggi, 2020, p. 1).

[2] Fujimori governed Peru for ten years between 1990 and 2000.

[3] See the 2015 loan PE-L1169 (Improving Management for Universal Health Coverage Program I). According to the IDB (2017, p. 54) ‘it is expected that among of the components of the second operation will be to define contract supervision mechanisms for health care investment projects awarded through PPPs, and to strengthen Health Ministry of Peru (MINSA) capacity to implement PPP contracts’.

[4] Proinversion: https://www.proyectosapp.pe/modulos/JER/PlantillaProyectosResumenes.aspx?are=0&prf=2&jer=5680&sec=22 (accessed on 12 August 2019).

[5] https://www.gov.uk/government/speeches/budget-2018-philip-hammonds-speech