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Debate

The lack of data and the conceptual mistakes in assessing public-private partnerships as a form of healthcare privatization

La falta de datos y las equivocaciones conceptuales al evaluar los partenariados público-privados como un tipo de privatización sanitaria

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Introduction

Very often, the literature on public-private partnerships in healthcare assimilates public outsourcing, public-private management competition, market emulation... with privatization.[1,2] And from any of these managerial formulas some authors jump to political views on consequences such as an eventual reduction of finance (austerity, budget cuts), elimination of services or inequity. This is supposed to be driven by lower utilization, which is always assumed to be related to a poorer quality, leading to worse outcomes for the population in terms of mortality often under very short latency times anchored to some convenient political horizon.

The process is empirically measured by private spending, more than by funding. The private sector expenditure however aggregates data from a wide range of situations: different contracts with a wide extent of policies[2], including in some cases cleaning, security or catering services; legal and accounting management tasks; consulting services; IT support; ambulances and transfers; social workers and certain home care services. To the miscellany of content must be added the diversity of recipients,[3] including transfers to charities and private not-for-profit organizations. And when data are compared, it is common to make *tabula rasa* of the legitimate healthcare policy actions, according to the limits of the public responsibilities; for example, mixing up the case of the English regions —with no political autonomy— with the Spanish autonomous communities, or the Italian local authorities —with quite large political decentralisation—, or even inside countries —say between England and the rest of nations in the United Kingdom![4]

In assessing impacts, commonly language does not help either: in Spanish, "could affect" sounds similar to "might affect". That semantic dissociation emerges when one reads the abstract of some papers, or the implications derived from the results, with the complete more enriched content of the analysis. By forgetting the associations that are not statistically significant in alternative measures to those chosen, or the endogeneity of the relations that impede causality, the policy-making purposes of the exercise seems to neglect the study; particularly on the disclaims that the authors make when discuss the results, or on the required future research agenda to "know better". These caveats usually come too late to be considered for political recommendations.

Having acknowledged this, it is true that if we want to emulate in Spain such a nonsense approach in judging the effects of public-private partnerships, even a daring analyst cannot do so properly due to lack of data (risk premium for private finance, proper case-mix adjustments in comparing activity, actual direct and indirect transaction costs, public deficits overruns or time delays in care provision, existing public finance restrictions, short and long term effects of those policies, etc.).

What are we talking about when we speak about privatization?

First of all, in order to put the debate on the right track, it is necessary to clarify the meaning of privatization[1]. There is often an abuse of concepts, including indirect public management services (medium-long term "administrative concessions" or year by year contracting-out or *conciertos*), private collaboration in building infrastructures, running some facilities, the logistical management of some equipments or publicly delegated management know-how of some public healthcare services. All of them are forms of public management, under budgetary finance and public regulation: not a pure privatization of a social service. This should be identified by limited access just to those individuals who can pay for it with no risk mutualisation. Without this clear-cut clarification, any public vs. private analysis in my view loses academic interest from the beginning. The cards are marked when any form of public provision with public responsibility but no public production is labelled as "privatisation".[1]

Second, translating all the forms and modalities of public-private partnerships in a unique variable does not make sense. If

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all the contractual diversity is quantified in an item of expenditure, the account unit cannot be interpreted thereafter for efficiency analysis: the one who spends is not necessarily the same one who has financed the service, or who is ultimately responsible for it. From this it does not seem plausible to derive a pure coefficient that measures "the marginal impact of the resources utilisation", say on "mortality".

Third, to translate resources from the "healthcare industry" into population health outcomes is a triple somersault; even more if they are measured as mortality rates.[5] It is well known that mortality is affected by so many and such diverse factors, like education, lifestyles, income or social capital,[6,7] that the *caeteris paribus* assumption either in cross sectional studies or over time is systematically violated, leaving causality and the implications for health policy in speculative grounds.[8]

Fourth, comparisons across countries are impossible without fully accounting the institutional settings. Even beyond the label of National Health Services, the health systems of Greece, Italy, Spain or England (not to say countries within UK) are very different realities.[2] Think of the English GP (basically, self-employed professionals) and the Spanish statutory staff (salaried public servants); or with respect to some East European countries, still with serious *under-the-table* pay problems. "Privatization" does not mean the same in each of those countries; not to say in USA.

Finally, some analysts seem to move too quickly from the Hippocratic Oath of the health professional to the selfish behaviour of the *homo economicus*. As Repullo puts it (personal communication, 2022): "A good public management would be one that reduces the 'privatization' promoted by public employees themselves when using their publicly contracted time for private activities; when using public resources for private gain; when conducting amicable or lucrative cuttings of waiting lists; when fishing patients from the public to the private side; when preferentially using public diagnostic tools for private patients; when receiving payments to obtain public assistance; or through the 'dichotomy' with which a specialist or a laboratory unit or an imaging unit rewards referrals and tests with a percentage to the doctor who has prescribed them". As other authors have emphasized,[6,9] one must also ask oneself whether poor public governance allows welfare state servants to use the state for their own welfare.

In brief, public-private partnership is an ambiguous, polyvalent and equivocal concept.[9,10] In a very recent paper,[11] Fabre and Straub conclude that the existing evidence on public-private partnerships paints a rather mixed picture: "The jury is still very much out regarding the efficiency gains provided by PPPs, and more good-quality studies with convincing identification strategies are needed. What is abundantly clear, however, is that the evidence is closely linked to the institutional context in which they are implemented, to the historical and political landscape in which they take place, and to the specific contracts and regulatory designs". Indeed, as commented, no normative theory allows expanding effects and prescriptions out of those environments. In addition, methodologies must be robust to endogeneity and adjust to case by case analysis. Macro prescriptions *urbi et orbi* with aggregate data if associated to health outcomes to derive causality are particularly inadequate.

In Spain, as in some other countries, decisions regarding the collaboration or confrontation of public and private interests in the provision of healthcare services seem to be led more by ideology rather than by a well-founded debate.[12-14] So far, existing reviews do not clarify adequately the arena of the public-private debate, due to lack of data; and when information does exist, it can also be biased. We do not have moreover empirical evidence on data on different debt risk premium for private finance, proper case-mix adjustments in comparing activity, actual direct and indirect transaction costs, public deficits overruns or time delays in care provision, existing public finance restrictions, short and long term effects of those policies, and so on. Without all these adjustments, we argue that with such data lacking, plus the absence of robust methodological approaches for the analysis, the supposed *evidence-based* evaluation of public private partnerships becomes an act of faith under political premises.

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Conflicts of interest

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