

Unhealthy development

The UK Department for International Development
and the promotion of healthcare privatisation

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This report was written by Dr Jane Lethbridge, Director of the Public Services International Research Unit (PSIRU). PSIRU investigates the impact of privatisation and liberalisation on public services, with a specific focus on water, energy, waste management, health and social care sectors. Other research topics include the function and structure of public services, the strategies of multinational companies and influence of international finance institutions on public services. PSIRU is based in the Business Faculty, University of Greenwich, London, UK. Researchers: Prof. Steve Thomas, Dr. Jane Lethbridge (Director), Dr. Emanuele Lobina, Prof. David Hall, Dr. Jeff Powell, Dr. Mary Robertson, Sandra Van Niekerk, Dr. Yuliya Yurchenko

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This report was commissioned by UNISON as research into the UK government's promotion and funding of private healthcare provision in the Global South. The aim of the research was to highlight the damaging impact that the promotion of private healthcare has on public healthcare provision, communities and workers and the benefits it provides to multi-national healthcare companies.

The report addresses this brief by examining the following:

- DFID and the UK government's promotion of and financial support for private healthcare since 2010;
- Public-private healthcare partnerships;
- How the promotion of private healthcare is not informed by evidence of effectiveness;
- Influence of healthcare companies driving the agenda;
- Three case studies: Kenya, Liberia and Nepal.

UNISON is the UK's largest public service trade union, serving more than 1.3 million members. UNISON represents members, negotiates and bargains on their behalf for better working conditions and pay and campaigns for quality public services.

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“No society can legitimately call itself civilised if a sick person is denied medical aid because of lack of means.”

Aneurin Bevan, founder of the NHS

Introduction

Quality public health services protect the most vulnerable in society. They reduce income inequality, act as an equalising force and enable people to access healthcare when they need it, not when they can afford it. Publically funded healthcare is more efficient, effective and more equitable than privately funded systems. However, despite its benefits, publically funded healthcare has been under an intensive attack for the last 30 years, as private healthcare providers, lobbyists and international finance institutions have demanded the commercialisation of healthcare.

The UK's National Health Service (NHS) has been a victim of creeping privatisation in recent years, driven by a flawed ideology that competition drives up standards and market forces improve efficiency. In reality Public Private Partnerships (PPPs) have driven up costs, and more recently clinical commissioning has enabled companies to cherry-pick services based on high profits and low costs. Despite these challenges, the NHS is still recognised as one of the best health services in the world. This paper shows how the UK government and particularly DFID, instead of supporting quality public health services in the global south, are using the credibility of the NHS to aggressively promote their ideology of healthcare privatisation to poorer countries.

Since 2010 the international development debate in the UK has primarily focused on the campaign to get the British government to invest 0.7 per cent of Gross National Income (GNI) in Overseas Development Assistance (ODA). This was successful in 2013, and the target was enshrined in law in 2015. It was a commendable achievement, but as this paper evidences, whilst attention focused on the size of the aid/development budget and defending the concept of aid, DFID's priorities changed, including a far stronger emphasis on economic growth.

The UK's 2015 aid strategy “Tackling global challenges in the national interest” provides a clear sense of the government's vision for the private sector in development:

“Its priorities will include improving the business climate, competitiveness and operation of markets, energy and financial sector reform...”

Far from being a radical solution to poverty alleviation, the privatisation agenda has been tried and tested on developing countries for the last 30 years. This has had devastating consequences for the millions of people plunged deeper into poverty, but the rewards have been significant for multinational companies.

DFID's health policy also shows the level of its support for private health services. It emphasises the role of government not as a provider of health services, but as a regulator and a provider of finance to non state providers.

DFID is increasingly relying on multilateral agencies to implement its pro privatisation strategies, including the World Bank, Regional Development Banks and the International Finance Corporation (IFC). The IFC has invested heavily in private hospitals in a number of countries, and IFC loans have supported the expansion of several global healthcare multinational companies.

Despite their toxic reputation and extortionate cost, DFID and other government departments are actively promoting UK expertise in developing public private partnerships in healthcare to poorer countries. Healthcare UK is one example, established in 2013 to promote UK healthcare providers to “do business overseas”.

Multi agency projects like HANSHEP are also changing the way public healthcare systems operate. Through HANSHEP, DFID was able to fund the establishment of a Public Private Partnership advisory facility managed by the IFC, supporting healthcare services for the poor.

This paper details how much of DFID’s work is now delivered by private providers and consultants, many of which specialise in the privatisation of public services, public private partnerships and public management reforms.

The CDC group, the UK government’s bilateral development finance institution has invested heavily in a range of private health initiatives, particularly private fee paying hospitals, targeting middle and high income groups.

DFID is increasingly using the UK’s development/aid budget to promote the commodification of healthcare. Rather than contributing to the eradication of poverty, it is resulting in the channeling of scarce public resources in poorer countries to the private sector, including multinational health companies.

This paper highlights the scale and scope of this strategy, and some of the damage it is already doing. It also makes the case for the alternative; quality public health services which have been proven to be the fairest, most efficient and effective way to meet the health needs of the whole population.

UNISON calls on DFID to reassess its health strategy and end its support for initiatives that promote the privatisation of healthcare. Instead it should focus on the eradication of poverty, through support for quality public healthcare systems.

Dave Prentis, General Secretary, UNISON

What is healthcare privatisation – transforming public healthcare systems?

Public funding

Public funding for public health services, paid from general taxation, provided free at the point of access, is considered the most effective in redistributing resources from high to low income groups, if measured by the improvements in health and impact on economic growth. Many national healthcare systems have been established through public funding. The underlying principle is that a system of universal healthcare provision funded through taxation allows the risks to be shared across the population. Some people use health services more at certain times in their lives than at others. People from high income groups generally live longer in better health than those from low income groups, who have a shorter life expectancy and higher levels of morbidity. Other individuals have certain conditions which need a high level of health treatment.

The allocation of funds reflects some of the factors that influence demand for healthcare and are part of a process of allocating risk, for example, regions with a high proportion of older people or high levels of unemployment and socio-economic disadvantage. Governments have developed different methods of calculating how much healthcare to fund, with many governments introducing new payment systems over the last 20 years. These have changed from redistributive systems to more market-based pricing systems within healthcare systems, which pay for treatment per person according to a specific type of diagnosis (diagnostic related groups). Although the principle of a tax based healthcare system is that it is free at the point of access, some governments have made care more restricted or subject to user fees.

The disadvantage of tax based healthcare is that it may be subject to changes in government spending priorities. Austerity policies have affected healthcare spending. Hypothecated taxes on specific products, for example, tobacco, alcohol, can also be used to fund public healthcare, which will not be influenced as much by changes in government spending priorities.

Publicly funded healthcare is more efficient, effective and more equitable than privately funded systems. They enable people to access healthcare when they need it rather than when they can afford it. Publicly funded health services contribute to redistribution of income more than privately funded services.

Privatisation of health services takes many forms. It is an implicit element of health sector reform, which is underpinned by fiscal reform. New systems of fiscal control, new ways of allocating resources in line with overall government goals and pressure to improve the use of resources are three dimensions of fiscal reform that have implications for the health sector.¹ Allocation of resources in line with government goals has meant that the interests of the finance and treasury ministries are dominant. This may affect the health sector directly because the goals of the finance ministry will often not be those of the health ministry.² It also leads to a greater emphasis on performance management.³ Outputs and outcomes are not always easy to define in the health sector and can lead to a distortion of healthcare delivery e.g. increases in “throughput”, which focus on the numbers of patients treated rather than the quality of care.

New systems of fiscal control are often accompanied by the introduction of market mechanisms, which affect the health sector in several ways: business principles and practices are introduced to healthcare institutions, often as part of wider organisational

restructuring. This process is known as corporatisation and is taking place in both developing and developed countries.⁴ It is almost always accompanied by the introduction of the purchaser-provider split within a national healthcare system to create an internal market. The outsourcing and contracting out of services, for example, catering, cleaning, facilities management, hospital management and clinical services, is part of an overall process of privatisation. Drug manufacturing and drug distribution may also be privatised. Together these processes constitute a process of marketisation.

The processes that result in healthcare privatisation cover what can be seen as a continuum of commercialisation. These start from the introduction of internal markets to public health systems, corporatisation of public hospitals, contracting out of services, public-private partnerships and ultimately the privatisation of healthcare services.

Table 1: Typology of privatisation and marketisation for the health sector

Process	Examples
Marketisation and privatisation of assets and services	<ul style="list-style-type: none"> • Commissioning of public services from private & voluntary sector – diverse or mixed providers • Marketisation and expansion of private services • Private financing of infrastructure and services with public-private partnerships/ private finance initiative • Choice and personalisation of services • Deregulation/ liberalisation and reregulation • Commercialisation of public services • Sale of assets to private sector • Sale and lease back of government buildings • Increased household responsibility for payments and care – informal payments, user fees
Privatisation of governance and democracy	<ul style="list-style-type: none"> • Contract governance • Corporatisation of quasi-public bodies, e.g. hospitals • Private companies established within public services • Privatisation of public interest information and resulting reduction of transparency and disclosure
Privatisation of public domain	<ul style="list-style-type: none"> • Public service values replaced by market ideology and commercial values • Privatisation of public intellectual capital

Source: Adapted from Whitfield, 2006⁵

This table shows some of the different categories of public and private arrangements for healthcare provision. These will not necessarily apply to all countries but will be shaped by the existing arrangements for healthcare provision. For example, some countries have an existing charitable/ non-governmental organisation healthcare sector. The healthcare systems of Africa and Asia have different histories with differing influences of the not-for-profit and private sector. Part of health sector reform involved the decentralisation of budgets to district hospitals, the introduction of self-management for hospitals and the introduction of business models and private sector forms of management. The introduction of the purchaser-provider split and informal payments, user fees and co-payments were also introduced as part of health sector reform.

Since the late 2000s, there has been a noticeable change in the way in which healthcare privatisation has been promoted. This paper will show that this can be characterised by three processes:

- Development of larger health providers from small/ medium sized private healthcare providers; Establishment of new healthcare enterprises;

- Promoting health insurance for low income groups;
- Creating consumer awareness of market opportunities for buying healthcare.

Poverty reduction and economic growth

The UK government has consistently argued that it is one of the few national governments which are committed to maintaining its aid/development budget at 0.7% of Gross Domestic Product (GDP) during a period of austerity, when the budgets of other government departments are being cut. In 2013, the UK became the only G20 country to achieve the UN target of spending 0.7% of Gross National Income as Official Development Assistance (ODA).⁶

In order to understand how the aid/development budget is used, a wider analysis of DFID policies in relation to poverty reduction and economic growth is set out below. Economic development has become a priority for DFID, which is part of a process of working together across several government departments to promote economic development in new markets. In 2015/16, DFID plans to spend £1.8 billion of the bilateral budget on economic development.⁷ In 2014-15, the DFID bi-lateral aid budget was £4.3 billion so that assuming the bi-lateral aid budget remains about the same size, about 40% of it will be spent on economic development.

The private sector is seen as playing a crucial role in reducing poverty and this justifies DFID's increasing involvement with the private sector at international, national and local levels. This is affecting the way in which DFID works and the skills that DFID staff are expected to develop. In 2014-15, DFID reported that all senior DFID civil servants are required to complete Commercial Awareness Training and 200 Senior Responsible Officers in DFID have also received training. Commercial advisers are being appointed to strategic DFID departments to "provide commercial expertise on the ground."⁸

This focus on commercial skills is also taking place in the Foreign and Commonwealth Office (FCO) and other government departments. In 2011, 'Guidance for DFID, UKTI and FCO staff on HMG's Commercial Diplomacy and Untied Aid Agenda' was published which set out the UK government's strategy for working with business for development. The Conservative-led Coalition government had stated that "promoting UK commercial interests will be central to its foreign policy."⁹

However the position of DFID is different to that of other governments because the International Development Act (2002) does not allow DFID to use staff time or resources to promote UK commercial interests. The 2011 Guidance does state that "if development assistance that is provided by DFID satisfied the tests in the IDA, it is legitimate for DFID to support spin-off commercial benefits to the UK resulting from that assistance, provided they are not its primary purpose".¹⁰ The Guidance makes recommendations about how UK Trade & Investment (UKTI) and Foreign & Commonwealth Office (FCO) staff should "ensure DFID colleagues and beneficiary government and aid agency in-country representatives are aware of how the expertise of the UK commercial sector could contribute to the delivery of a particular country's development strategy."¹¹

These policies are continuing under the new Conservative government, as seen in the recently published 'UK aid: tackling global challenges in the national interest' (2015) strategy, which is published by the UK Treasury and DFID.¹² This strategy aims to cover strengthening of global peace, security and governance, resilience and response to crisis as well as promoting global prosperity and tackling extreme poverty and helping the most

vulnerable. The promotion of global prosperity will be implemented through a new cross-Government Prosperity Fund, led by the National Security Council.

“Its priorities will include improving the business climate, competitiveness and operation of markets, energy and financial sector reform, and increasing the ability of governments to tackle corruption. These reforms will contribute to a reduction in poverty in developing countries, and will also create opportunities for international business, including UK companies” (p.17 UK Aid 3.15 Promoting Global prosperity).

‘UK aid: tackling global challenges in the national interest’ does not mention the protection or strengthening of public services or even make any reference to public services. There is a fine line between the core work of DFID and the promotion of commercial interests. This report will go on to examine how this process works in practice in relation to healthcare privatisation.

DFID health policies

DFID published a ‘Health Position Paper Delivering Health Results’ in 2013. An analysis shows how DFID is approaching health policy as well as the role of the private sector in its delivery. The position paper sets out some of the underlying assumptions and philosophies that DFID has in relation to the role of public and private providers. Health systems are always defined as consisting of public and private providers.

“It aims to maximise health gains through targeted, cost-effective health interventions that are delivered through strengthened, more efficient and effective health systems (including both public and private providers) and that engage communities in the promotion and protection of their own health.”¹³

Although DFID’s overall approach is to support the long term development of the health system, sometimes it will support the private sector:

“In some circumstances this means supporting private sector providers (for-profit or non-profit, formal or informal) to deliver more good quality essential health commodities and services to poor people, and helping to strengthen the capacity of governments to regulate these providers and to finance use of the services by the poor. For example, the African Health Markets for Equity programme is supporting the provision of cost-effective essential health services by franchised private providers in Kenya, Ghana and Nigeria, as well as supporting governments to build their capacity for engaging with and regulating the private sector, and introducing demand-side financing mechanisms to ensure that poor people can benefit from the services.” P.10

DFID identifies the role of government as that of financing health services and regulating diverse providers. It emphasizes that some people will be too poor to make a contribution to the cost of healthcare and so government will have to cover their costs.¹⁴ Although admitting that privately provided services can be of variable quality, DFID still maintains that:

“private providers can be much more sensitive to demand and sometimes offer better value for money than public providers. There are therefore great potential benefits from improving their incentives to deliver better quality services more equitably. Developing governments’ capacity to contract, regulate, supervise and monitor private provision of services so that non-state providers become an integral part of scaling up cost-effective coverage of quality health services for the poorest is a very

challenging but an increasingly pressing need if all people are to be reached with services at reasonable cost.”¹⁵

DFID’s health policy shows that it supports the promotion of private health services. The role of government is seen as one of regulation and the provision of finance for health services but not being a provider of health services.

The size of the DFID bi-lateral aid budget for the health sector has increased since 2009 from £696,996,000 (14.5% of total bi-lateral aid) to £1,297,140 (19.20%) in 2013. The structure of this budget has changed during this period with the ‘basic health’ expenditure increasing from £252,717,000 to £757,105,000 in 2013. In the DFID Annual Report 2014-15, it reported that “DFID supports the provision of good-quality health services for all. DFID also supported 30 countries to strengthen their systems for financing health and deciding how to allocate resources.”¹⁶ This can be interpreted as support for health systems reform.

Table 2: DFID Bi-lateral aid – health sector 2009-2014 and as % of overall bi-lateral aid

Health	2009	%	2010	%	2011		2012	%	2013	%
	696,996	14.50	780,957	15.00	946,230	18.0	1,076,713	19.40	1,297,140	19.20
Health, general	140,676	2.90	178,88	3.40	127,908	2.40	177,710	3.20	209,453	3.10
Basic health	252,717	5.30	269,250	5.20	422,816	8.00	473,501	8.50	757,105	11.20
Population policies	303,602	6.30	332,819	6.40	395,506	7.50	425,501	7.70	330,581	4.90

Source: Data.gov.uk/dataset/statistics/statistics-on-international-development-2014/

International policy context

DFID operates within global/ international policies. One example is the concept of Universal Health Coverage (UHC), which has been promoted by the World Health Organisation (WHO) and the World Bank as a way of giving people access to adequate healthcare. It is significant that the ‘problem’ is seen as a financial one rather than one of delivery of care, free at the point of use. Universal Health Coverage requires a health financing system, which pools funds to provide services to the population, often as a basic package of healthcare services.¹⁷ In this sense, it separates the financing from the provision of services and facilitates the entry of private insurance companies and private providers into national strategies of universal health coverage. Governments may only partially be involved. It complements many of the changes that have been introduced through health sector reforms, which have increased the role of the private sector in healthcare provision.

Increasingly, DFID is relying on multi-lateral agencies, such as the World Bank Group, Regional Development Banks and alliances of international agencies, to implement part of DFID strategies. The DFID multilateral budget has increased since 2010. The way in which DFID uses multilateral agencies to implement many of its policies means that DFID funds are closely tied to the implementation of World Bank/ IFC policies such as ‘Markets for Poor people’ and the IFC strategy to promote small healthcare providers.

Table 3: Contributions to multi-lateral agencies 2013-2014 of over £200,000 (£ thousands)

	2013	2014
African Development Fund	200,951	208,033
Clean Technology Fund	229,000	111,692
EC Development Share of Budget 2	812,615	816,311
EC European Development Fund	406,876	327,528
Global Alliance for Vaccines and Immunization GAVI	323,330	269,446
Global Fund to Fight AIDS, Tuberculosis and Malaria	542,525	285,000
International Bank for Reconstruction and Development (part of World Bank Group)	716,547	602,442
International Development Association (IDA) –part of World Bank Group	1,112,000	1,641,180
UNICEF	324,069	323,132
UNDP	269,701	234,720
World Food Programme	282,805	245,068

Source: DFID Table A11 UK ODA by Multilateral Agencies 2013-14

The largest contribution is to the International Development Agency (IDA) which is part of the World Bank Group. This has increased from £1,112,000,000 to £1,641,180,000 in 2014. The International Bank for Reconstruction and Development, also a part of the World Bank Group was £716,547,000 in 2013 but dropped to £602,442,000. Another large contribution is to the EC Development Share of Budget 2 and the EC European Development Fund. Contributions to the Global Alliance for Vaccines and Immunization (GAVI) and to the Global Fund to fight AIDS, Tuberculosis and Malaria have both dropped since 2013.

DFID's increased multi-lateral agency expenditure has been subject to criticism by Parliament. The contributions to multi-lateral agencies are expected to fall from 42% of the DFID budget to about 38%.¹⁸ The International Development Committee, in its investigations of DFID expenditure/ operations at country level and through specific projects, has been critical of the lack of control that DFID has of its multilateral spending. (This will be discussed in the Liberia case study).

World Bank and Regional Development Banks

The World Bank has been promoting health sector reform for over two decades by implementing decentralisation, public-private partnerships and the legislative and managerial changes required to implement these policies. It works with other multi-lateral agencies and national development agencies, for example, DFID, to promote these agendas. Many recent World Bank projects show that 'payment by results' or 'performance based financing' are being introduced to make health services more efficient. Funding is made available using these mechanisms, so that health facilities will only be given funding if they provide services which have an impact on health status. The underlying assumption is that health workers need incentives if they are to deliver services efficiently and effectively. A recently approved project on improving maternal and child health services for the Democratic Republic of Congo (DCR) is using 'results based financing' which pays for outcomes and results rather than inputs. Income from performance based financing is used by health facilities and health

administration to buy inputs and performance bonuses. This introduces a competitive element into the healthcare system. Performance based financing is an integral part of World Bank projects in Chad, Cameroon, Moldova, Zambia, Ethiopia, Nigeria. DFID also uses 'payment by results' to implement its funding.

Some of the same themes that are evident in World Bank projects also emerge in health projects funded by the Asian Development Bank. 'Results based lending' is a form of 'payment by results' and is part of technical support for the India National Urban Health Mission. Public-private partnerships (PPPs) are also part of ADB funding projects. A project in Thailand is explicitly aiming to improve the capacity of the Public Health Ministry to 'identify, develop and implement PPP projects and to draw more private sector funding into the health sector'. In Mongolia, a project is aiming to improve the social insurance system through institutional strengthening.

The emphasis of Africa Development Bank health projects is more on ways of addressing communicable diseases, e.g. HIV/AIDS and tropical diseases, and providing basic health services.¹⁹ The underlying approach to the provision of basic health services is through the provision of a 'safety net'. For example, the Africa Development Bank has funded a project in Morocco which supports the 'universal coverage of the social safety net'. It will focus on the management and financing of the reforms, the extension of medical coverage and the regulation and provision of care. It is also investing in a network of high quality tertiary care and education centres in East Africa, which will stimulate social economic development. Upgrading and improving nursing and other forms of health worker training is another priority of Africa Development Bank health projects, for example, Egypt, which will be delivered through a public-private partnership.²⁰ In 2015, the African Development Bank made an investment of US\$ 25 million in the Abraaj Growth Markets Health (Africa) Fund, part of the Abraaj Growth Markets Health Fund, a private equity fund.²¹ This loan will provide finance for "scalable and sustainable healthcare models for lower-middle and low-income segments of the populations in Africa".²²

International Finance Corporation (IFC)

The International Finance Corporation is part of the World Bank Group with a specific remit to promote the private sector in low and medium income countries. It plays a significant role in the promotion of private healthcare. Its recent healthcare investments are set out in Table 4.

Table 4: IFC healthcare investments 2012-2016

Date	Project	Company	Country	IFC investment for loan US\$m	IFC investment for equity	Total IFC loan approved
09/04/2012	MNT Saglik Hizmetleri Ve Ticaret As	MNT Saglik Hizmetleri Ve Ticaret As	Turkey	15	15	30
22/05/2012	IHH Healthcare Berhad	IHH Healthcare Berhad	East Asia		47.29	47.29
20/10/2012	Concord Medical	Concord Medical Services Holdings Ltd	China	50		50
30/04/2013	Chad Clinic	Clinique La Provence	Chad	1.38		1.39
08/05/2013	Fortis Healthcare	Fortis Healthcare	East Asia	55	45	100
14/05/2013	AAR Healthcare	AAR Healthcare	East Africa		4	4
30/05/2013	STS Holdings Ltd	STS Holdings	Bangladesh	17.5	11	28.5
13/11 2013	Intermed	Intermed Medical Centre LLC	Mongolia	10		10
30/01/2014	Sala Uno	Sala Uno	Mexico		2.24	2.24
17/02/2014	IFHA II	IFHA II Cooperatief	Africa		24	24
04/03/2014	Nephro Plus	Nephro Plus Health Services Private Ltd	India		7	7
29/04/2014	Metropolitano	Hospital Metropolitano SA	Nicaragua	4.35		4.35
24/06/2014	Adana Health	ADN PPP Saglik Yatirim AS	Turkey	46.16		48.66 includes

						US\$3m risk
07/07/2014	Centro Hospitalario Serena Del Mar	Centro Hospitalario Serena Del Mar	Colombia	20		20
11/07/2014	Kayseri Health	ATM Saglik Kayseri Yatirim AS	Turkey	43.66		45.66 (incl. +2 risk investment)
10/09/2014	Rede Dor II	Rede D'Or Sao Luiz SA	Brazil	50		50
06/10/2014	Asia Heart Wuhan	Asia Heart Hospital	China	35		35
31/10/2014	Etlik Health	Ankara Etlik Hastane Saglik Hizmetleri Isletme Yatirim AS	Turkey	85.02		88.02 (incl 3m risk invesmtset
03/11/2014	ESIP EyeQ	Eye-Q Vision Pvt Ltd	India		5.36	5.36
10/04/2015	Ciel Healthcare	Ciel Healthcare Ltd	Africa		6.75	6.75
0/05/2015	Conclina	Conjunto Clinico Nacion CA	Ecuador	15		15
28/07/2015	Iso Health Ltd	Iso Healthcare Ltd	Kenya	4.41	1.31	5.73
14/09/2015	Hygeia 2014	Hygeia Nigeria Ltd	Nigeria		12.4	12.4
16/09/2015	Falck Africa SPV	Falck A/S	Africa		20	20
14/10/2015	UFH Guangzhou Loan	UFH Guangzhou United Family Hospital	China	60		60
13/11/2015	Columbia China	China Rehabilitation hospital Private Hospital	China	25	25	50
16/03/2016	HCG	Healthcare Global Enterprises Ltd	India		19.9	19.9

Source: IFC

Hospitals have remained the main focus of IFC healthcare investments over the last decade. India has received six investments and China and Turkey five each. These reflect the emphasis on the development of a corporate healthcare sector in all three countries. Kenya has received three investments and Colombia two, which again reflect the emphasis on the development of a private healthcare sector, perhaps on a smaller scale. Three of the Turkish investments needed risk guarantee loans taken out by IFC. These are the only IFC hospital investments which have required this, an indication of Turkey's political instability.

Table 5: Number of IFC healthcare investments by country

Country	Number of investments
India	6
China	5
Turkey	5
Kenya	3
Colombia	2
Chad	1
East Asia	1
Bangladesh	1
Mongolia	1
Mexico	1
Nicaragua	1
Brazil	1
Africa	1
Nigeria	1
Romania	1
Georgia	1

Another important feature of IFC investments over the last decade is that several companies have started to emerge as global healthcare multinational companies. IHH Healthcare Berhad and Fortis Healthcare have expanded throughout Asia.²³ AAR Healthcare has expanded in Africa.²⁴ Falck A/S is a Danish company which has expanded with emergency health services throughout Europe and is now moving into Africa and other parts of the world.²⁵ This shows how IFC loans can provide a springboard for the expansion of multinational healthcare companies.

Although the overall aim of IFC investments is to support private sector development in several sectors, its healthcare investments remain concentrated in larger hospital projects. Several investments are public-private partnerships. An analysis of IFC healthcare policy over the past decades shows that initially there were plans to expand health insurance companies as well as healthcare providers but this has not led to an expansion of health insurance. This has some implications for existing healthcare investments in that private healthcare providers are dependent on private patients being able to pay.

DFID makes its largest multi-lateral agency contribution to the International Development Association which is part of the World Bank Group. IFC healthcare investments fit into DFID's overall plan for promoting private healthcare but particularly through growing companies which can expand globally.

Multi-lateral Investment Guarantee Agency (MIGA)

The Multi-lateral Investment Guarantee Agency (MIGA) is also part of the World Bank Group and has a remit to promote foreign direct investment and loan guarantees to private sector investors. Although most of its investment are in infrastructure, for example, waste water, roads, in 2015 it invested in a Turkish hospital project. This was to build a 475-bed hospital in Yozgat as part of the Turkish Health Public-Private Partnership Program (PPP) to renovate public hospital infrastructure.²⁶ A loan of \$51.7 million has been made to Meridiam Eastern Europe SARL of Luxembourg and Siemens Financial Services covering their investments in YZG Sağlık Yatırım A.Ş. in Turkey. The coverage is for a period of up to 20 years and 18 years respectively and covers the risks of transfer restriction, expropriation, and breach of contract. The contract is for a 27-year design, build, finance, operate, and transfer project agreement and it is hoped that it is the first of many more PPP projects.²⁷

Consultants and private providers

The promotion of healthcare marketisation and privatisation is not just the result of funding by DFID, other government departments and multi-lateral agencies. Consultants and private providers of management advice contribute to the dissemination of market based approaches to healthcare delivery. Much of DFID's work is delivered by consultants. The top DFID private sector implementers in 2014 were:

Table 6: DFID private sector consultants and implementers (2014)

	Name	Activities	Amount awarded DFID funding
1	Crown Agents Headquarters: London, U.K. Awarded DFID funding:	Works with governments on issues of health, governance, humanitarian response, economic development	£191.6 million
2	Pricewaterhouse Coopers Founded: 1998 Headquarters: London, U.K. Chairman: Dennis Nally	Professional services & accountancy services	£122.2 million
3	Adam Smith International Founded: 1992	Economic & government reform	£88.4 million

	Headquarters: London, U.K. Managing director: William Morrison		
4	DAI Founded: 1970 Headquarters: London, U.K. President and CEO: James Boomgard	Social and economic development problems caused by inefficient markets, ineffective governance and instability	£58.3 million
5	GRM International Future Founded: 1965 (as Gunn Rural Management) Headquarters: Brisbane, Australia Managing director: Kim Bredhauer	Development project planning, design and management services, and feasibility studies.	£50.5 million
6	Mott MacDonald Group Founded: 1989 Headquarters: London, U.K. Managing director: Richard Williams	Infrastructure	£39.4 million (including member companies such as BMB Mott MacDonald, Cambridge Education and HLSP)
7	Oxford Policy Management Headquarters: Oxford, U.K.	Policy review & implementation	£26.7 million
8	Coffey International Development Headquarters: Canberra, Australia	Wide range of development issues – government reforms	£23.7 million
9	Abt Associates Founded: 1965 Headquarters: Massachusetts, USA Managing director: Kathleen Flanagan	Health, social and environmental policy and international development	£21.4 million
10	Maxwell Stamp Founded: 1959 Headquarters: London, U.K	Economics consultancy	£19.9 million
11	Health Partners International Headquarters:		£19.4 million
12	ECORYS Headquarters: Rotterdam, The Netherlands	Economic and social development	£17.7 million

13	Options Consultancy Services Founded: 1992 Headquarters: London, U.K. Managing director: Jo Elms	Sexual and reproductive health, maternal & child health, HIV/AIDS, citizen voice and accountability, gender, social inclusion, and equity to strengthen pro-poor health systems.	£15.4 million
14	IMC Worldwide Founded: 2011 Headquarters: Redhill, U.K. Managing director: Gavin English Previously owned by WSP Group until 2011	Planning, design and management of global infrastructure projects	£14.3 million
15	IPE Global Private Limited Headquarters: New Delhi, India Founded: 1998 Managing Director: Dr. Swapan Kanti Chaudhuri	Technical assistance and solutions for equitable development and sustainable growth in developing countries	£13.6 million
16	Charles Kendall & Partners Founded: 1948 Headquarters: London Global Operations Director: Mark Kendall	Supply chain management & procurement consulting	£11.3 million
17	International Procurement Agency Founded: 1981 Headquarters: Bossum, The Netherlands	Supply services, Procurement services, Consultancy services and Emergency Response	£10.8 million
18	KPMG Founded: 1987 Headquarters: Amstelveen, the Netherlands Awarded DfID funding: 10.1 million pounds	Global professional services & accountancy services	£10.8 million
19	Air Partner Founded: 1965 Headquarters: London Managing Director:	Chartering aircraft	£9 million
20	Atos Consulting Founded: 1997 Headquarters: London, U.K.	IT and outsourcing	£8.5 million

Source: Devex ²⁸

In 2011-12, consultants and private providers accounted for 9% of DFID's aid expenditure.^{29 30} Apart from the large sums of money that each consultant/company receives, two of the largest global professional and accountancy services companies (PWC and KPMG) are included. Adam Smith International is part of the Adam Smith Institute, a think tank that promotes market solutions. Several companies specialise in economic and government reforms. Another group of companies promote privatisation of public services, public-private partnerships and public management reforms. All these companies have expertise to promote public sector reforms and the privatisation of health services.

The range of projects that these private sector consultancies are involved in show how their expertise is used to 'strengthen health systems'. The Crown Agents have implemented two health projects recently: results based financing in Zimbabwe, commissioned by UNICEF and; improving public health supply chains – lessons from the private sector, Zambia. Options are responsible for implementation of many UKAID funded projects, which include 'Strengthening Urban Health Systems in Bangladesh' and one element of the project is promoting the use of voucher schemes "so urban poor can access health services that would otherwise pay for".³¹ In Kenya, Options is delivering a programme on Maternal and Newborn Improvement Project which includes performance based financing for clinics. Options is also working with the Crown Agents and Oxford Policy Management to deliver health systems strengthening in Nepal.³²

Mott MacDonald has worked on health projects in Nigeria, Bangladesh and Turkey. In Turkey, Mott MacDonald is as an adviser to lenders for four integrated health complexes delivered through public-private partnerships at Kayseri, Etlik and Bilkent in Ankara, and Ikitelli in Istanbul. Mott MacDonald will assess design, planning and construction, facilities management and lifecycle proposals. Etlik and 3700 bed Bilkent campuses will be among the largest in the world.³³

DFID and Development Finance

The implementation of DFID policies for development finance takes place through a range of agencies and initiatives. The most important agency is the CDC Group, the UK bi-lateral development finance institution.

The CDC Group

The CDC Group was founded in 1948 as the Commonwealth Development Corporation. It has a long history of investing in development infrastructure projects. Since 2004, it has focused on obtaining a commercial return on its investments. This is in contrast to other national development finance institutions which often invest where commercial returns on investment are more difficult.³⁴ The National Audit Office, in a report for the International Development Committee in 2010, commented that although the performance of CDC since 2004 was higher than expected, and that although it was accepted the economic growth was a "precondition for pulling and keeping people out of poverty, the direct effect of specific investments on poverty reduction for poor people is harder to demonstrate".³⁵

Table 7: CDC Investment portfolio proportion for healthcare

Year	% on healthcare
2010-11	10%
2011-12	6%
2012-13	3%
2013-14	4%

Source: Annual reports 2010-2014

Table 8: CDC healthcare investments

Year	Project
2010	Fund manager Actis invested in healthcare provider Sterling Add-Life, which has 770 beds across five multispeciality hospitals in Ahmedabad, Baroda, Rajkot, Mundra and Bhavnagar. In 2013, sold by Actis to Girish Patel, AddLife Investments. ³⁶
2011	1,100 bed Tertiary and specialty care beds, mostly in underserved geographical regions through three hospital investments in a South Asia fund.
2012	Beams Hospitals is only one of three chains in India offering out-patient laparoscopic surgical services. The capital from Ambit Pragma will help the company expand from a single physician practice to five centres.
2013	US\$17.5m Equity investment for Rainbow Healthcare, India – a 450-bed paediatric and maternity healthcare chain based in the southern Indian state of Andhra Pradesh. Investment will be used to build more hospitals.
2014	Narayana Health is the third largest hospital business in India and is becoming India's leading low-cost healthcare company. CDC investment will help expand hospitals in Kolkata, Lucknow, Bhubaneshwar and Bangalore.

Source: CDC Annual Reports 2010-14

CDC does not receive money directly from DFID but raises funds for investments through commercial investors and other development finance institutions, for example, national or international public agencies investing in the private sectors of emerging economies.³⁷ The percentage of its portfolio invested in healthcare has declined since 2010. However, in 'UK Aid: tackling global challenges in the national interest' (2015) DFID announced that it would be investing £735 million in CDC.³⁸

An analysis of CDC investments in health services in India shows that the majority of investments are in hospitals, with a smaller proportion in drug and pharmaceutical companies. Only one hospital investment, Vaatsalya, aims to provide affordable healthcare in smaller towns in Karnataka and Andhra Pradesh, by bringing primary and secondary care together. It has 15 hospitals and is the first hospital network to target smaller towns.³⁹ All the other CDC investments are in private, fee paying hospitals as seen from their websites, which have systems for electronic payment of fees as well as electronic appointment

systems. These features suggest that they are likely to attract high and middle income groups. Several companies are specific about targeting international medical tourists from Europe and the United States.

In the case of India, these investments need to be seen in the context of the expansion of the private healthcare sector in hospital care in some states in India, for example, Andhra Pradesh, Gujarat, Kerala and Maharashtra. In these states, middle and high income groups have moved out of the public sector and poor people rely solely on the public hospital sector.⁴⁰ This has implications for cross-subsidisation of universal healthcare services. If middle and high income groups leave the public services, they will be unwilling to contribute through taxation to public healthcare services, leaving public healthcare services underfunded and of poor quality.

DFID has also set up several initiatives to involve the private sector in partnership. These cover direct funding arrangements for the private sector as well as the creation of public-private partnerships. They are smaller investments which show how DFID's healthcare funding is not just made available to large hospitals but is also targeted at small and medium sized enterprises. Three initiatives which involve the development of small-scale healthcare services are:

- HANSHEP Harnessing non-state actors for better health for the poor
- Business Innovation Facility (BIF);⁴¹
- Impact Investment Fund (IIF).⁴²

HANSHEP Harnessing non-state partners for better health for the poor

HANSHEP shows the nature of the healthcare projects that DFID is promoting. HANSHEP is a group of development agencies and countries, established by its members in 2010, which aims to 'improve the performance of the non-state sector in delivering better healthcare to the poor by working together, learning from each other, and sharing this learning with others'.⁴³ The members are:

- African Development Bank (AfDB)
- Bill & Melinda Gates Foundation
- Government of Rwanda (Ministry of Health)
- Government of Nigeria (Ministry of Health)
- International Finance Corporation (IFC)
- KfW Entwicklungsbank (KfW) and Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) on behalf of the German Federal Ministry for Economic Cooperation and Development
- Public Health Foundation of India (PHFI)
- Rockefeller Foundation
- UKaid from the Department for International Development (DFID)
- United States Agency for International Development (USAID)
- World Bank.

This range of members draws together a mix of government departments, charitable/ private foundations, the World Bank Group and a regional development bank. It shows how

alliances are being created at international level between governments, foundations and international financial agencies.

The range of HANSHEP projects show how DFID funds projects which facilitate changes in the way in which public healthcare systems operate. They cover the creation of health markets and market innovations, health enterprises and the development of public-private partnerships in different contexts. For example, in 2012, HANSHEP set up a Pilot Health PPP Advisory Facility, which is managed by IFC, to provide advice for governments in developing and implementing public-private partnerships supporting healthcare services for the poor. Between 2012 and 2016, the initiative has been collecting evidence on the adaptation and implementation of health PPPs in low income countries and disseminated this evidence to health and finance policy makers in low income countries. It aims to provide comprehensive technical assistance for senior government officials in low and lower middle income countries so that they can evaluate health PPPs. This initiative will also test the effectiveness of health PPPs in low income settings so that they can be used as a way of accessing private sector investment 'for better delivery of health services to the poor, women and girls'.⁴⁴

Table 8: HANSHEP projects with specific DFID involvement

Project	Countries	Time period	Funding
African Health Markets for Equity	Nigeria, Kenya, Ghana	2012-2017	DFID/ Bill & Melinda Gates Foundation (BMGF)
Health Enterprise Fund	Ethiopia, Kenya, Nigeria	2013	DFID/Rockefeller Foundation/ USAID
Mining health initiative	Africa/Asia	2011-2013	DFID/IFC/Rockefeller Foundation
Center for Market Health Innovations	Africa/Asia	2012-2016	DFID/ BMGF
Increasing Care seeking behaviour for Childhood illnesses (ICARE)	Nigeria	2014-2016	DFID/ Bill & Melinda Gates Foundation
Pilot for PPP Advisory Facility	Low income countries	2012-2016	DFID/IFC
Markets for Health (M4H) Training	Developing countries	2013-2016	DFID/ World Bank

Source: HANSHEP www.hanshep.org

DFID expenditure for HANSHEP between 2011 -2018 will be £34.7 million. Table 9 sets out the DFID budget for HANSHEP from 2010-2018.

Table 9: HANSHEP Budget 2011-2018

Financial year	Value
2011-2012	£1,204,651
2012-2013	£5,440,886
2013-2014	£8,488,397
2014-2015	£6,971,832
2015-2016	£6,071,375
2016-2017	£4,914,860
2017-2018	£1,696,732

Source: Devtracker ⁴⁵

The projects are supported by partnerships between DFID and IFC, Bill and Melinda Gates foundation, USAID and the Rockefeller Foundation, showing the range of institutional relationships which support the privatisation of public health services.

The Business Innovation Facility

The Business Innovation Facility (BIF) scheme has been running from 2010-2013 and supports companies to develop innovative business models which then contribute to growth, wealth creation, poverty reduction and meeting the Millennium Development Goals. Nigeria, Zambia, Malawi, India and Bangladesh are the target countries.

PwC, one of the top DFID private sector implementers, coordinates this initiative by sub-contracting to several alliance partners, e.g. Accenture Development Partners, International Business Leaders Forum and Imani Development. ⁴⁶ Country management teams are based in these “local corporate entities” national companies and screen, manage, evaluate BIF projects. An Advisory Board has coordination and oversight responsibilities but no legal accountability for outputs. A selection committee consists of 3 senior business experts and a senior DFID representative and has veto over project selection. ⁴⁷ This shows the influence of private and corporate interests in the selection process.

BIF was funded with £3.1 million but this also covered the costs of PwC coordination, so the total funds available for distribution are less. PwC was given a contract for managing the project but it is unclear what the PwC fee for project coordination is.

There were three objectives in the BIF pilot phases: technical assistance, the creation of partnerships between investors and companies and sharing knowledge. Research undertaken by Dalrajani (2013) found that applications were developed with the country manager of each pilot country and evaluated by the selection committee but the criteria for assessment were not publicly available. ⁴⁸ Some examples of funded activities include inclusive business strategy, developing internal business case for inclusive venture, mapping value chains and options, convening partners, investors, and stakeholders or providing sector specific expertise. The BIF does not have any criteria to assess whether a business can contribute to development. There are no formal open calls for proposals. ⁴⁹ One criteria that BIF has identified was that a project had to have operational constraints that would

prevent a business project from becoming main stream business opportunity, to receive funding.

A BIF briefing note stated that the target companies are those with projects that ‘are innovative; have the potential to achieve large scheme development impact through benefits to poor people; are private sector-led, with clear potential for commercial viability’.⁵⁰ An evaluation of the work of BIF, found that the term “large scale development impact” was an ambiguous term which tended to influence funders to choose companies where size was emphasised more than quality. BIF has funded two health projects which both show the blending of healthcare with small business development.

One Family Health (OFH) will establish a network of clinics providing healthcare services to the poor in rural, slum, and peri-urban areas of Zambia. BIF funding provides support from OFH personnel, access to start-up loans, training, and negotiation assistance with suppliers and regulators.⁵¹

“The clinics will be owned and run by local nurses and community health workers operating under the OFH brand. OFH operates a business format franchise that aims to maintain standards, scale widely, and achieve economies of scale. The clinics will specifically target a short list of the main diseases causing approximately 70% of illness and 40% of death in sub-Saharan Africa including respiratory infections, malaria and dysentery.”

One Family Health started operations in Rwanda and is currently expanding into Zambia, Nigeria, Ghana. The founder and CEO is Dr. Gunther Faber is also Vice President of Sub-Saharan Africa for GlaxoSmithKline Consumer Nigeria plc and has worked for 30 years in the pharmaceutical industry.⁵²

Another BIF project in Nigeria is the Aceso Healthcare Partners project which is developing medical diagnostic clinical services. Aceso Healthcare Partners (AHP) is a healthcare diagnostics provider that has only recently been registered in Nigeria. The owners are a group of Nigerian doctors who trained and practised in the United States. They are aiming to develop alternative model of medical diagnostics services, provide value to investors and have a social benefit to the local community. It will use a “variety of payment models’ to make their services available to poor urban communities”. It also aims to “identify access to different income streams” to support long term goals.^{53 54}

DFID Impact Investment Fund

In 2012, DFID created a £75m impact investment Fund which is managed by CDC. Impact investments are a type of investment which aim to generate measurable social and environmental impact alongside a financial return.⁵⁵ Investments are made into companies, organisations and investment funds. The Impact Investment fund has three partners:

- The Global Impact Investing Network (GIIN) - a non-profit organisation which aims to promote impact investing through activities, training and research.

- The CDC Group, the UK's development finance institution, manages the DFID Impact Fund, a Fund of Funds. It will make investments of up to £75 million over 13 years.
- CDC aims to provide finance to more than 100 enterprises in Sub-Saharan Africa and South Asia via impact investment intermediaries and drawing in additional private capital. CDC will be expected to generate “reasonable financial returns” and achieve a strong development impact, through the creation of jobs, both directly and indirectly.
- PwC acts as the Programme Coordination Unit for the Impact Programme, working with CDC and the GIIN. PwC coordinates the programme, manages the technical assistance fund and implements a monitoring and evaluation framework. The value of the PwC contract for its work as programme coordinator was £2,479,814 for 2012-15.⁵⁶

The innovative element of this impact fund is the attempt to bring together social and environmental impact with financial return. In January 2014 it was announced that CDC, had chosen Novastar Ventures to be the first beneficiary of the IIFund. Novastar Ventures is a venture capital fund which finances new businesses. It will invest up to \$15 million dollars over 10 years, investing venture capital in East African businesses that offer low-income household access to affordable healthcare, energy, housing and safe water.^{57 58}

Public Private Partnerships

Public-private partnerships (PPPs) operate at global, national, regional and local levels. Increasingly the contributions by the public-private partnerships of the GAVI Alliance and Global Fund to fight AIDS, TB and Malaria have continued to grow. NGO contributions have also continued to expand. Overall, the contribution of public-private partnerships and NGOs has started to overtake contributions by governments in overseas development assistance (ODA).⁵⁹

The 2013 Health Policy Position statement illustrates DFID's perspectives on PPPs.

“Two types of PPP operate there: with NGOs/not-for-profit agencies and with the commercial private sector and larger corporate groups. While both types have shown high levels of utilisation and benefits, recent assessments highlight the need for active performance monitoring, sound contract management, basic cost and quality monitoring. To get the most out of these partnerships and to ensure the poorest benefit, there is need to build capacity within the public health system to design and manage these partnerships.”⁶⁰

As well as including NGOs and not for profit agencies as well as the commercial sector, DFID has identified the need for more public sector capacity to design and manage the contracts. This does acknowledge that there have been problems with PPPs but there is no recognition that it might be the way in which the private sector negotiates and the type of contracts that might be major problems.

Although the range of public-private partnerships is continuing to expand, there is growing evidence that PPPs do not always deliver the expected solutions to the provision of infrastructure. One of the arguments in favour of PPPs emphasises the ability of PPPs to access funding for infrastructure and public services faster than the public sector in times of austerity and cuts in government funding.⁶¹ A major reason why governments use PPPs is that the money borrowed does not feature in the government accounts, thus reducing perceived government debt. However, PPPs do not provide access to new sources of capital. Money is borrowed from the same institutions, e.g. banks, pension funds and other investors as the government would borrow from, so there is no obvious benefit from using the private sector. In the longer term, the government will pay more for the infrastructure project because it pays back to the private sector partners to cost of building and then managing the service.⁶² The costs that the government pays for the investments and service provision made by the private sector are funded through taxation, in the case of health services.

A report for International Institute for Sustainable Development (IISD) (2011)⁶³ found that in a survey of PPPs around the world, the emphasis was on 'value for money' rather than any consideration of social and environmental factors. Poor communities, particularly women, are often not involved in project design and remain 'voiceless' in the process of developing a PPP. PPPs involve partnerships of construction, service and financial service companies with the public sector/government. There are problems of transparency in PPPs because they do not appear on government accounts and they are more difficult to evaluate because of a lack of access to commercial records.⁶⁴ Government officials often do not have the skills to negotiate good deals with private sector companies involved in financial services. Poorly negotiated contracts can result in increases in government indebtedness. The balance of costs, benefits and risks are not always clear in PPPs.⁶⁵

A Eurodad report on PPPs (2015) also found that PPPs were the most expensive way of financing health infrastructure projects with increasing costs to public expenditure. There is also considerable risk involved in PPPs for public institutions. The complexity of PPP contracts and the resulting high transaction costs results in only large companies bidding for contracts. This limits the choice of private sector partners for governments, which limits competitiveness. There is also limited evidence of increased efficiency from PPPs. The long term impact of PPP payments on the public sector is beginning to be felt by completed PPP projects which will weaken the budgets of public health services. There is a lack of transparency in PPP contracts which obscures the profits that the private sector consortium are making. This limits public accountability of projects,⁶⁶

PPPs are being promoted as part of the solution to the post-2015 agenda.⁶⁷ There is a network of international financial institutions (IFIs), governments and corporate bodies which promote PPPs through marketing and campaigning globally. The IFIs include the IMF, the World Bank Group, and regional development banks. IFIs use their public funds to subsidise PPPs. PPPs are also promoted in inter-governmental bodies and global corporate events. National development agencies also promote PPPs through funding and advice, for example DFID. International legal, accounting and consultancy companies, such as PwC, are commissioned by national governments to publish advice and are then commissioned to

provide consultancy advice for government to implement PPPs. This process of international lobbying for PPPs has an impact on public debates and decision making. Public policy becomes focused on PPPs rather than on how to reach social and economic objectives and the creation of publicly funded and managed infrastructure.

Many of the IFC hospital investments are PPPs. One of the best documented hospital PPPs is the Queen Mamohato Memorial Hospital in Lesotho. This was described as a 'IFC flagship model PPP'. In 2006, the government of Lesotho launched a PPP to build a hospital to replace the Queen Elizabeth II hospital. The new hospital cost US\$153 million. The private sector partner, Tsepong, has an 18 year contract. The government pays an annual fixed services payment for the delivery of all services and the healthcare network has to meet all the performance standards to qualify for payment.⁶⁸

Table 10: Loans for the Queen Mamohato Memorial Hospital, Lesotho

Source of loan	Size of loan
Government of Lesotho	US\$58
Equity capital Tsepong	US\$ 474.6
Development Bank of South Africa	US\$ 94.9

Source: Oxfam (2014)

The total loan is ten times the budget of the health ministry but the government has also had to provide a loan guarantee for Tsepong. The Development Bank of South Africa is also using government money. The payments are now US\$67 million per year which is three times what the old hospital would have cost. This has required a 64% increase in government health spending over the three years (2014-2017). It is diverting resources away from the rural areas where the majority of the population live. The project is expected to generate a 25% return for the PPP shareholders.⁶⁹

IFC provides advice for the development of new PPPs. Table 10 shows three examples of recently negotiated PPPs in three poor Indian states. Two are examples of new-build hospitals and a third is the building of pathology laboratories. Indian commercial partners are involved in all three PPPs. Patna Hospital will be part of one of the largest multi-specialty hospitals in India. IFC advice in setting up the PPPs was funded through the HANSHEP project which is funded by DFID. This shows how DFID funding is being used to develop PPPs which involve Indian commercial healthcare companies.

Table 11: Three examples of IFC PPPs & DFID funding

Project	Consortium	Amount	HANSHEP
Jharkhand Pathology Services – 25 pathology laboratories	Medallo Healthcare Private Limited & SRL Ltd	US\$2 million private sector and US\$360,000 concession for government 10 year contracts	IFC advice funded through HANSHEP project funded by DFID

Bhuhaneswar Health Network – new hospital	KPC Group – part US-Indian hospital group	US\$35 million private investment 34 year contract	IFC advice funded through HANSHEP project funded by DFID
Bihar (Patna) PPP Design, Build, Finance, Operate, Transfer (DBFOT) hospital	Global Health Patliputra Private Ltd (GHPPL) a unit of Medanta the Medicity (one of largest multi-specialty hospitals in India)	33 year concession	IFC advice funded through HANSHEP project funded by DFID

Source: IFC

The promotion of PPPs is also taking place through the work of Healthcare UK, an organisation set up in 2013, to promote UK healthcare providers to “do business overseas. We do this by promoting the UK healthcare sector to overseas markets and supporting healthcare partnerships between the UK and overseas healthcare providers.”⁷⁰ It is a joint initiative of the Department of Health (DH), UK Trade and Investment (UKTI) and NHS England.

The Healthcare UK Business Plans and Annual Reports show that 16 national healthcare markets that are targeted. The priority markets are mainly in Asia and the Middle East but the new markets show that Latin America is becoming a focus of growth. In Peru, the government has just chosen a competition based PPP system which will be managed by ProInversion, an arms-length organisation.⁷¹

Table 12: New and Priority Markets

Priority markets	Turkey, Kuwait, Libya, Brazil, Saudi Arabia, Oman, UAE, India, Hong Kong, China, Indonesia
New markets	Colombia, Mexico, Peru, Nigeria, Middle East & North Africa

Healthcare UK has facilitated several partnerships between King’s College Hospital and partners in India and Abu Dhabi. KCH Management is a commercial, consultancy, marketing and business company set up by King’s College Hospital Foundation Trust. In April 2015, it signed a Memorandum of Agreement with the Indo Healthcare Private Ltd and the Punjab government. KCH is a strategic clinical partner for the first Indo Institute of Health in New Chandigarh, India, which is funded by Elara Capital.⁷²

The example of King’s College Hospital Foundation NHS Trust also shows how civil servants and politicians are involved in this process of public-private partnerships. The Chair of King’s College Hospital Foundation NHS Trust is Lord Kerslake,⁷³ who was Head of the UK Civil Service, Permanent Secretary of the Department for Communities and Local

Government, and chief Executive of two local authorities before he became a cross-bench peer in 2015.⁷⁴ Lord Maghnad Desai is a director of Elara Capital and a Labour peer in the House of Lords. He was previously an academic.⁷⁵

Sir David Nicholson, former head of the NHS, provides further evidence that previous public sector managers are now operating with private healthcare companies. He is head of the Abraaj Group Health Markets Fund Impact Committee.⁷⁶ The Abraaj Group is an investment company which is investing in Asia, Middle East and Africa. An example of a recent successful investment was in the Acidabem hospital group, the leading private hospital group in Turkey. Abraaj Capital investment contributed to the expansion of the hospital group from six to fourteen hospitals. In 2012, Abraaj Capital sold its shares to IHH (Singapore/ Malaysian healthcare holding company)/Khazanah (Malaysian government investment fund) in exchange for cash and shares in IHH. IHH was then launched on the Singapore Stock Exchange and Abraaj Capital then sold its shares.

There are several examples of politicians and civil servants who have links (own shares or act as advisers) to private companies which work with DFID. Lord Glendonbrook has shares in Siemens AG. Lord Freeman is Chair of the Advisory Board of PWC. Lord Ribiero was a former adviser on hospital re-organisation to PWC. Lord Harris of Haringey was a former senior adviser to KPMG. Mark Britnell is now Chair and Senior Partner for Global Medical Practice at KPMG. He previously worked for the NHS.⁷⁷

Kenya – case study

Table 13: Health profile of Kenya

	% GDP healthcare spending	% GDP Public health expenditure	% out of pocket spending (as % private spending)	Life expectancy		Infant mortality rate/1000 live births	Maternal mortality rate/100,000 live births
2012	5.5	60.5	67.3	W 62	M 59	38	540
2013	5.6	60.1	67.4	63	59	37	525
2014	5.7	61.3	67.4	63	60	36	510

Source: World Bank Indicators

The amount of GDP spent on healthcare is just over 5% with over 60% from public health expenditure. Infant mortality and maternal mortality rates have improved since 2012. Out of pocket spending as a percentage of private healthcare spending has remained at 67% since 2012. 66% of the population are at risk of catastrophic surgery expenditure. Catastrophic expenditure is defined as direct out of pocket payments for surgical and anaesthesia care exceeding 10% of total income.⁷⁸

Out of pocket spending as a % of private health expenditure has to be understood in relation to overall private sector overall spending and public health spending. In medium income countries, such as Kenya, where there have been decreases in public health spending but high levels of out of pocket spending, households will be strongly affected by these changes. Individual households have to pay more directly for medicines and healthcare treatments.

For individuals or households who are unable to afford the costs of health insurance and are unable to access publicly funded healthcare, their only option may be to pay for healthcare when they need it. This may involve paying a private practitioner or a public facility. This has important implications for households because a decision whether to access healthcare will be determined by whether they have enough money to pay rather than their healthcare need.⁷⁹ Individuals may leave treatment until a condition is more serious. It can lead to higher rates of catastrophic healthcare expenditure, which can devastate household income. Only very small increases in fees can result in a decrease in service use by poor households. This reduced access to healthcare results in worsening levels of ill-health and higher mortality rates.⁸⁰

The DFID Kenya Health Programme (£106.3m) ran between 2009 and 2015. It was implemented with partners Population services International (PSI), World Health Organisation (WHO), the MENTOR Initiative, Family Care International (FCI) MENTOR Initiative, and Kings College London (KCL) All organisations work closely with the Ministry of Health.⁸¹ Although part of the DFID health programme is focused on malaria prevention

and control, HIV/AIDS and reproductive health, the strengthening of health systems forms an important part of the programme.

DFID has been working in the same environment as the Health Policy Project, which is funded by USAID and PEPFAR (The US President's Emergency Plan for Aids Relief) and aims to strengthen health systems during a transition period to devolved government and decentralised health infrastructure and to strengthen the use of results-based health financing and budgeting. Technical assistance is provided to:

“formulate effective new health policies and laws. We also work with government and health institutions to develop effective and efficient financing mechanisms that maximize the country's funding resources to deliver high-quality, equitable, and affordable healthcare services to all Kenyans.”⁸²

The Health Policy Project is in the process of changing the way in which the health system is financed and organised, with an emphasis on containing costs and monitoring services. The World Bank and WHO are two multi-lateral agencies involved in this project.

A report (2012) 'The Next 33,000,000' by Open Capital Advisors, a company providing investment advice in Africa, was written for healthcare investors and shows how Kenya is seen as having investment and innovation opportunities in the healthcare sector. The report sets out the case for the private sector role in the healthcare sector and shows how the healthcare is seen as a commodity which requires the development of a market. Investors recognise that Kenya has a growing demand for healthcare and have invested in medical insurance and healthcare provision. It argues that public healthcare expenditure is expected to continue to fall and as a result the private sector will have opportunities for expanding into provision of healthcare services. It estimated that Kenya private healthcare sector will need \$US1.4 billion by 2025. This size of investment will require private equity investors rather than “retained earnings or debt”.⁸³

The report argues that the challenge for the private healthcare sector is to change the focus of 'consumers' to become more value-focused rather than cost sensitive. “Entrepreneurs will have to price carefully in the face of competitors subsidized by aid, NGOs and government.”⁸⁴

The report then examines the options for private healthcare insurance - private mass market health insurance. The development of private health insurance is one of the first hurdles that private healthcare providers have to solve because without private health insurance, patients can only pay 'out of pocket' which restricts what can be sold to the patient. The Open Capital Advisors report shows how Kenya is being promoted as a potential growth centre for private healthcare. It complements a recent DFID funded project which shows how the promotion of privatisation is not just through the funding of private and corporate hospitals and facilities. It is also through the development of a way of working which is being promoted to local healthcare workers and services users. One of the biggest challenges for private healthcare in many low/ medium income countries is for people to be willing to pay for higher quality and therefore more expensive healthcare.

The DFID funded project 'Private sector Innovation Programme for Health' (PSP4H) applied the Making Markets Work for the Poor (M4P) approach to healthcare. It worked with 12 projects to develop local healthcare markets for 2.5 years. These were:

- Health insurance for informal workers
- Bungoma Midwives
- Business Schools training
- City Eye hospital
- County engagement with PHPs
- Jacaranda Maternal health services
- Labnet
- Pharmnet
- PSK-Tunza
- Tanaka Nursing home
- Live Well Viva Afya

The programme was evaluated by Cardno Emerging Markets, a consultancy group which works in a wide range of sectors. The evaluation conclusions show the underlying assumptions about private healthcare which have been made by the evaluators. The Bungoma Midwives project was described as having a “NGO mentality and expected financial support in return for cooperation.”⁸⁵ The City Eye Hospital project was felt to need to “work on developing a sound business model (e.g. understanding breakeven, product mix, cross-subsidy).”⁸⁶ The Jacaranda Maternal Health Services Project was evaluated as not understanding Markets for Poor People (M4P) well and so opted for donor funds and failed to assess financial sustainability. The overall conclusion was that the project has only been implemented for 2.5 years and more time was needed. This points to a focus on how the projects often failed to either understand the process of business planning or chose other options to develop their services. Overall, the PSP4H project was trying to introduce business thinking to local healthcare services.

Kenya is an example of a country which received three IFC loans for new hospital and healthcare services. It is the focus of attention for private healthcare investors. DFID is contributing to attempts to change the balance of health services from public to private.

Liberia – case study

Table 14: Liberia health profile

	% GDP healthcare spending	% GDP Public health expenditure	% out of pocket spending (as % private spending)	Life expectancy		Infant mortality rate/1000 live births	Maternal mortality rate/100,000 live births
2012	10.2	33.2	44.8	W 61	M 59	57	762
2013	9.3	30.6	44.8	62	60	55	741
2014	10.0	31.5	44.8	62	60	53	725

Compared to Kenya, Liberia has a higher % of GDP spending on health but a lower percentage of this is public health expenditure. Infant mortality and maternal mortality rates are higher than Kenya, although they have improved slightly since 2012. Out of pocket spending as a % of private spending is lower than in Kenya but the risk of catastrophic health surgery expenditure is about the same at 60%.

In Liberia, DFID has contributed to the Health Sector Pool Fund (HCSF) and the Liberia Reconstruction Trust Fund (LRTF), which are both multilateral donor funds. It took a lead in the Health Sector Pool Fund (HSPF), which was established in 2008 to coordinate donor agencies and the Government of Liberia's national health policies and plans. DFID is a member of the Steering Committee, alongside the World Health Organisation (WHO), the World Bank, the European Union and USAID, who are part of a Joint Financing Agreement with the Ministry of Health & Social Welfare. All activities funded by the HSPF are based on proposals initiated by the Ministry of Health and Social Welfare and agreed by the Steering Committee. DFID provided £12 million for the Health Sector Pool Fund between 2010 and 2013.⁸⁷

DFID spends £15 million in Liberia, 65% of its total budget, through multi-lateral agencies. DFID staff sit on programme boards, e.g. Liberia Reconstruction Trust. The International Development Committee, following a visit to Liberia, reported that there was good cooperation between DFID and World Bank staff because they shared a "similar world view".⁸⁸ NGOs based in Liberia had questioned DFID's use of multilateral agencies because they did not always provide adequate oversight of projects.⁸⁹ Other centrally managed programmes were often run by consultants rather than DFID staff. Again, NGOs were critical of the influence of commercial consultancies which had limited experience of social programmes.

An example of how multi-lateral agencies promote PPPs in healthcare can be seen in the report from the EU about a second Poverty Reduction Strategy (PRS-II) for Liberia in 2012. The EU reported that:

“The PRS-II also stresses the importance of improving efficiency and effectiveness, e.g. by developing viable and equitable healthcare financing options, efficient use of key inputs such as human resources for health and efficient models for public-private partnerships.”⁹⁰

As part of DFID’s aid budget goes to the EU, this shows how support for multi-lateral agencies is also supporting the promotion of PPPs.

Although DFID support had been essential to the improvement of Liberia health services, the International Development Committee “were shocked to find that \$3.9 million of \$60 million EU health sector support had been passed on from the Ministry of Finance to the Ministry of Health over a two year period, leaving the Liberian health system struggling.”⁹¹ DFID and the EU had not been active in resolving this situation. Although this problem has now been addressed, this illustrates the power of finance ministries over health ministries, an underlying feature of health sector reform.

One of the major problems facing the Liberia health system after Ebola crisis is the shortage of trained nurses and doctors. The International Development Committee (IDC) commented on this and were concerned that about 10% of trained nurses were working in the UK. It recommended that DFID should make contacts with UK healthcare institutions and professionals and those working in Liberia and Sierra Leone.⁹²

The future of DFID funding of the Liberia health sector was also raised by the IDC and illustrates the potential impact of changes in DFID’s priorities which are moving from direct bi-lateral aid to working with multi-lateral agencies on wider issues of poverty reduction. DFID funding of the Liberia health sector was due to end in 2014. Although funding has continued as a result of the Ebola crisis, health funding is not expected to continue long-term. The initial reaction of the Liberia Health Ministry to the proposed cut in funding was to recommend that user fees would have to be re-introduced. DFID’s funding of the health sector since 2008 has enabled Liberia to abolish user fees for health services.

Nepal – case study

Table 15: Nepal health profile

	% GDP healthcare spending	% GDP Public health expenditure	% out of pocket spending (as % private spending)	Life expectancy		Infant mortality rate/1000 live births	Maternal mortality rate/100,000 live births
2012	5.9	41.9	79.0	W 70	M 67	32	291
2013	5.7	39.0	79.9	71	68	31	275
2014	5.8	40.3	79.9	71	68	29	258

In Nepal, the percentage of GDP spent on healthcare is over 5%, similar to Kenya but the percentage of public health expenditure is lower than Kenya. Out of pocket spending as a % of private spending is higher than either Kenya and Liberia and the risk of catastrophic health surgery expenditure is also higher at 75%.

DFID has been involved in funding a Nepal Health Sector Support Programme which aims to address ways of financing health services as well as developing a health financing strategy with other sector partners.⁹³

DFID was involved in a PPP for TB control in Lalitpur municipality, Nepal, where 50% of patients were managed by private practitioners. This is an example of a PPP which worked with private practitioners, rather than using private capital. There are over 14,000 new cases of TB notified each year in Nepal. Over 50% of cases in urban areas are treated by private practitioners. The Lalitpur District Public Health Office (DPHO) was responsible for managing the PPP scheme. This included providing training for laboratory staff and Directly Observed Treatment (DOT) supervisors, supervising workers involved in TB control, ensuring supply and distribution of medicines, and ensuring that five Treatment Centres (TCs) followed standard NTP recording and reporting guidelines. A semi-governmental hospital (Patan Hospital), three NGOs (Yala Urban Health Programme (YUHP), Nepal Anti-TB Association (NATA) and a private nursing home which ran private outpatient clinics in the mornings and evenings) were invited to become treatment centres for Directly Observed Treatment. No financial incentives were paid to the participating organisations.

An evaluation found that if the scheme was to be scaled up there were several issues which would have to be addressed: the low staff costs as compared to other health systems; the use of unpaid volunteers which might have replaced by paid staff in other systems and; the high social costs to patients. Although patients were given free treatments, they had to pay for travel to clinic and for diagnosis costs. The cost of accompanying women patients was higher than for male patients. Overall costs for women patients were higher than for men because women required more chaperoning. Costs by men who self-referred or were

referred from semi-government facilities were also higher than for women although the numbers in the sample were small. The study found that the costs for families of patients were significant and could limit patients from accessing treatment.⁹⁴ This example of a PPP is a contrast to larger PPP infrastructure projects and it shows that the process of collaborating between the public and private sector can be focused on a specific treatment.

Conclusion

This report has shown that DFID's expenditure through CDC and multilateral agencies, such as the World Bank Group, is contributing to the implementation of policies which are promoting the privatisation of health services and encouraging healthcare to be considered a commodity to be bought rather than a public service which is free at the point of use. This is a fundamental change for many countries and will benefit investors in healthcare rather than patients. The hospital investments of the IFC will benefit higher income groups. The smaller partnership investments which DFID contributes to will support the development of smaller private healthcare providers.

DFID expenditure is contributing to the expansion of PPPs. This results from DFID support for multi-lateral agencies, such as the International Finance Corporation (IFC), which invest directly in PPPs. DFID has also set up initiatives which encourage and facilitate the development of PPPs, for example, HANSHEP. In this sense, DFID is not only directly promoting PPPs but is also creating policy environments which will promote PPPs in future.

All three country case studies showed that out-of-pocket spending was already high and the risk of catastrophic surgical spending was much higher. The majority of the populations lacks access to safe, reliable and free health services. The promotion of privatisation at whatever level will not increase accessibility but will channel resources to a private sector. Recent DFID policies do not recognise the role of the public sector except as a last resort for very poor people. This means that the concept of universalism, where risks are shared across the whole population, is being abandoned. There is evidence to show that public health services reduce mortality and contribute to economic growth. Public health services should be recognised as the foundation of all aid and development policies.

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