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A "common sense" response to health inequalities in Peru? Public Private Partnerships in health and the implications for the right to health and economic inequality.

Introduction

Global health policies have become increasingly framed by the importance of leveraging new financial assets to provide much-needed resources while health priorities have been guided by the creation and dissemination of efficiency grounded metrics (Adams 2016; Tichenor et al. 2021). This has led to an overreliance on technocratic jargon and buzzwords, detracting from the crucial role of global health policies in protecting health, while creating a dominant discourse that critics have labelled "global health nonsense" (Stein, Storeng, and de Bengy Puyvallée 2022). One of the most concerning aspects of this dominant discourse is the obscuring, obfuscation and omission of relevant information (Stein, Storeng, and de Bengy Puyvallée 2022). Moreover, this has come at the detriment of a rights-aligned approach to health policy, grounded in international human rights law, including Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) (Shawar, Ruger, and Robinson 2018). Following the 2008 global financial crisis, some governments in low- and middle-income countries (LMIC) began to frame their development programs, especially health financing, around notions of "mutual benefit", connecting health with economic and trade interests (Hunter 2023). In addition, we have witnessed the rise of a narrative supporting Public-Private Partnerships (PPPs) in health (Gideon and Unterhalter 2020). Such narrative calls on private finance to bridge a so-called "financing gap" whereby poorer states are encouraged to use public finance and overseas development assistance to "unlock" private finance to fund development projects (Mawdsley 2018). Furthermore, following the adoption of the Addis Ababa Action Agenda and the

Sustainable Development Goals (SDGs) in 2015, support for PPPs further intensified as development donors expanded their use to fund the SDGs, including health-related goals. Before the COVID-19 pandemic, the SDG3-specific calculation of the financing need stood at US$371 billion annually (Stenberg et al. 2017), serving as justification for reorienting development finance institutions to leverage private finance (Gabor 2021; Hunter 2023).

Promoting PPPs by governments and international financial institutions (IFIs), such as the World Bank Group, is not new (International Finance Corporation 2008). However, the global advancement of PPPs has intensified in recent years, as their advocates describe them as an effective means to finance and deliver infrastructure and social-related needs (Bayliss and Van Waeyenberge 2018). Although the initial “waves” of PPPs were focused on high-income countries, attention has increasingly shifted to LMICs, including Latin America (Romero and Gideon 2020). A growing number of LMICs have implemented PPPs in the health sector as countries work towards meeting the SDG health targets, including target 3.8, which advocates the need to achieve universal access to health services and to ensure financial protection for all. Countries, such as Chile, Colombia, Mexico and Peru, have established specialist PPP units and drafted regulatory reforms encouraging health authorities to undertake specific forms of PPPs (World Bank 2020; Llumpo et al. 2015). Indeed, as the World Health Organization (2020) observes, within LMICs, health PPPs resemble “Maslow’s Hammer” – the overreliance on a single available tool. However, as the World Health Organization (WHO) warns:

> “In this context, Ministries of Health are armed with a hammer – a highly complex tool that bundles together in a single contract an extensive range of complex services

> – and they need only to find a suitable nail. The consequences of this process - finding a problem to match a solution - can be dire” (World Health Organization 2020, 169).

As we demonstrate in this paper, the promotion of PPPs in the health sector encompasses a central tension. On the one hand, they are promoted by global health actors and States as a mechanism to implement universal health coverage (UHC) and to ensure the achievement of the highest attainable standard of health for all (Gideon and Unterhalter 2020). However, as we argue here, PPPs can potentially increase inequalities and divert resources away from other vital healthcare services, negatively impacting the enjoyment of the right to the highest attainable standard of physical and mental health, which is protected under Art. 12 of the ICESCR as well as other relevant human rights treaties. Indeed, the former United Nations (UN) Special Rapporteur on extreme poverty and human rights, Philip Alston, argues that the rights and requests of the poor and marginalised have been “lost in the fog of an overriding focus on Public-Private Partnerships with troubling track records” (Alston 2020, 12). Moreover, as we demonstrate in the case of Peru, PPP hospitals are often only accessible to those benefiting from specific social health insurance schemes and raising questions about their ability to ensure equal access to healthcare services without discrimination, a fundamental component of the right to health.

The paper starts with an overview of the literature considering the equality impacts of health PPPs. We then introduce the case of Peru and offer a summary of the structure of the health system as well as reflecting more broadly on Peru’s commitments to the Right to Health before

considering the planning and implementation of three PPP hospitals in Peru. We primarily focus on unpacking the contradictions between the right to health and PPPs, which we understand as an example of commercial approaches to healthcare provision. Drawing on empirical evidence from Peru, we demonstrate how the government has consistently pursued IFI agendas in the healthcare sector. At the same time, we highlight how the Peruvian media has reinforced the "common sense" narrative that the private sector offers the only solution to the deeply entrenched inequalities that shape the Peruvian health system, reinforcing embedded commercial interests. The final section of the paper draws on empirical evidence to consider the equality impacts of the PPP hospitals. We conclude that the on-going promotion of the PPP model within the Peruvian health sector raises important concerns regarding the government's commitment to ensuring the Right to Health across the population.

Health PPPs and economic inequality: the evidence

PPP is a loose term that covers a wide range of arrangements across different sectors, and it is open to a diverse range of interpretations (Romero and Van Waeyenberge 2020). However, common to all is the notion of a shared financial and governance arrangement between the public sector, primarily financed by tax revenue and sometimes aid, and the private sector, which may comprise local or global capital (Gideon and Unterhalter 2017). Within health, PPPs are intended to increase efficiency and bring much-needed finance to fiscally strained health systems. An evaluation of World Bank health projects states that PPPs in the health sector are intended to "leverage capital, managerial capacity, and know-how from the private sector"(The

World Bank 2016, 3). Leveraging private finance is intended to free up government resources to focus on specific aspects of the health system (health promotion and prevention services or deprived areas) with less business interest (Parker, Zaragoza, and Hernández-Aguado 2019; Roehrich, Lewis, and George 2014). PPPs can be politically attractive for moving public spending off the government balance sheet and transferring risk to the private sector.

Nevertheless, while support for PPPs has grown, the evidence on their impact has tended to be narrowly framed, often limited to the short-term project level without concern for the broader systemic effects, with little attention to the equity impacts. Within the health sector, initially research was dominated by experience in the USA and the UK but has begun to expand to other regions as PPPs have spread across different parts of Europe and many LMICs (Roehrich, Lewis, and George 2014). Several meta-studies have synthesised PPP research findings (Roehrich, Lewis, and George 2014; Tabrizi, Azami-aghdash, and Gharaee 2020; Parker, Zaragoza, and Hernández-Aguado 2019; Joudyian et al. 2021). In general, these studies have found that PPPs are associated with positive outcomes regarding clinical standards at the project level. PPP facilities tend to be delivered on time and to budget (Tabrizi, Azami-aghdash, and Gharaee 2020; Adamou, Kyriakidou, and Connolly 2021; Hellowell 2019). However, quality is not unambiguously better (Roehrich, Lewis, and George 2014). Long-term contracts can encourage commitment and stability in a contract, but they may also stifle innovation and lead to complacency and be inflexible (Roehrich, Lewis, and George 2014).

A World Bank evaluation (Independent Evaluation Group 2018, 181) lists numerous challenges for health PPPs: retention of healthcare professional staff, inefficient referral processes, matching healthcare resources with infrastructure expansion, insufficient state capacity to manage PPPs, limited fiscal resources, and unclear roles and responsibilities. Moreover, the governance of PPPs is heavily impeded by asymmetries in information, expertise, and capacities (Roehrich et al., 2014). Critics also maintain that PPPs weaken accountability structures and are subject to corporate private-sector governance structures and practices raising concerns about poor accountability to citizens (Stafford and Stapleton, 2017). WHO warns that "the fact that in many low-income countries, the capacities needed to steward the private sector effectively are weak or non-existent implies major risks to public health" (2020: 113). Lack of competition leads to weak contestability in contract tendering, undermining the health benefits of PPPs (Hellowell 2019).

There are extensive concerns about the impact of PPPs on socioeconomic rights (Romero 2018; Eurodad 2022). One concern is that PPPs are expensive and create a significant fiscal drain in the long run. PPP critics point to the high long-term liabilities (Hellowell 2019), which led to their termination in the UK (NAO 2018). Additionally, a narrow focus on the project may obscure practices where costs (such as treating more complex patients) are diverted to others in the health system (Babacan 2021). Hellowell (2019) found that the Lesotho Hospital PPP was drawing the public health budget away from other critical areas of the health system. Consequently, resources were diverted from clinics delivering most of the care to most of Lesotho's population, and district health facilities were rendered ill equipped through cuts to

health personnel and vaccines (Mukherjee et al. 2020). Similar concerns were raised in Sweden, where the construction costs of a PPP hospital considerably overran, leading it to be dubbed "the world's most expensive hospital" (Lethbridge and Gallop 2020: 19). Within a Latin American context, analysis of a PPP hospital in Bahia, Brazil found that hospital users requiring more costly treatments were often excluded in order to limit costs and meet targets (Bayliss et al. 2021).

Policymakers acknowledge the need to assess the broader socioeconomic effects of PPPs. Issues related to PPP sustainability and inclusivity are stressed as part of PPP best practice, and the PPP assessment usually includes some type of economic impact assessment (World Economic Forum 2021; Alvarado 2017). While it is widely accepted that the management of the PPP after the contract award is crucial to outcomes, it has generally not been an important priority for governments. The World Bank Group rarely provides "aftercare" for contract management (World Bank 2016: 26). A World Bank (2018) review of its projects finds that most WBG-supported health sector PPP interventions explicitly emphasised reaching the poor but needed more suitable indicators, baselines, and targets. If PPPs are intended to support countries in achieving UHC and meeting the SDGs, more attention must be given to their impacts on inequalities. However, there is little evidence in practice that PPPs can deliver universal access to quality healthcare (Gideon and Unterhalter 2020). A scoping review of PPPs in public health care demonstrates the inability of the private sector to meet the needs of marginalised groups (Joudyian et al. 2021), and similar findings were highlighted in a study of Indian health PPPs (Nandi et al. 2021). Other critics have pointed to the urban bias of health PPP projects (Hellowell

2019). Ravindran and Philip (2021) contend that PPPs contribute little to UHC and may not represent the best use of the limited resources available for investing in health services. Moreover, disquiet has also been raised regarding the lack of data on the broader effects of the PPP on health systems indicating a need to understand better how the state facilitates PPPs (Baru and Nundy 2021; Gideon and Unterhalter 2020).

In sum, the limited research that has been conducted into the effects of PPPs on economic inequality and the right to health highlights numerous channels through which inequalities are exacerbated. Health facilities and projects contracted under PPPs are expensive, they absorb a large share of the health budget, and they tend to be in urban and wealthier areas. While they bring finance upfront, in the long run PPPs lead to an outflow of funds from users and taxpayers to offshore shareholders. Regulation and accountability have been lacking. Likewise, the equity impacts have been widely neglected in the policy framing and evaluations. There is a need for a more open and wider debate on the impact of PPPs on the right to health.

The Peruvian health system

The Peruvian health system is highly fragmented and segmented, severely constraining the state's capacity to deliver quality healthcare for all (Lazo-Gonzales, Alcalde-Rabanal, and Espinosa-Henao 2016; Göttems and Mollo 2020). This fragmentation has implications for governance and healthcare provision (Gianella, Gideon, and Romero 2020; Carrillo-Larco et al. 2022). Moreover, the segmentation of the sector is reflected in the financing as well as in the provision of health care. The financing of the health system is complex, deriving from several

sources (general taxation, budget according to results, direct contributions), which are then allocated to different units (regional government, the Ministry of Health (MoH), health care facilities and insurance companies). Service provision is linked to different insurance schemes, with two providers being the most significant. Firstly, the *Seguro Integral de Salud* (SIS) is mainly funded through general taxation, and primarily targets those living in poverty, providing free healthcare for a series of prioritised health conditions. In 2022 around 62% of the Peruvian population was covered by SIS (SUSALUD 2022). Secondly, the Social Security health insurance program, EsSalud, provides health care to 27% of the population (SUSALUD 2022), as well as pension and welfare coverage, and is financed through payroll deductions from formal sector workers. EsSalud is incorporated within the Ministry of Labor and Promotion of Employment and is a public entity that enjoys technical, administrative, economic, financial, budgetary and accounting autonomy, including the capacity to sign PPPs contracts without the oversight of the MoH. The rest of the population is covered by other public insurance schemes (for example, a specific scheme for the Police and Army) and private insurers.

EsSalud provides health care through a nationwide network of 395 health facilities, mainly hospitals offering secondary and tertiary care. Although Peru has a network of 8873 primary care facilities within the public health system, only 309 (3.52%) are incorporated within EsSalud. Recent calculations suggest that EsSalud needs to provide an additional 227 primary healthcare facilities to cover the infrastructure gap within primary healthcare (Carhuapoma Yance 2022) while the MoH requires an additional 1760 primary healthcare facilities (Ministerio de Salud

2021). The lack of MoH facilities has particular implications for lower income groups yet, as discussed below, PPP investments are focused on EsSalud rather than the SIS.

The Peruvian health system and the Right to Health

The 1993 Peruvian Constitution recognises the right to health. Article 7 sets out that: "Everyone has the right to protection of its health, its family environment, and community, just as it is its duty to contribute to their development and defence" (República del Perú 1993). Moreover, Article 9 identifies the State's central responsibility in governing health care services: "The State determines health policy … [and] is responsible for the pluralistic and decentralised implementation to facilitate access to healthcare for everyone". Article 6 adds that "the State guarantees free access to health services" (República del Perú 1993).

Peru also signed and ratified the ICESCR, whose Article 12 recognises the right of everyone to the highest possible standard of physical and mental health. The Committee on Economic, Social and Cultural Rights (CESCR) has specified, in General Comment 14, that the right to health includes universal and timely access to available, acceptable, accessible, and quality healthcare services, (GC 14, CESCR). CESCR further specifies that States' obligation include "preventive, curative, rehabilitative health services and health education." (CESCR 2000). These services must be accessed without discrimination, and this is an obligation of immediate effect that is not subject to progressive realisation (CESCR 2009; MacNaughton 2009). Furthermore, Peru has signed and ratified other human rights treaties that contain health-related provisions, including the

Convention on the Elimination of all forms of Discrimination against Women (CEDAW), the Convention on the Rights of the Child (CRC) and the Convention on the Rights of Persons with Disabilities (CRPD).

These human rights obligations apply also when private actors are involved in healthcare. While the CESCR, in its General Comment 14, emphasises that States may *fulfill* the right to health through "the provision of a public, private or mixed health insurance system which is affordable for all," it also warns on the risks of healthcare privatisation, noting that the obligation to *protect* the right to health under ICESCR requires that "the privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services." (CESCR 2000). More recently, General Comment 24 of the CESCR further adds that "private health-care providers should be prohibited from denying access to affordable and adequate services, treatments or information" (CESCR 2017).

Importantly, the United Nations Guiding Principles on Business and Human Rights also detail states' duty to *respect*, *protect*, and *fulfill* human rights, including when third parties are involved in health care, as well as the corporate responsibility to respect human rights (UN Office of the High Commissioner for Human Rights 2011). General Comment 14 also specifies that States have a duty to *protect* human rights from third-party abuses. Therefore, Peru must *protect* the right to health when third parties, such as private healthcare actors involved in PPPs, are included in delivering healthcare services. In the Latin American context, the case *Ximenes Lopes v Brazil* before the Inter-American Court of Human Rights (Corte Interamericana de Derechos Humanos, CIDH) is a good example of how this obligation works in practice at regional level (Inter-American

Court of Human Rights 2006). In 1999, Mr. Damião Ximenes Lopes, a person with a mental health condition, was hospitalized in a private psychiatric clinic that operated within the public health system of Brazil. After three days of hospitalization, Mr. Ximenes Lopes died after being exposed to inhuman and degrading hospital conditions. The CIDH found that the Brazilian State had violated the American Convention on Human Rights for the treatment of Mr. Ximenes Lopes by the private clinic. The Court was also critical of the lack of investigation and respect for the right to a fair trial, which perpetuated the impunity of this case.

While more scrutiny in this area is urgent, scholarship on the right to health and private actors in healthcare is still limited (Toebes 2006, 2008 ; Nolan 2018; Arenas Catalán 2021; De Falco et al. 2023). Likewise, human rights treaty bodies and special procedures are increasingly discussing the implications of involving private actors in healthcare (Toebes 2008 2006). The human rights framework on private actors in healthcare stems from human rights treaties and has been clarified in the interpretative work of human rights institutions, as in the case of including the General Comments and Concluding Observations of UN Human Rights Treaty Bodies in the area of social rights as well as specifically about the right to health(GI-ESCR 2023). In other country contexts, for example, Tajikistan, the Committee on Economic, Social and Cultural Rights (CESCR), the human rights body in charge of monitoring the ICESCR, has recommended that "any public-private partnership has no negative impact on the affordability of medical services, particularly for the most disadvantaged persons" (CESCR 2022). While CESCR and other UN Human Rights Treaty Bodies have expressed concerns regarding private actors in healthcare in several Latin American countries, including Chile, Costa Rica, and Brazil, they have not analysed this problem in the case of Peru (De Falco et al. 2023). Thus, even though the right to health is constitutionally

protected in Peru, challenges still exist in practice. As discussed in more detail below, Peru still faces significant disparities in access to health care and the distribution of morbidity and mortality (Carrasco-Escobar et al. 2019; Carrillo-Larco et al. 2022).

In the following sections of the paper, we consider how Peru has engaged with PPPs within the health sector with particular reference to the establishment of a number of PPP hospitals. In addition, we consider the role that the Peruvian media has played in promoting a "common sense" narrative that private finance is the only solution to address the challenges faced by the health sector. It is clear that within the mainstream media there is little space for critical debate nor any exploration of alternative – and potentially more equitable – ways of funding the system – for example through increased taxation. Although at present the evidence base remains limited, the final sections of the paper reflect on the potential implications of the implementation of health PPPs for the right to health and we consider what the available evidence reveals about their impacts from an equalities perspective.

Public Private Partnerships in Health in Peru

The emergence of PPPs in Latin America builds on decades of market-oriented reforms dating back to the Washington Consensus in the 1980s. Latin America has historically attracted significant private participation in infrastructure (PPI) and in 2020, despite challenges posed by the COVID-19 pandemic, received the largest global share of PPI (The World Bank 2020). Much of the region has passed specific laws to facilitate PPPs and have included PPPs in national development and sectoral plans. Similarly, Peru developed legislation for PPPs in relation to general infrastructure, maintenance and service provision in 2008. As elsewhere, donors have

played an active role in promoting health PPPs. The World Bank approved policy loans to reform the Peruvian health sector and PPP laws and in 2015 the Inter-American Development Bank (IADB) approved a loan to strengthen the capacity of the country to implement health PPPs. In 2018 the Peruvian government announced the National Plan on Competitiveness and Productivity 2019-2030, which features PPPs as a way of "increasing social and economic infrastructure"(Gobierno del Perú and CEPLAN 2018). The MoH also released a *Multiannual Report of Investment in PPP in Health 2019-2021*, which includes proposals for health care facilities to be managed and operated by the private sector (Ministerio de Salud 2018). Multilateral bodies such as the IADB have supported the development of PPPs through loans aimed to strengthen the country's capacity to implement PPPs in the health sector and Peru is part of the IADB Latin American and Caribbean PPP Risk Management Group.

The Peruvian government started the implementation of health PPPs at the end of 2013 (Zevallos, Salas, and Robles 2014) and three PPP hospitals have subsequently been in operation. Two of these, Guillermo Kaelin de la Fuente and Alberto Barton Thompson hospitals, are integrated PPPs (i.e. combining infrastructure renewal with delivery of clinical services, and general maintenance e.g. laundry and cleaning) belonging to EsSalud, and are located in Lima and Callao (two major cities). The contracts were signed in 2010 and will run for 32 years (two years for the construction of infrastructure and 30 years for the operation of the hospitals). The third PPP is a specialist children's hospital, operated by the MoH and located in Lima. Here the PPP provides maintenance services (e.g. cleaning and laundry) and some diagnostic services

(laboratories), however, health workforce contracts, and clinical care services are provided by the MoH.

As has occurred elsewhere in Latin American, contracts are allocated directly (Polack, Ramírez Chaparro, and Martínez Silva 2019) to a single applicant that met the technical requirements defined by EsSalud. In the Peruvian context, once awarded, most PPP contracts are subject to multiple renegotiations, which further delegitimize and neutralise the financial benefits of the PPP model, that is derived from a competitive process of investment promotion (Quiñones Alayza and Aliaga 2019).

Peruvian media debates on the need for private sector participation in health care provision

In Peru, in line with the rest of the region, the popular narrative is that PPPs will bring added financial resources and expertise to the health sector. Yet, unlike countries such as Chile and Colombia where there has been significant debate around the need for a new model of health and social policy, the neoliberal model of service provision remains largely unchallenged in Peru. Our research contends that the mainstream media plays an important role in narrowing public debate around the role of the private sector in health, promoting as "common sense" the notion that the private sector is the only solution to the prevailing problems. Similar evidence is found elsewhere in Latin America (Porta and Cianci 2016) and beyond (Silke and Graham 2017). Moreover, critics have highlighted the ways in which the media pursues its own agenda, shaping the space and giving voice to different political viewpoints and actors (McCombs 2011). Studies from Peru have previously shown that the printed media is a vital space used by actors, particularly from government, the private (commercial) sector and academia, to present and

defend their positions around highly contested issues (Gianella 2017) and as Gloppen (2016) contends, newspapers are a space for what she terms "social lawfare".

We analysed the media presentation of PPPs through a review of the opinion pieces or "op-eds" of the national newspaper, *Gestion,* which is part of "El Comercio" Group, one of the most powerful groups in Peru controlling the media. Our analysis covered 1280 opinion pieces published between 2016 and 2020 (see Table 1). This enabled us to identify critical junctures (i.e. debates at the parliament, health system crisis related to corruption or Covid 19) and select the 111 columns (op-eds) .

Table 1 here

The media analysis was conducted by two of the researchers (MS and CG) informed by content analysis which enables the identification of the prominent discourses in the media around private sector participation in health. Content analysis is a method used to build a model to describe the phenomenon in a conceptual form (Bengtsson, 2016; Krippendorff, 2018). The researchers followed the process in three phases: preparation, organizing, and reporting, following an inductive procedure. We selected the units of analysis and read all the information, trying to make sense of the data as a whole. We then started an open coding, taking notes while reading, forming categories and then groups of categories with a degree of relation and hierarchy. This strategy was useful not only to identify the emerging themes but also to generate unanticipated insights (Nowell et al. 2017) and identify the most relevant examples. The following sections examine the most significant themes emerging from the analysis.

The failings of the public healthcare provision

One of the most prominent themes identified is the relationship between private sector participation and improved efficiency in health care provision. This relationship is built up through analysis that highlights major failures of the public health care system, such as delays in accessing medical appointments, the lack of trained professionals and overall lack of accessibility to health facilities, with an emphasis on the need for better primary health care. The following quotes illustrate this point:

> "A clear example is the vicissitudes we face in public health. There are delays in care, coverage problems and cases of corruption such as the events in the SIS. Achieving timely medical care seems almost a miracle" (Op-ed, 7.03.18; author translation from Spanish).

> "The commission's analysis tries to be realistic and without a doubt the basis of the proposal is a wish that we would all like to see fulfilled (free universal insurance), but the problem has many more edges and is not solved only by improving financing. Some of the conditions suffered by users of public health or EsSalud hospitals have to do not only with the high demand for services and the limited supply, but also with the internal malfunction of hospitals, obsolete ways of assigning appointments and manage processes, lack of specialists, lack of instruments, lack of criteria in the administrative staff and medical personnel without vocation" (Op-ed. 11.15.17; author translation from Spanish).

The state is portrayed as an incapable actor, that stubbornly insists on getting involved in issues for which it has no capacity.

> "It is difficult to understand how, with the total abandonment of infrastructure in roads, ports, airports, communications, electricity, internet coverage and, of course, health, education and security by the State, some voices demand its participation in activities that it does not know how to attend to. Security on the part of the State, some voices demand its participation in activities State doesn't has expertise. There is therefore a total disconnection of politicians with the reality and needs of their constituents. Something that in recent times has become more dramatic". Op-ed 6.6.19 author translation from Spanish)

Here we see, as Porta and Cianci (2016) argue, the building of a crisis framework that justifies arguments in favour of the need to carry out neoliberal interventions. Thus, in the opinion pieces analysed, authors stressed the inability of the state to guarantee access to timely and quality health care. In this scenario, private sector actors' intervention is portrayed as the tool to solve the problem of precarious healthcare.

Support for Public Private Partnerships in Healthcare Provision

Our analysis also highlighted another prominent discourse that emphasises the need for the public and private sector to work together. This collaboration should take the form of PPPs to improve health care services, equipment and infrastructure. In addition, the discourse advocates the importance of developing comprehensive and integrated health networks to allow the participation of private providers as part of the services offered to the policyholders. Private

services will be paid with public funds. The opinion pieces propose a stronger relationship between the MoH and the SIS, EsSalud and the private health insurance companies providing health care to formal workers (*las Entidades Promotoras de Salud* - EPS). It is also stated that the public sector should work with the private sector, academia, and civil society to develop guidelines to improve the health system. These pieces subtly elevate the private sector to the level of an equal stakeholder in health service provision, on a par with the state agents.

> "Between 2011-2016, 8.4 billion PEN have been allocated for this (health care) investment portfolio. However, the gap is still large and by 2021 it is necessary to develop efforts to close it through public-private investment and works for taxes, among other modalities" (Op-ed 10.03.16; author translation from Spanish).

> "To advance universal access, integration and public-private synergies have an urgent role to play. Tomorrow's children need improvements to start today." (Op-ed 10.03.16; author translation from Spanish).

This discourse offers no debate on the risks of involving the private sector and omits any reflection regarding the major corruption uncovered in 2016 that involved SIS buying services from private health providers at excessive prices, or paying for services that were not provided (Comisión Interventora del SIS 2017). Similarly, EsSalud PPPs are portrayed as good examples to follow, without a cost analysis, or assessment of equity considerations. Articles particularly emphasise positive innovations, such as the adoption of electronic medical records, without a

profound analysis of the economic impact of these innovations (value for money) and consideration of what this might mean for the wider availability of resources for health care.

The mainstream media accepts without question the limitations of the state and the supposed need for the private sector, thus playing an important role in shaping a receptive and uncritical environment for the private sector in health. PPPs pose significant risks for social equity across the population but these are not acknowledged.

Impacts of health PPPs on economic inequality and the right to health

Health PPPs risk worsening economic inequality and negatively impacting on the right to health through several pathways. While the impacts of the private sector projects on social equity in Peru have not been formally assessed, emerging evidence supports potential concerns. The value for money of the PPPs experiences in Peru is not clear, nor the equity impact on the distribution of resources of EsSalud. The PPP contract states that EsSalud should pay an annual capitation payment for a fixed number of policyholders and in return, the PPP contractor, IBT-Group, commits to complying with 40 indicators relating to quality, safety, and user satisfaction. The annual operating capitation payment granted to IBT- Group in 2010, excluding VAT, was US$263.41, which is subject to an annual adjustment according to the behaviour of price indicators (Videnza 2021). By 2016 this payment had reached US$297.92. These amounts are higher than the annual operating capitation payment of EsSalud for the non PPP services (Organización Internacional del Trabajo and Seguro Social de Salud 2019). In addition it is unclear what the rationale for the projection of 500,000 policyholders is while it is also not clear what

criteria have been applied to justify paying a higher amount for the services provided by the PPPs hospitals. PPP contract details are not made public, raising concerns for accountability but what information is available suggests that higher fees are paid to the PPP contract holder than to public health providers. In human rights terms, it is questionable whether PPP are consistent with Peru's obligations to invest its maximum available resources for the full realisation of the right to health without discrimination.

Although research has found positive outcomes in Peruvian PPP hospitals such as shorter waiting time and higher number of attentions per physician (Zinelli Reyes 2022; @IPEopinion 2023), analysis has failed to consider the wider systemic effects and implications for socioeconomic inequalities. An analysis by Zinelli Reyes (2022) compared the overall management performance of two EsSalud level II-2 hospitals by evaluating hospital efficiency, financial management and user satisfaction data for the period 2016-2018. One hospital was managed with a PPP model and the other with a traditional management model, and Zinelli Reyes found that there were no significant differences between the two models. The hospital efficiency indicators appeared slightly more favourable in a traditional format model vs. the PPP management model, with the most notable being "physician output per hour". Financial management indicators did not significantly differ between either model but overall user satisfaction was higher in the PPP hospital compared to the non-PPP hospital. Therefore, based on the criteria of this study, a PPP hospital does not seem to present better overall results compared to a non-PPP hospital (Zinelli Reyes 2022). Moreover, there are some limitations in this research. For example, the "physician output per hour" metric omits some key variables, such as the type of consultation, and

complexity of the care offered by the hospitals. It is not known if the output refers to a consultation made at an emergency room, general practitioner, or specialist. This evaluation also omits to mention if the PPP hospitals receive cases that require specialised care, if the outputs are from the general practitioners, of if the hospital transfers the more complex (and sometimes expensive) cases to other hospitals.

A second area of concern around Peruvian PPP projects is accountability, which is a central feature of rights-aligned approaches to health and requires transparency, access to information and active participation (Yamin 2008). The monitoring and evaluation process is mainly conducted by a small group of private consultants. In the case of the two EsSalud hospitals, supervision is provided by a private consortium comprising a private company, ADIMSA, and a private university, ESAN, who, in turn, play the role of advisors and evaluators of the processes of developing proposals and implementing PPPs. The difficulty in accessing information, together with the complex contractual language and content, has contributed to the creation of a niche of "experts". However, independent research conducted at the Barton PPP Hospital (Andia Perez 2020), found evidence of non-compliance with contractual goals along with other variables and indicators related not only to user care service, but also to the management of contracted human capital.

When considered in the context of the wider evidence on outcomes from health PPPs, above, these findings raise concerns regarding the ability of PPPs to comply with Peru's human rights obligations to realise the right to health without discrimination on any grounds. There are, significant questions regarding how far health PPPs are able to effectively address widespread

health inequalities and guarantee the right to health for significant sectors of the population. The positive impacts on meeting human rights in health is far from evident. Yet, these tensions and contestations lack visibility in national policy debates.

Conclusions

Our analysis demonstrates the ways in which public debates around PPPs in health have narrowed in Peru and the significant role played by the media in this process. From a human rights perspective, healthcare services, whether publicly or privately provided, have to be accessible, available, acceptable and of the highest quality possible (CESCR 2000). The role of the State in this aspect is not only to collect the resources needed for such services, but also to ensure that they place human rights at the centre. The fact that media scrutiny demonises public healthcare services and predominantly supports PPPs, that often do not deliver on human rights goals, is thus highly concerning. Indeed, Chapman (2014) noted that one of the consequences of including private actors in healthcare is the progressive erosion of societal solidarity; and that higher privatization weakens the State, making it more complex for governments to strictly monitor and regulate such private providers.

For the mainstream media, the main question is no longer whether or not the private sector is needed or more efficient, instead, the sole question is when and how private funding can be sourced. This is happening despite little evidence of any long-term successful outcomes from health PPPs and significant concerns regarding their role in promoting the right to health.

Moreover, the institutional space is dominated by a small number of consultants that operate primarily from an economic and financial perspective with little acknowledgement of the potential social or equity impacts of PPPs.

As we contend, media analysis shows that discourses supporting PPPs in health in Peru rely on generalised assumptions around the advantages of private financing and management but without any due consideration of how these policies might play out in the context of the Peruvian health system. In the words of Stein, Storeng, and de Bengy Puyvallée (2022), this is yet another way in which "global health nonsense" continues to circulate and reinforces a particular approach to health care financing and delivery. Our review highlights the ways in which the Op-eds identify the managerial limitations of the state and the complexities of the health system as a justification for private sector intervention, yet at the same time, wider evidence suggests that these challenges are not something that the private sector has the capacity to overcome. Cleary further research is needed to better understand the role of the media in promoting this "global health nonsense". Yet as we can see in the Peruvian case, the direct allocation of contracts and monitoring of the PPPs through private consultancy groups have promoted monopolies and concentrated power in a small number of private consultancy groups raising, significant concerns over the protection of the right to health.

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