

Exploring Public Private Partnerships in health and education: a critique

- The landscape of partnerships in international development has been changing rapidly over the past decade, with significant realignment of roles between the state, private and third sectors. Public Private Partnerships (PPPs) have emerged as a key form through which healthcare and education are defined, delivered, and, evaluated in developing countries. PPPs are deemed to offer potential for addressing inequalities in provision and access to public services across the Global South, ensuring that resources are targeted equitably and effectively. The articles in this special issue review some of the evidence on PPPs considering whether and in what ways they deliver on addressing intersecting inequalities.

PPPs have been promoted as an important development financing mechanism in support of the Sustainable Development Goals (SDGs). SDG 17 outlines a vision for partnerships between governments, private sector and civil society, and delineates these as 'inclusive partnerships built upon principles and values, a shared vision, and shared goals that place people and the planet at the centre, are needed at the global, regional, national and local level.' (UN, 2015). The goal envisages these partnerships as an effort 'to mobilize, redirect and unlock the transformative power of trillions of dollars of private resources to deliver on sustainable development objectives' (ibid). Under Goal 17, there is an explicit target on PPPs: 'Encourage and promote effective public, public-private and civil society partnerships, building on the experience and resourcing strategies of partnerships (UN, 2015).

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 (see Languille, this volume). Nevertheless, common to all, is the notion of some shared financial and governance arrangement between the public, that is the state sector, largely financed by revenue, and sometimes aid, and the private sector, which may comprise local or global capital. When PPPs have a significant transnational element they are referred to Global Public Private Partnerships (GPPs). One of the central justifications made by supporters of GPPs is that they have led to large increases in the amount of money that is available for health and education interventions, which was not forthcoming from national revenue collection or aid budgets. However, this same observation comprises one of their major critiques, in that the financialization of the means of social reproduction in sectors such as health and education, skews the direction of policy and practice in the direction of enhancing the profits of the large corporations involved with this process, rather than entailing substantive engagement with social development or equalities.

PPPs are not new arrangements only emerging to deliver on the SDGs. They first emerged in the Global North in the 1980s as part of an approach to infrastructure development.

Presented as a means to raise finance without increasing public sector debt, PPPs were heralded as a way to avoid perceived public sector inadequacies through greater involvement of private sector agents with alleged efficiency and cost effectiveness advantages. By the late 1990s, PPPs were being promoted by donors across the Global South as the solution to growing demands for public services. Critics, however, have argued that PPPs are part of a shift towards 'welfare pluralism', representing a trend towards private financing and provision which fosters access for multinational companies to markets in public services (Standing, 2007). They point out this necessitates reform of the state through the introduction of market forces, which alter conditions of work and the form of social development. A number of studies of PPPs in the global north and south? conclude that there is insufficient evidence to support many of the claims surrounding the presumed benefits of PPPs and their contribution to reducing poverty and inequalities (Romero, 2015; Trebilcock and Rosenstock, 2015; UNDESA, 2016). A concern in drawing conclusions regarding the effectiveness of PPPs to deliver on global visions, such as the SDGs, is that research has tended to remain in sector-specific silos, failing to address cross-sectoral linkages, challenges or insights, constraining evaluations of PPPs in general as a means to overcome inadequacies in the public sector and enhance social development as a connected project to address intersecting inequalities. For example, within the health sector, systematic reviews of one type of PPP program, health voucher schemes that seek to promote better access to health care services, question their long term impact, particularly in relation to overall health systems. (Nachtnebel et al., 2015; Murray et al., 2014). Similar points have been made in relation to research on education voucher schemes in Chile (REF NEEDED), but there is little connected commentary on these cross sectoral effects. Scholars have argued that questions of equity are not sufficiently addressed through PPP health projects and the issue of accessibility and quality of care remains an on-going challenge (Jehan et al., 2012; Kanya et al., 2014) and similar points are made in relation to a form of education PPPs, where overseas development assistance is spent on low cost private schools, where provision is uneven and many of the poorest children are not reached . Despite the prevalence of PPP-promoted voucher schemes in education (Chakrabarti and Peterson, 2009; Education International, 2009; Härmä and Rose, 2012; Klee, 2008), very little comparative analysis has taken place of how these schemes work across sectors. Moreover, current promotion or opposition to PPPs have largely failed to address the nature and history of both the public and private sectors in particular regions and countries. Much writing has focused on the perceived benefits and limitations of public and private agents (Hanson et al., 2008; Heyneman, 2003; Patrinos et al., 2009). Yet increasing concerns have been raised around the accountability of PPP relationships (Brien et al., 2014; Buse and Harmer 2007) as well as the nature of these partnerships and the power relations embedded within them. It has been suggested that the global level donor partners impose their agendas regarding PPPs on recipient countries, thereby undermining national priorities and the voices of diverse stakeholders (Buse and Harmer, 2007; Koivusalo and Mackintosh, 2011). Furthermore, results (or performance) –based health care or education evaluation, linked to narrowly defined

outcomes is often the guiding orientation in planning for GPPPs/ GHIs. These approaches often fail to take into account the broader social dimensions of health or education (Hanefield et al., 2007) and the complexities of processes of change in these areas.

The criticisms of PPPs have not dented the ways large international organisations view their potential. Within the health sector, the introduction of PPPs sit at a nexus of concerns with unleashing large amounts of private money to solve particular kinds of health problems (ignoring others), building a focus on personal responsibility for poor health, and a wider movement looking at health systems and the ways in which they help build provision of health and right. The World Health Organisation has reinforced the importance of taking broader social determinants of health approach, which includes looking at gender issues, arguing this must sit alongside the need for money to advance goals. The implication of this for some of the critical engagements with PPPs, forms of development assistance and approaches to the SDG agenda need analytic attention. In the education sector, a simple focus on getting girls into school sometimes through PPP initiatives, without reference to or action on the broader gendered constraints that they face within and beyond school, has been a major concern of UNESCO, some other UN organisations a education activists and large aid programmes (UNESCO, 2014). agenda around girls' education in a historical context and critically review some of the policies and practices entailed.

(some refs on ed and health).

The papers within this Special Section aim to bring together an assessment of the literature on PPPs in education and health to assess what the research evidence tells us regarding similarities and differences in the experience with PPPs and aspects of equalities across two sectors. . In her overview paper Sonia Languille SUMMARY NEEDED

In their paper, 'Public-private partnerships in sexual and reproductive healthcare provision: establishing a gender analysis', Jasmine Gideon, Benjamin Hunter and Susan Murray seek to develop a gendered critique of PPPs in Sexual and Reproductive Health through the examination of the case of maternal health vouchers in India. the use of health care vouchers to deliver SRH services has proliferated throughout the Global South but as the paper argues there is very little conclusive evidence to show that services delivered via PPPs are more effective at reducing health inequalities than public services. Moreover, as the paper highlights, the expansion of SRH vouchers raises a number of concerns from a gender perspective as it is not clear how far such programmes are really able to tackle deeply embedded gendered inequalities which shape individuals' pathways into poverty and poor health.

Elaine Unterhalter's paper reviews some of the existing literature on PPPs in education, and shows how the girls' education is given a particular prominence, but that addressing wider questions concerning substantive gender equality and women's rights tend to be ignored. She takes the example of the large DFID funded programme Girls Education Challenge, delivered as a PPP, and

considers both the expansion of provision it secured and some of the limitations in failing to address questions of sustaining work around equalities.

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