Case Study of the Alberto Barton-Callao Hospital III Public-Private Partnership and its Primary Care Centre, of la Red Asistencial Sabogal de EsSalud

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CHAPTER 7

CASE STUDY OF THE ALBERTO BARTON-CALLAO HOSPITAL III
PUBLIC-PRIVATE PARTNERSHIP AND ITS PRIMARY CARE CENTRE,
OF LA RED ASISTENCIAL SABOGAL DE EsSalud

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ABSTRACT
This case study describes the process of privatisation in Peru since the 1990s, as well as the institutional system developed with the advice of international organisations in order to promote the implementation of Public Private Partnerships (PPPs) as a solution to Peru’s infrastructure deficit. It analyses in depth the Alberto Barton-Callao Hospital PPP and its Primary Care Centre of the health-care network entitled La Red Asistencial Sabogal de EsSalud, which is currently in operation, observing that it is a complex project which has not been adequately negotiated, since there are gaps in the contract, in relation to the level of the establishment, the definition of the services, and the periodicity for the follow-up of the indicators and for their modification, among others; in addition, addenda have been signed that are detrimental to EsSalud, with serious signs of corruption.

Regarding transparency, it is evident that the main actors have not been consulted, either within or outside EsSalud, and that the documents that support the decisions made with regard to the contract and addenda have not been published. The monitoring reports that allow citizen oversight are not being published, either.

This situation increases the tension between the interests of the operating company - to obtain as many benefits as possible - and EsSalud, which must look after the interests of the users. This has an impact on the quality of the services that these users should receive.
The company has not only not met the quality targets, with the poor results mainly affecting the health of women, but has also infringed upon the labour rights of its personnel, the majority of whom are women.

We conclude that the Barton PPP has produced higher costs than direct public investment and management, both in the financing of infrastructure, and in the cost of operating the services. The annual payments that EsSalud has to make for the next 30 years do not match the services to be provided by the PPP, thereby compromising the investment in care provided by other health services.

In the face of this, union and social movements continue to resist in order to stop the implementation of PPPs and the privatisation of public services, with the aim of guaranteeing quality services for the population as a whole.

**Abbreviations**

- **AFIN** Asociación para el Fomento de la Infraestructura (Association for the Promotion of Infrastructure)
- **APP (PPP)** Asociación Público Privada (Public Private Partnership)
- **BID (IDB)** Banco Interamericano de Desarrollo (Inter-American Development Bank)
- **BM (WB)** Banco Mundial (World Bank)
- **CAS** Contrato de Asignación de Servicios (Administrative Services Contract)
- **CGTP** Confederación General de Trabajadores del Perú (General Confederation of Workers of Peru)
- **CONFIEP** Confederación Nacional de Instituciones Empresariales Privadas (National Confederation of Private Business Institutions)
- **COPRI** Comisión de Promoción de la Inversión Privada (Commission for the Promotion of Private Investment)
- **Covid-19** Coronavirus Disease 2019
- **CPIP** Comité de Promoción de la Inversión Privada de EsSalud (Committee for the Promotion of Private Investment of EsSalud)
- **CPISS** Comité de Promoción de Infraestructura y Servicios de Salud (Committee for the Promotion of Infrastructure and Health Services)
- **CR** Certificado de Reconocimiento de Derechos Irrevocables (Certificate of Recognition of Irrevocable Rights)
- **D.L.** Decreto Legislativo (Legislative Decree)
- **D.S.** Decreto Supremo (Supreme Decree)
- **EF** Economía y Finanzas (Economy and Finance)
- **EPS** Entidades Prestadoras de Salud (Health Care Providers)
- **EsSalud** Seguro Social de Salud (Social Health Insurance) (formerly IPSS)
- **FED-CUT** Federación Centro Unión de Trabajadores del Seguro Social de Salud del Perú (Federation Workers’ Union Centre of the Social Health Insurance of Peru)
- **FMI (IMF)** Fondo Monetario Internacional (International Monetary Fund)
- **FOMIN (MIF)** Fondo Multilateral de Inversiones (Multilateral Investment Fund)
FONAFE  Fondo Nacional de Financiamiento de La Actividad Empresarial del Estado (National Fund for the Financing of the State’s Entrepreneurial Activity)

FONCEPRI  Fondo de Promoción de La Inversión Privada en las Obras Públicas de Infraestructura y de Servicios Públicos (Fund for the Promotion of Private Investment in Public Infrastructure Works and Public Services)

FOROSALUD  Foro de la Sociedad Civil en Salud (Civil Society Forum on Health)

IGV (GST)  Impuesto General a las Ventas (General Sales Tax)

INDES  Instituto Interamericano de Desarrollo Económico y Social (Inter-American Institute for Economic and Social Development)

INVERTE.PE  Sistema Nacional de Programación Multianual y Gestión de Inversiones (National System of Multi-Year Programming and Investment Management)

IPRESS  Instituciones Prestadoras de Servicios de Salud Privadas (Private Health Service Providers)

IPSS  Instituto Peruano de Seguridad Social (Peruvian Institute of Social Security) (became EsSalud with Law No. 27056, of 1999)

MEF  Ministerio de Economía y Finanzas (Ministry of Economy and Finance)

MINJUS  Ministerio de Justicia y Derechos Humanos (Ministry of Justice and Human Rights)

MINSA  Ministerio de Salud (Ministry of Health)

MMM (MMF)  Marco Macroeconómico Multianual (Multi-year Macroeconomic Framework)

OC  Operating Company

OCI  Órgano de Control Interno (Internal Control Body)

OECD  Organización para la Cooperación y el Desarrollo Económicos ( Organisation for Economic Co-operation and Development)

OMS (WHO)  Organización Mundial de la Salud (World Health Organization)

OPS (PAHO)  Organización Panamericana de la Salud (Pan-American Health Organization)

PCM  Presidencia del Consejo de Ministros (Presidency of the Council of Ministers)

PNIC  Plan Nacional de Infraestructura para la Competitividad (National Infrastructure Plan for Competitiveness)

PPE  Equipo de Protección Personal (Personal Protection Equipment)

PPP  Public Private Partnership

PROINVERSIÓN  Agencia de Promoción de la Inversión Privada (Private Investment Promotion Agency)

PROMCEPRI  Comisión de Promoción de Concesiones Privadas (Commission for the Promotion of Private Concessions)

RPI  Retribución por Inversiones (Remuneration for Investments)

RPO  Retribución por Operaciones (Remuneration for Operations)

RPS  Retribución por el Servicio (Remuneration for Service)

S/  Sol (plural: Soles) (Peruvian Currency)

S.A.C/SAC  Sociedad Anónima Cerrada

SINAMES  Sindicato Nacional de Médicos de EsSalud (Doctors’ National Union of EsSalud)

SINAMSSOP  Sindicato Nacional Médico del Seguro Social del Perú (National Medical Union of Social Security of Peru)
INTRODUCTION

The objective of the study is to provide evidence on the PPP of the New Alberto Barton Hospital III and its Primary Care Centre, the health-care network entitled La Red Asistencial Sabogal de EsSalud (Alberto Barton PPP) from a feminist intersectional analytical framework, which makes it possible both to prevent and to resist the negative impact of PPPs on the human rights of women, and other less favoured social sectors.

Considering the precarious situation of the health sector in Peru, it is extremely important to analyse the impact of PPPs in this sector, in order to guarantee both women’s right to health and that of the population as a whole. EsSalud is Peru’s equivalent of a social security programme, and is funded by taxes paid by employers, calculated as a percentage of employee wages. It covers 25 per cent of the population (Instituto Nacional de Estadística e Informática, 2019). Given that private insurance covers a tiny amount of citizens, the EsSalud (Seguro Social de Salud) and MINSA (Ministerio de Salud) programmes are crucial for Peruvians.

The study begins with a general review of the context in which PPPs are promoted - the evolution of the legal framework, and the main actors - and then moves on to focus on the characteristics of the Barton PPP, its implementation, and its impact on the human rights both of women and other less favoured social sectors. It then analyses the transparency of the selection process until its implementation, and finally analyses the resistance that has taken place during this process on the part of social organisations.

1. CONTEXT

1.1. Background

At the beginning of the 1990s, the countries of Latin America adopted a market-based economic system, implementing macroeconomic stabilisation programmes and structural reforms. These measures were aimed - from the perspective of the Washington Consensus -
at generating the conditions for sustained growth of the economy based upon private investment, as well as the re-integration of the countries of the region into the international financial market.

In the case of Peru, the above-mentioned measures were implemented during the government of Alberto Fujimori (1990-2000). The stabilisation programme began in August 1990, based upon monetary and fiscal policy. The process of structural reforms began in March 1991, “including the liberalization of trade, the capital market, the financial system and the labour market” as well as the reform of “public activity and government management” (Otero, 2001: p. 9). In other words, restrictions on foreign investment were removed, the economy was opened up to international trade, markets were de-regulated, and public enterprises were privatised.

The privatisation process began in September 1991 with the enactment of the Law for the Promotion of Private Investment in State-Owned Companies (D.L. 674). This law states that the growth of private investment is to be promoted in all areas of national economic activity, that the business activity of the state has not, on the whole, yielded positive results, and therefore the necessary conditions should be created for the development and growth of private investment in the area of state enterprises, in order to achieve the modernisation, re-organisation, and invigoration of the activities under their responsibility. The bodies promoting private investment were also created: the Commission for the Promotion of Private Investment (COPRI, for its acronym in Spanish) and the Special Committees, the same ones that had made the implementation of an ambitious privatisation programme possible.

D.L. 758 was issued on 8 November 1991 for the Promotion of Private Investments in Public Service Infrastructure. Within this regulation’s framework, public works include, among others, infrastructure work for transportation, environmental sanitation, energy, health, education, fishing, telecommunications, tourism, recreation, and urban infrastructure. The concept of public services refers, among others, to public transportation, sanitation, telecommunications, and public lighting, as well as to education, health, and recreation services. D.L. 839 was published on 21 August 1996, approving the Law for the Promotion of Private Investment in Public Infrastructure Works and Public Services, by which the promotion of private investment in the field of public infrastructure works and public services, under the modality of concession, is declared to be of national interest. The Commission for the Promotion of Private Concessions (PROMCEPRI) was created, which assumes all powers for the concession of infrastructure public works and public services. At
the same time, the Fund for the Promotion of Private Investment in Public Infrastructure Works and Public Services (FONCEPRI) was created to finance the activities involved in the granting of concessions.

The privatisation of public companies was a fundamental component in the programme of structural reforms in the search to modernise the economy: “it was conceived as a tool through which the state would transfer the productive and entrepreneurial initiative to the private sector”, and, thus, supposedly achieve greater efficiency in the allocation of resources and the production of goods and services (Ruiz, 2002: p. 10).

The subsidiary role of the state was consolidated in the new constitution enacted in 1993, in whose economic regime it is established that “the state can only carry out subsidiary business activity, directly or indirectly, when authorised by express law for reasons of high public interest or of manifest national convenience. Business activity, whether public or non-public, receives the same legal treatment” (Article no. 60).

Furthermore, in order to facilitate private investment, various normative instruments were created, such as law contracts, by virtue of which the state established guarantees and provided security for investors, preventing the state from implementing radical changes in tax and regulatory policies, which could imply a higher cost in investment projects.

“At the beginning of the nineties, the state had an important intervention in different sectors of the economy, assuming the role of entrepreneur in almost all economic activities. Its participation covered 186 companies, of which 135 were non-financial and 51 were linked to the financial system.” (Otero, 2001: p. 17)

The process of privatisation meant the withdrawal of the state from important productive sectors, and the reduction of its participation in others.

A decade after the process of privatisation of public companies in Peru began, it was detected that “some were sold at undervalued prices, that in certain cases privatisation was not justified, that it was poorly conceived and that the resources obtained from their sale were not used properly” (Ruiz, 2002: p. 9). In addition, it was known that efficiency had not been achieved in the privatised sectors, so the principle that had justified them had not been fulfilled (Ruiz, 2002).

In spite of this, all subsequent governments - Toledo, García, Humala, and Kuczynski, including the current one of Vizcarra - continued with the policy of promoting and facilitating
this process, with special emphasis on investments that were linked to the concession of infrastructure works and public services, perfecting the legal instruments to facilitate their implementation, as can be seen in the Compendium of Legislation for the Promotion of Private Investment (Ministry of Justice and Human Rights, 2012), and in subsequent legal regulations.

1.2. Economic Policy and PPPs

Since the 1990s, Peruvian economic policy has maintained an international trend that seeks to reduce the state’s participation in the economy. In accordance with this, one of its main public policy instruments is the National Policy for the Promotion of Private Investment in PPPs and Asset Projects (Ministry of Economy and Finance (MEF), 2016) - formulated at the end of Ollanta Humala’s administration (2011-2016) - which aims to promote the participation of the private sector in the modalities of PPPs and Asset Projects, supposedly to contribute efficiently to closing the gap in the country’s public infrastructure, to improve the scope and quality of public services, to energise the national economy, to generate productive employment, and thus achieve the much-desired competitiveness of the country.

“To this end, the state must generate the appropriate conditions at the political, regulatory, institutional, social and economic levels, among others, that favour the fulfilment of the objectives” of the aforementioned policy (MEF, 2016: p. 2), which deepens the process of the privatisation of public spending implemented by the MEF.

In this context, the economic policy guidelines set out in the Multi-year Macroeconomic Framework (MMF) 2020-2023, (MEF, 2019a), to achieve sustained economic growth, are based upon boosting investment, competitiveness, and productivity, in line with the main international practices, thereby seeking to make Peru a member of the OECD.

As a result, the boost to GDP will be given mainly by strengthening the dynamism of private investment. Here, the National Infrastructure Plan for Competitiveness (PNIC, for its acronym in Spanish) (MEF, 2019c) constitutes one of its pillars, in which 52 infrastructure projects have been prioritised for an amount of 30,060 million USD, in which 66 per cent of the investment will be made under the PPP modality (see Table 1).

In addition, rules have been approved to improve the regulatory framework for PPPs and “tax works”, and monitoring committees have been set up to ensure the implementation of large investment projects. Furthermore, the Private Investment Promotion Agency
(PROINVERSION) has been applying measures to encourage private investment, such as legal stability agreements, tax refunds and early recovery of the General Sales Tax (GST) (MEF, 2019a). In its 21 years of existence, PROINVERSION (n.d.) has carried out processes, that is to say, actions, contracts, agreements, etc., permitted for public works that have meant more than 50 billion USD in investment contracts.

In turn, the guidelines of the MMF’s fiscal policy (MEF, 2019a) aim to improve the process of public investment management, and thus reduce infrastructure gaps. To this end, standards have been approved in the National System of Multi-Year Programming and Investment Management (known as INVIERTPE), as well as in the PPPs and “Tax Works” systems, which seek to streamline processes, reduce time, increase both the efficiency and the quality of projects, and “continue to promote the participation of the private sector through the optimisation of the National System for the Promotion of Private Investment and Tax Works” (MEF, 2019a: p. 10).

**Table 1: Modalities of execution of the projects prioritised in the national infrastructure plan for competitiveness**

<table>
<thead>
<tr>
<th>EXECUTION METHOD</th>
<th>PROJECTS</th>
<th>INVESTMENT (US$ Millions)*</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Private Partnerships</td>
<td>Self-financed</td>
<td>18</td>
<td>6.032</td>
</tr>
<tr>
<td></td>
<td>Co-financed</td>
<td>11</td>
<td>13.729</td>
</tr>
<tr>
<td>Public Work</td>
<td>17</td>
<td>9.320</td>
<td>31 %</td>
</tr>
<tr>
<td>Active Projects</td>
<td>6</td>
<td>980</td>
<td>3%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>52</strong></td>
<td><strong>30.060</strong></td>
<td><strong>100 %</strong></td>
</tr>
</tbody>
</table>

**Source:** (*) Exchange rate used 3.3 soles. Adapted from the National Infrastructure Plan for Competitiveness (MEF, 2019c, p. 41) Prepared by the author.

The PPP projects awarded by sector have focused on energy, transport, communications, and sanitation, as well as those prioritised in the PNIC. In this case, the prioritisation criteria are based upon competitiveness, growth, and social development in
productive terms (MEF, 2019d). The projects do not take into account the impact on gender gaps, and neither economic policy nor the national policy take account of the impact on productivity and competitiveness in order to consider reducing them.

1.3. The Health Sector and the PPPs

The health reform in the 1990s was part of the general reform or modernisation process of the state (Mesa-Lago, 2005): “it was expressed by sector together with the formulation of the Health Policy Guidelines 1995-2000” (PAHO, 2002: p. 3), in which it was stated that “the state must guarantee the provision of basic health services and that human development, including health, is a social responsibility that includes the public and private sectors” (MINSA, 1998: p. 31). In this way, there is a re-formulation of the state-civil society relationship towards a relationship of complementarity and competition between the state health services, social security, and private health services, for greater access and better health care for the population. To this end, it is “imperative to reform the health sector. This implies accepting and effectively facing the challenge of making changes that lead to pluralism and competitiveness, removing anachronistic regulations that reduce the productive potential of the sector and building new financing, management and service provision models to achieve equity, efficiency and quality.” (MINSA, 1998: p. 43)

From 1995, “the reform was centrally managed by the authorities of the Ministry of Health. The design of the reform was based on the guiding principles contained in the ‘Sector Policy Guidelines 1995-2000’; the financing of field experiences and the implementation of the process took place through projects supported by the IDB, the World Bank, the Public Treasury and international technical cooperation.” (PAHO, 2002: p. 5)

“The legal framework of the sector was renewed in 1997 with two laws” (PAHO, 2002: p. 9): the General Health Law (Law 26790), which established the responsibility of the state in the provision of public health services and in the promotion of universal and progressive insurance. The Law for the Modernisation of Social Security in Health (Law 26790) introduced new forms of care for the beneficiaries of social security with the participation of private providers. In this law, “Health Care Provider Institutions (EPS, for its acronym in Spanish) are understood to be public or private companies and institutions, other than the IPSS whose sole purpose is to provide health care services, with their own infrastructure and that of third parties” (Art. 13). Likewise, the employing entities may grant health coverage to their active workers, through their own services or through health plans or
programmes contracted with the EPS, and thus enjoy a credit with respect to their contributions.

Subsequently, other strategies for private sector participation have been implemented, such as the outsourcing and intermediation of services, and, more recently, the hiring of Private Health Service Providers (IPRESS) under the Framework Law on Universal Health Insurance (Law No. 29344, 2009).

In this context, PPPs have been used as a mechanism to expand service coverage. There are currently four PPP projects in operation in the health sector, three managed by *EsSalud* and one by the Ministry of Health (MINSA); see Table 2.

### Table 2: PPP projects in the health sector as of 2020

<table>
<thead>
<tr>
<th>IN CHARGE OF MANAGEMENT</th>
<th>NAME</th>
<th>TYPE OF PROJECT</th>
<th>SCOPE</th>
<th>YEAR OPERATION ASSIGNED</th>
<th>DURATION OF THE CONTRACT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EsSalud</strong></td>
<td>Callao Hospital and Sabogal Network</td>
<td>Private initiative/Se lf-financed</td>
<td>Design, construction, medical equipment and comprehensive care with assigned population.</td>
<td>2010/20 14</td>
<td>30 years of operation + 2 of construction</td>
</tr>
<tr>
<td><strong>EsSalud</strong></td>
<td>H. V. M. T and Rebagliati Network</td>
<td>Private initiative/Se lf-financed</td>
<td>Design, construction, medical equipment and comprehensive care with assigned population.</td>
<td>2010/20 14</td>
<td>30 years of operation + 2 of construction</td>
</tr>
<tr>
<td><strong>EsSalud</strong></td>
<td>Network of stores and</td>
<td>Private initiative/Se lf-financed</td>
<td>Construction of stores, remodelling of hospital</td>
<td>2009/20 12</td>
<td>10 years of</td>
</tr>
</tbody>
</table>
2. LEGAL AND REGULATORY FRAMEWORK FOR PPPs

As mentioned above, it was in the early 1990s, during the Fujimori administration, that a whole regulatory framework was put in place to provide a strong incentive for the promotion of private investment within the state, which continued with the successive governments, including the current one, and has been the legal framework for PPPs ever since.

However, the publication of Decreto Legislativo (D.L.) 1012 (2008) is a milestone. This is the framework law for public-private partnerships which was specifically approved for the participation of the private sector in the operation of public infrastructure or the provision of public services in order to make their implementation viable, generate productive employment, and improve the country’s competitiveness.

The aforementioned D.L. defined PPPs as “modalities of participation of private investment in which experience, knowledge, equipment and technology are incorporated, and risks and resources, preferably private, are distributed with the purpose of creating, developing, improving, operating or maintaining public infrastructure or providing public services” (Art. 3).

In turn, PPPs were classified as self-sustaining and co-financed. Self-sustaining PPPs are those that demand a minimum or no guarantee financed by the state and whose non-financial guarantees have a minimum or no probability of demanding the use of public
resources. Co-financed PPPs are those that require the co-financing or the granting or contracting of financial guarantees or non-financial guarantees that have a significant probability of demanding the use of public resources (Art. 4).

Thus, depending on the financing modality and origin of the initiative, there are four types of PPPs, as shown in Table 3.

**Table 3: Types of PPP projects**

<table>
<thead>
<tr>
<th>CLASSIFICATION</th>
<th>ORIGIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Initiative / Self-financed</td>
<td>State Initiative / Co-financed</td>
</tr>
<tr>
<td>Private Initiative / Self-financed</td>
<td>Private Initiative / Co-financed</td>
</tr>
</tbody>
</table>

**Source:** D.L. 1012, 2008. Prepared by the author.

The principles under which projects should be developed under the PPP modality were also established:

- **Value for money.** It establishes that a public service should be provided by a private entity that can offer a higher quality at a certain cost or the same quality results at a lower cost;

- **Transparency.** It establishes that all quantitative and qualitative information used for decision-making during the evaluation, development, implementation and accountability stages of a project must be made known to the public, under the principle of publicity established in Article 3 of the Consolidated Text of the Law on Transparency and Access to Public Information (D.S. No. 043-2003-PCM);

- **Competition.** It establishes that competition must be fostered and promoted in order to ensure efficiency and lower costs in the provision of infrastructure and public services, as well as to avoid any anti-competitive and/or collusive act;

- **Adequate risk allocation.** There must be an adequate distribution of risks between the public and the private sectors.

D.L. 1012 was in force during the process of signing the Barton PPP contract. Its Fifth Final Complementary Provision states that *EsSalud*, within the framework of the autonomy granted by the law, is empowered to promote, process, and sign PPP contracts with the purpose of incorporating private investment and management in the services that it provides to the insured.
Subsequently, other regulations have been issued to strengthen the promotion of private investment, such as the Legislative Decree of the Framework for the Promotion of Private Investment through Public-Private Partnerships and Projects in Assets (D.L. 1224, 2015) and its Regulations (D.S. No. 410-2015-EF).

The current government issued D.L. 1362 (2018) on Public-Private Partnerships and Projects in Assets, which created the National System for the Promotion of Private Investment (SNPIP, for its acronym in Spanish), formed by public entities belonging to the Non-Financial Public Sector (Art. 2). That is to say, it includes all public entities of the national government, regional governments and local governments, and the non-financial public enterprises.

The SNPIP is a functional system for the development of public-private partnerships and asset projects (Art. 5.1). It is composed of principles, rules, procedures, guidelines, and technical normative directives aimed at promoting and speeding-up private investment (Art. 5.2).

The system has been perfected to increase private investment at all levels of government. Despite this, there are no mechanisms in the legislation to evaluate and to monitor the results, to know whether the PPP modality is more adequate than traditional public investment, or to evaluate the impact of projects on environmental and social rights, or on gender gaps.

Likewise, the principles are declaratory, because there are no adequate mechanisms to apply them, or exceptions are generated that weaken their application.

For example, the Regulations of D.L. 1362 (D.S. No. 240-2018-EF) established a simplified procedure for state initiatives. Its special rule focuses on the fact that the opinion of the MEF is limited to the state’s capacity to pay, and to the verification of the classification of the project. This procedure applies to PPPs whose total cost is less than 15,000 Tax Units (UIT), which, by 2018, meant about 19 million USD, an amount higher than the annual budget of most of the country’s district municipalities. Therefore, in practice, all municipalities could go ahead with projects with weak oversight controls.

As several authors have pointed out, the weakness of the organisations in charge of managing the processes and the deficiencies of the regulatory framework, among others, has made it possible for PPPs to be a breeding ground for corrupt practices, generating greater
economic and political costs for society (Alarco, 2015; Baca, 2017; Benavente, 2017; Alarco and Salazar, 2019).

On the other hand, there are no mechanisms in the system to incorporate the voice of the communities or people involved in the prioritisation and development of the projects, or in the monitoring of their implementation. Rather, it is against their rights. In the procedural rules of D.L. 1362, the public entities which are the title-holders of the projects executed under the PPP modality are obliged to “initiate early on the process of identification, acquisition, clean-up, and expropriation of the lands and necessary and supportive areas for the execution of the project, as well as the release of interferences under responsibility”. They are also authorised to “carry out the processes of relocation or resettlement that allow the release and clean-up of lands and areas for the implementation of the project” (Art. 30).

3. **MAIN ACTORS**

The main actors are: a). the state; b). private enterprises; c). international organisations; and, d). civil society.

- The state regulates and promotes private investment through PPPs and projects in assets, and has generated an institutional framework that cuts across all public entities at all levels of government (see Table 4).

The SNPIP is presided over by the Ministry of Economy and Finance, which establishes the policy for the promotion of private investment. Its governing body is the General Directorate of Private Investment Promotion Policy, which establishes the guidelines and issues binding opinion (see Table 4). In turn, PROINVERSION, as an attached entity, aims to promote private investment through PPPs, projects in assets, and “tax works”, for their incorporation in public services, public infrastructure, in assets, projects and state enterprises. Chart 1 shows the structure of PROINVERSION, whose board of directors is made up of authorities of the highest level.

**Table 4: National System for Private Investment Promotion**

<table>
<thead>
<tr>
<th>CENTRAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ministry of Economy and Finance;</td>
</tr>
<tr>
<td>The Private Investment Promotion Agency – PROINVERSION;</td>
</tr>
<tr>
<td>Special Committees.</td>
</tr>
</tbody>
</table>
| REGIONAL | The Ministries;  
| Private Investment Promotion Committee-CPIP;  
| Specialised body for project management>300,000 UIT. |

| LOCAL | Regional Government;  
| Private Investment Promotion Committee-CPIP;  
| Specialised body for project management>300,000 UIT. |

| LOCAL | Local Government;  
| Private Investment Promotion Committee-CPIP;  
| Specialised body for project management>300,000 UIT. |

Other public entities authorised by law.

Private Investment Promotion Committee-CPIP.

Specialised body for project management>300,000 UIT*.

Source: (*) UIT 2020 Approx. 1,265 USD. Based upon the D.L. No. 1362, 2018; D.S. No. 240-2018-EF. Prepared by the author.
Chart 1: Participation of the Ministry of the Economy and Finance in the Private Investment System

Source: Based upon: MEF Organisation Table (2019b); D.L. No. 1362, 2018; D.S. No. 240-2018-EF. Prepared by the author.
• The private company participates directly in the bidding process or by proposing projects; in many of the latter, there has been corruption:

“This (...) includes all the neoliberal regimes of the last 25 years. Its main means have been public-private partnerships (PPPs) with the aim of achieving the allocation of public infrastructure and services, allowing cost overruns and limiting benefits to users.” (Alarco, 2017).

In addition, through business associations, private companies are able to influence the state to formulate policies that favour private investment in PPPs. The National Confederation of Private Business Institutions (CONFIEP), for example, promotes and disseminates this type of investment. This year, it was the president of the CONFIEP, Maria Isabel León, who accompanied the ambassadors of six countries to the EsSalud Hospital Alberto Leopoldo Barton. She took the opportunity to highlight that the private sector, through PPPs, could help the state to provide the services which it gives to its citizens with greater dynamism and quality (CONFIEP, 2020).
It also guides the type of sectors with regard to where to invest: according to their interests, PPPs have concentrated, in terms of the amounts invested and the number of projects executed, on transportation, energy, and communications, as can be seen in Charts 3 and 4. This is reinforced in the National Infrastructure Plan 2016-2025, proposed by the Association for the Promotion of Infrastructure - AFIN (Bonifaz et al., 2015).

**Chart 3: Amount of investment in PPP awarded by sector**

![Chart 3: Amount of investment in PPP awarded by sector](image)

*Source: Adapted from MEF statistics (n.d.). Prepared by the author.*
• International organisations, which promote and provide theoretical, technical, and financial support to PPPs.

The World Bank, in its report entitled “Investing in Health” (1993), “laid down the basic principles of the reforms and the new systems. The IMF, USAID, and the IDB, as well as private insurers/providers and prepaid, government officials, and academics have helped shape those principles.” (Mesa-Lago, 2005: p. 35)

In the above-mentioned report, the WB proposes a three-pronged approach to improve health conditions in developing countries: firstly, to promote growth policies; secondly, to direct public spending on health to low-cost and high-efficiency programmes; and thirdly, to facilitate greater diversity and competition in the financing and provision of health services. It recommends that governments finance only essential services, while all other services be covered by private financing, through private or social insurance. It also recommends
encouraging competition and private sector participation in the provision of public health services. Along these lines, the WB advised in the elaboration of EsSalud’s Master Plan 2013-2021, which prioritises, among others, the use of PPPs both for new investments and for the management of health units (EsSalud, 2014).

In turn, the Inter-American Development Bank (IDB) considers PPPs to be a mechanism for developing infrastructure and improving access to services in the region. It states that the state use of the benefits of PPPs depends largely on an adequate distribution and management of the associated risks, as well as the associated contingencies for the state. For this reason, it promotes the development of the institutional capacities of governments for the evaluation and management of these risks (IDB, ND). Peru is part of the PPP Risk Management Group, which is dedicated to generating a space for exchange and co-operation among specialists in public-private financing.

Within the framework of capacity-building, the IDB, together with the Multilateral Investment Fund (MIF), the Inter-American Institute for Economic and Social Development (INDES), and in co-ordination with the MEF, developed a training programme on public-private partnerships in Peru entitled “Analysis of the New Legal Framework”.

The IDB also promotes and finances the structuring of projects. EsSalud has received an allocation under its regional advisory programme for PPP investments in order to develop a PPP project in the city of Piura (EsSalud, 2019).

In 2014, the OECD established the “Country Programme” as an instrument to support emerging economies in the design of their reforms and the strengthening of their public policies. Peru signed up to this programme in December of that year. It included a set of projects which were carried out over a period of two years (2015-2016), in order to support Peru in its reform agenda, and to improve its public policies in key priority areas. The programme involved the inclusion of some OECD legal instruments, such as the Council Recommendation on Principles for Public Governance of Public-Private Partnerships, the participation in OECD programmes and bodies, and the effective implementation of OECD standards and good practices. (MEF, 2016). The legal regulations issued from 2015 onwards have aimed at complying with these principles.

- Civil society is represented in part by academic sectors such as universities and research centres, which provide analysis and evidence on the advantages and disadvantages of PPPs, as well as information on the corruption cases that have been
generated. The dissemination of these facts is seen more as a problem of the corruption of officials and businessmen, rather than as a questioning of the promotion of private investment by the state.

Another very important sector of civil society is made up of social movements\(^9\) that denounce and oppose PPPs and the privatisation of public services. This will be analysed in more detail in the section on resistance (Section 7) below.

4. **THE CHARACTERISTICS OF THE BARTON PPP**

4.1. **Process**

*EsSalud* (2008) approved its Strategic Plan 2008-2011 and its Strategic Investment Plan, then had to perform a cost-benefit analysis to define the investment modality, and opted for a PPP.\(^\)\(^10\)

The principle of value for money, which is the basic criterion to determine the convenience of using a PPP, was not applied. According to the regulations of D.L. 1012 (D.S. No. 146-2008-EF), the Public-Private Comparator (numerical expression of the value for money) was to be applied to projects of more than 100,000 UIT, which, in 2008, meant projects of more than 112 million USD, and the reference projected investment of the Barton PPP was 39.9 million USD.

In public initiatives, the state defines the characteristics of the goods and services that must be offered by the interested parties. *EsSalud*, on the other hand, used the modality of private initiative by which private proponents are requested to present proposals under a set of requirements. *EsSalud* published the international invitation on 26 and 30 March 2008. Only the consortium *BM3 SALUD*, made up of four Spanish companies (*Ribera Salud S.A.*, *Mensor Consultoría y Estrategia S.L.*, *BM3 Obras y Servicios*, and *Exploraciones Radiológicas Especiales ERESA*), expressed its interest in participating and developed a proposal that met the technical requirements established in the Bases and the Draft Contract.

The *EsSalud* board of directors declared the proposal submitted by the consortium to be of public interest. It was published and disseminated so that, within 90 days, interested third parties could submit their expressions of interest regarding the execution of the project, together with a letter of guarantee. Only the *BM3 SALUD* consortium submitted a tender to execute the project, so there was no competition. On 10 February 2009, the board of directors of *EsSalud* approved the direct awarding of the contract to the *BM3 SALUD* consortium.
4.1.1. The Contract and the Participants

The PPP contract of the New Hospital III Callao and its Primary Care Centre of the Sabogal Healthcare Network of EsSalud was signed on 31 March 2010, between the Social Health Insurance-EsSalud and the company Callao Salud S.A.C. (EsSalud, 2010a).

EsSalud is a de-centralised public organisation, with legal status under domestic public law, attached to the Ministry of Labour and Employment Promotion. Its purpose is to provide coverage to the insured and their beneficiaries, through the granting of benefits that correspond to the Social Security in the Health Contribution System (Law 27056, 1999).

In order to fulfil its purposes, EsSalud, according to its founding law, may enter into all types of contracts and/or agreements permitted by Peruvian law, including contracts for the realisation of medium- or long-term investments and services, as established in its Strategic Investment Plan (DS No.025-2007-TR).

The company Callao Salud S.A.C., hereinafter the Operating Company\textsuperscript{11} (OC) is made up of seven Spanish companies (BM3 Obras y Servicios S.A., Ribera Salud S.A., Mensor Consultoría y Estrategia S.L., IBT Health, BM3 Iberosalud S.L., Exploraciones Radiológicas Especiales S.A., and Ibérica de mantenimiento S.A.). The majority shareholder is IBT Salud, a member of the IBT Group, a business group specialised in the development and execution of public works, equipment projects, and concessions (Callao Salud SAC, 2016).

4.1.2. Addenda

The OC requested amendments to the contract on 21 February 2011. After the respective administrative processes, the Central Office for the Promotion and Management of Investment Contracts issued the consent for the amendments requested. Addendum No.1 was signed on 7 April 2011 (EsSalud, 2011). The amendments accepted clearly benefit the OC, inexplicably harming EsSalud and the Peruvian state. Some of these amendments are:

- The transfer of ownership of infrastructure or equipment to EsSalud automatically upon the issuance and delivery of each Certificate of Recognition of Irrevocable Rights (CR) Remuneration for Investments (RPI) (Section V). In this way, the OC avoids paying the temporary net asset tax, as established by Law 28424 (2004).
- In Section VI, Assets Regime, the paragraph referring to the fact that the improvements that are to be made will remain for the benefit of EsSalud without the OC being able to demand any reimbursement for them has been eliminated.
• In Section XIV, Guarantees, a sub-section has been included by which the OC, with prior authorisation from EsSalud, may assign its contractual position, as well as implement a tax on the Surface Right.

• In Section XIX, Termination of the Contract, a paragraph has been added, which stipulates that, in any case of termination, general expenses and investments made, plus the applicable General Sales Tax (IGV/GST), are recognised for the OC.

• Sub-section 19.21 is amended by deleting the paragraph that indicates that in no case will the amounts recognised for the OC be considered as additional payments for the Remuneration for Service (RPS), but, to the contrary, that these will replace the RPS.

• Sub-section 19.22 is amended by deleting the paragraph that indicates that, after the settlement date, EsSalud will issue an instruction to the trustee in order to stop disbursements and proceed to settle the trust, and the remaining debts will be paid directly.

• In Annex A, the area of the land where the New Hospital III will be built has been modified; originally, the architectural plan had to be adapted to an area of 24,465.05 m² and it has been reduced to 21,939.12 m². Despite the fact that the area of the land has been reduced by 10 per cent, the infrastructure costs have not decreased.

The second Addendum is a result of the communication sent by EsSalud to the OC for the termination of the contract, due to the fact that the OC had not confirmed the Financial Closing. That is to say, it had not proved that it had the commitment of the necessary financing to execute the Infrastructure Construction. After a process of direct treatment, the contract was continued and signed on 28 March 2012 (EsSalud, 2012).

For the purposes of the continuity of the contract, it is agreed that:

• The parties submit the information requested to Bank of America Merrill Lynch.

• Once the information has been delivered, the OC has 40 days to confirm the financial closing.

Regarding the responsibilities of each party in the operation, it is agreed:

• To develop the service indicators and minimum standards of care necessary to monitor the due fulfilment of the obligations included in both the health and the non-health services.
• To update the service portfolio and the equipment plan. To this end, a co-ordinated evaluation of the service portfolio, the equipment plan, and the insured population affiliated will be carried out.

• To resolve disputes that could arise relating to the quality manual and/or the result of the above-mentioned evaluation by means of an expert’s report.

It is mentioned that a co-ordinated evaluation of the updates agreed upon in the Addendum will be carried out, but this document is not available on the EsSalud website (ND). In Table 5, we summarise the agreements that modify the responsibilities of the OC and EsSalud. The evaluation carried out to determine whether a balance is maintained or whether the PPP favours EsSalud deserves to be known.

Table 5: Summary of agreements Addendum No. 2

<table>
<thead>
<tr>
<th>COMMITMENTS OF THE OC</th>
<th>BENEFITS THAT THE OC RECEIVES FROM EsSalud</th>
<th>REMARKS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haemodialysis centre and 60,000 sessions per year</td>
<td>Updating of the equipment plan (implies an investment by EsSalud, every 3 years for group II and every 10 years for group I).</td>
<td>The equipment plan was $11,449,870 in Group I and $1,375,240 in Group II. This could mean an investment greater than the services received.</td>
</tr>
<tr>
<td>Outpatient care.</td>
<td></td>
<td>In addition, the objective of the PPP is changed: EsSalud is going to invest so that the PPP can operate.</td>
</tr>
<tr>
<td>Diagnostic tests for the non-affiliated population as long as the availability of the offer exists for the affiliated population.</td>
<td></td>
<td>They depend on the demand of the population affiliated, so they may not be carried out.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The increased use of equipment for diagnostic tests will impact on the updating of the equipment that EsSalud would have to make.</td>
</tr>
<tr>
<td>Corporate purchases.</td>
<td>The OC may tend to lower costs and the control of the quality of services may become more complex.</td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>The OC can outsource services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Nowhere in the process have mechanisms been used that allow for the participation of important actors, both within and outside *EsSalud*, in order to examine criticism and suggestions.

### 4.2. Object

The object of the Barton PPP is the Design, Construction of Infrastructure, Equipment, Operation and Maintenance of the New Hospital III Callao and its Primary Care Centre of the Sabogal Healthcare Network of *EsSalud*, for the attention of an affiliated population made up of 250,000 insured persons assigned to *Contrato de Asignación de Servicios* (*Administrative Services Contract*) (CAS). To provide the following *white coat* services:

- Emergency treatment;
- Outpatient consultation;
- Hospitalisation;
- Obstetrics Centre;
- Surgical Centre;
- Help with diagnosis and treatment;
- Critical Care Unit;
- Medical-Surgical Day Hospital;
- Home care;
- Outpatient emergency care;
- Rehabilitation and physical therapy;
- Primary care centre;
• Haemodialysis centre; and
• Non-clinical services.

4.3. The Main Aspects of the Contract

4.3.1. Term
The project horizon is 32 years, two years of construction and 30 years of operation. The contract indicated that the construction schedule would begin after the financial closure. As this took two years, the terms between the awarding of the contract in 2010 and the start of operations on 30 April 2014 were extended.

4.3.2. The Economical and Financial Regime

White coat projects can be by per capita payment or by payment of services. In the Barton PPP, the per capita model has been used, considering the comprehensive care of the affiliated population, including the network care.

EsSalud has assigned the health care of 250,000 insured persons to the OC and a per capita amount is assigned for each insured person (regardless of the use of the services that they make, the per capita amount is calculated on an accident rate and the medical procedures to be performed). (Bravo, 2013)

The total income of the operating company (OC) is composed of a Remuneration for Investments (RPI) and a Remuneration for Operations (RPO). This monthly remuneration that EsSalud must pay is called Remuneration for Service (RPS).

The RPI is divided into two components:
• Remuneration for Investments in Infrastructure: RPI-I, payments are made monthly for the period of 15 years
• Remuneration for Investments in Equipment: RPI-E is paid monthly for ten years for the equipment of Group I and three years for the equipment of Group II.12

The first payment of the RPI is made irrevocably on the 31st month from the construction start date.

The RPO has two components:
• The costs of Assistance Operation: RPOA;
• The costs of Operation and Maintenance: RPMO.

They are both paid monthly from the date of the commencement of operations.
The **RPS** is equal to the sum of the above-numbered concepts, to which the GST must be added. In turn, the detailed concepts are subject to variations and/or adjustments.

\[
RPS = RPI \ (RPI \ I + RPI \ E) + RPO \ (RPOA + RPMO)
\]

The structure of payments to the OC to be made by *EsSalud* also considers deductions for penalties and adjustments.

### 4.3.3. **Investment and Operating Resources**

The projected referential investment, for the realisation of the obligations of the contract, according to the economic proposal, amounted to 39,917,100.11 USD. However, the investment capital was updated through Addendum No. 2 and amounted to 48,449,001.68 USD, without GST (*EsSalud*, 2018b). This meant an increase of 21 per cent on the initial proposal. The payment for RPI went from 6.9 million USD per year to 8.6 million USD. (See Table 6).

The operating cost at the time the contract was signed was 65.8 million USD. (See Table 6). This amount is much higher than the one defined in the study that was carried out to compare the costs of hospital services. The analysis determined that the public sector operated at 60 million USD per year, compared to the offer of the specialised PPP operator of 45 million USD per year (Bravo, 2013), which constituted a saving. However, in the end, the cost of the PPP was much higher.

**Table 6: Annual remuneration of the Barton PPP 2010-2018 in USD**

<table>
<thead>
<tr>
<th>SECTORS</th>
<th>2010</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infrastructure (RPI-I):</td>
<td>$4,772,775.36</td>
<td>$4,575,048.31</td>
</tr>
<tr>
<td>Equipment (RPI-E):</td>
<td>$2,306,538.12</td>
<td>$4,094,472.03</td>
</tr>
<tr>
<td>Assistance Operation (RPO-A):</td>
<td>$50,077,060.00</td>
<td>$76,668,865.25</td>
</tr>
<tr>
<td>Administrative Operation and Maintenance (RPM-O)</td>
<td>$15,776,000.00</td>
<td></td>
</tr>
<tr>
<td><strong>RPS</strong></td>
<td>$72,932,373.48</td>
<td>$85,338,385.59</td>
</tr>
<tr>
<td><strong>RPS + GST</strong></td>
<td>$86,789,524.44</td>
<td>$100,699,295.00</td>
</tr>
</tbody>
</table>
The increase in investment, the higher cost of operation, as well as the adjustments that EsSalud has to make, call into question the effectiveness of using the PPP mode.

4.3.4. **Supervision of the Contracts and Operations**

EsSalud exercises its administrative competences by itself and/or through a third party (supervisor). On behalf of EsSalud, the verification of the compliance with the obligations of the OC is carried out by the PPP Contract Execution Monitoring Office. In turn, EsSalud must hire a supervisor of the design, infrastructure and equipment, and of the Contract and Operations. The latter is responsible for carrying out the legal, financial, and economic audits, as well as technical audits on the indexes and standards defined from the date of commencement of operations. There are no mechanisms for the participation of trade unions, users, or other civil society entities.

EsSalud also has the power to review the standards and ratios of the operation of the services as initially defined. It is able to adapt them to the reality of the health care network, but the contract does not indicate how often the review will take place, nor the mechanisms to carry it out.

On the other hand, there are inconsistencies in the contract. The minimum requirements for the development of the private initiative project were defined for a Level III Hospital as shown in Annex X of the contract (EsSalud, 2010b). However, in Annex 1-3, where the service indicators and minimum standards of care are detailed, it is stated that “Since the proposed facility corresponds to the second level of care, it consequently has services (...) according to the approved service portfolio” (EsSalud, 2010b: p. 147). All this causes continuous discussions with the OC and generates inefficiencies that harm the insured. (EsSalud, 2019).

The permanent tension between, on the one hand, the interests of the OC, which tends to maintain or increase its profitability, and, on the other, EsSalud, which must look after the interests of the insured, is to the detriment of the health services that the insured receive.
5. **THE IMPACT OF NHB PPP ON HUMAN RIGHTS AND GENDER**

5.1. **The Economic Aspects**

Both the increase in investment and in the operating costs directly affect the coverage and quality of the services of the insured, since they reduce the possibility of investment in other health services.

In addition, there are the costs of the supervision of contracts and operations and the difficulties that *EsSalud* faces in administering the contract, monitoring the indicators, and the processes for reviewing the contract and negotiating mechanisms, among others (*EsSalud, 2019*).

There are the additional costs generated by presumed acts of corruption. The international bid for the presentation of private initiatives was for the development of a *Level III Hospital* and a primary care centre. But, according to what *El Comercio* (2018) publishes, the audit report 066-2015-2-0251 of *EsSalud’s* Internal Control Body (OCI, for its acronym in Spanish) found that the Committee for the Promotion of Infrastructure and Health Services (CPISS, for its acronym in Spanish), approved the winning proposal “without observing that the equipment and infrastructure plans did not consider the minimum services corresponding to a category III-1 hospital”, thus failing to comply with the terms of the international bid for the presentation of private initiatives.

Thus, when *EsSalud* classifies the Barton PPP as a Level II Hospital, it is favouring the OC, since low and medium complexity patients are referred to it, with lower care costs. The unions have expressed their opinion against this situation, and have denounced that the PPP Barton charges 300 million soles annually (S/ = Sol/Soles: Peruvian currency)\(^{14}\) and only assists simple pathologies (SINAMSSOP, 2017; SINESSS, 2017).

The aforementioned audit report also states that the CPISS “approved, at the request of the consortium, the modification in the definition of the cost of medicines”. According to the OCI, this caused patients with haemophilia and in need of biological treatment from Barton Hospital to be referred to Alberto Sabogal, which generated an expense of 576,499 soles which was transferred to Sabogal Hospital (*El Comercio, 2018*).

5.2. **Coverage and Quality of Services**

It is argued that the productivity and quality of the service provided are not controlled in state institutions. There are no prizes or penalties, which do exist in PPPs, even though the contract has not necessarily been respected. This may be because the quality indicators are weak
(Alarco and Salazar, 2019) or because the contract is deficient, and/or the supervision is not adequate, and/or the governance is weak.

This is verified in the Barton PPP. Although the contract specifies contractual penalties, the description of the penalties of the operation phase established in Annex VI of the contract does not include non-compliance with the service indicators and minimum standards of care.

This is why, only four years after the operations began, the Arbitration Court of the Lima Chamber of Commerce made an acknowledgement of the mechanisms for applying penalties imposed by EsSalud, through awards issued on 12 July and 15 August 2018 (EsSalud, 2018a).

Likewise, it was only in 2018 that three internal procedures were approved and implemented in order to improve the management of the Barton PPP contract:

- Procedure for applying hospital penalties by PPP modality v01.
- Procedure to grant compliance to the reports of the supervision of the operation contracts and supervision of the hospital operation contract by PPP modality v.01.
- Internal procedure to verify the penalties of the hospital operation contract by PPP modality v.02. (EsSalud, 2018a: p. 54)

Assigning categorisation II to the Barton Hospital harms both affiliated and referred patients who exceed the care capacities of the Barton PPP. These patients will not be seen or treated, and will be referred to other care centres with the possibility of the fatal consequences that this can bring in a patient with complex ailments.

The minimum standards of care and the agreed-upon indicators are another aspect that does not guarantee better quality of service, compared to other EsSalud facilities, because they are standards and indicators with lower goals than those formulated by MINSA or EsSalud itself. There are indicators that are poorly formulated and may even be harmful, such as the indicator of mammography screening coverage. Table 7 gives some examples of this situation.

In addition to the weakness of the agreed standards and indicators, the OC does not meet the established goals. In 2017, the measurement of the 40 service indicators showed that 15 indicators (38%) did not reach the target, as shown in Tables 8, 9, and 10.
### Table 7: Remarks on the minimum standards and indicators

<table>
<thead>
<tr>
<th>TYPE / NAME</th>
<th>REMARKS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum standard</td>
<td>The standard of the MINSA is 3-4 according to specialty (MINSA, 2013).</td>
</tr>
</tbody>
</table>

#### User Satisfaction Indicators

| Percentage of complaints | It limits the possibility of filing complaints since evidence or verifiable elements must be presented in order to be considered. |
| Percentage of complaints of the surgical service | |
| Percentage of complaints of the clinical service | |
| Percentage of complaints of the diagnostic service | |

#### Quality indicators

| Percentage of patients with deferrals of first appointments for outpatient clinic and/or diagnostic and therapeutic procedures. Greater than 5 days | Protocols should be established according to the type of symptoms, in certain cases 5 days may be too much. |
| Percentage of patients with deferrals of follow-on appointments for outpatient clinic and/or diagnostic and therapeutic procedures. Greater than 10 days | The standard in the MINSA (2001) is <7 days. |
| Percentage of patients with | Protocols should be established according to the type |
deferral for surgery greater than 30 days

Use of protocols and clinical practice guidelines, target 90%

Outcome indicators

Early diagnosis of breast cancer, goal >60%

Early diagnosis of the cervix, goal >60%

PAP screening coverage, target >60%

Mammography screening coverage in women over 40, target >60%

Caesarean section rate less than 38%

Use of protocols and clinical practice guidelines, target 90%

The use of protocols is a contractual commitment so it should have a goal of 99%.

Outcome indicators

The indicator should not be static; progressive targets should be set as MINSA does (2017).

The indicator should not be static; progressive targets should be set.

The standard for EsSalud (2016) is 70%. The indicator should not be static; progressive targets should be set.

PAHO recommends mammography screening for women aged 50-69 years. And for women aged 40-49 years, it is suggested that screening be conducted in a context of rigorous research, monitoring, and evaluation (PAHO, 2015).

MINSA's standard is 20%-25% (MINSA, 2013)

---

Table 8: Satisfaction indicators that do not meet the goals

<table>
<thead>
<tr>
<th>INDICATOR NAME</th>
<th>RESULT (%)</th>
<th>GOAL(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>User Satisfaction</td>
<td>83.46</td>
<td>90</td>
</tr>
<tr>
<td>Surgical service user satisfaction</td>
<td>88.85</td>
<td>90</td>
</tr>
<tr>
<td>Clinical service user satisfaction</td>
<td>64.04</td>
<td>90</td>
</tr>
</tbody>
</table>

**Source:** EsSalud, 2010b. Annex 1.3 Service indicators and minimum standards of care. Prepared by author.
### Diagnostic service user satisfaction

<table>
<thead>
<tr>
<th>INDICATOR NAME</th>
<th>RESULT</th>
<th>GOAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>83.64</td>
<td>90</td>
<td></td>
</tr>
</tbody>
</table>

**Source:** EsSalud, 2017. Prepared by author.

### Table 9: Quality indicators that do not meet the goals

**August, 2017**

<table>
<thead>
<tr>
<th>INDICATOR NAME</th>
<th>RESULT</th>
<th>GOAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of patients with deferrals of first appointments for outpatient clinic and/or diagnostic and therapeutic procedures. Greater than 5 days</td>
<td>27.60%</td>
<td>&lt;5%</td>
</tr>
<tr>
<td>Percentage of patients with deferrals of follow-on appointments for outpatient clinic and/or diagnostic and therapeutic procedures. Greater than 10 days</td>
<td>15.25%</td>
<td>&lt;10%</td>
</tr>
<tr>
<td>Availability of medicines: dispensing indicator</td>
<td>95.67%</td>
<td>&gt;99%</td>
</tr>
<tr>
<td>Percentage of patients with complicated hypertensive pregnancy disease.</td>
<td>42.03%</td>
<td>&lt;5%</td>
</tr>
</tbody>
</table>

**Source:** EsSalud, 2017. Prepared by author.

### Table 10: Outcome indicators that do not meet the goals

<table>
<thead>
<tr>
<th>INDICATOR NAME</th>
<th>RESULT</th>
<th>GOAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early diagnosis of breast cancer</td>
<td>33.33%</td>
<td>&gt;60%</td>
</tr>
<tr>
<td>PAP screening coverage</td>
<td>21.28%</td>
<td>&gt;60%</td>
</tr>
<tr>
<td>Mammography screening coverage in women over 40</td>
<td>16.01%</td>
<td>&gt;60%</td>
</tr>
<tr>
<td>Prostate cancer screening coverage.</td>
<td>34.77%</td>
<td>&gt;50%</td>
</tr>
<tr>
<td>Caesarean section rate</td>
<td>41.28%</td>
<td>&lt;38%</td>
</tr>
<tr>
<td>Immunizations - pentavalent vaccine coverage</td>
<td>60.27%</td>
<td>&gt;90%</td>
</tr>
<tr>
<td>Immunizations - polio vaccine coverage</td>
<td>0.25%</td>
<td>&gt;90%</td>
</tr>
<tr>
<td>Immunization coverage for measles, mumps and rubella.</td>
<td>88.88%</td>
<td>&gt;90%</td>
</tr>
<tr>
<td>Pre-natal control - attraction of pregnant women.</td>
<td>47.16%</td>
<td>&gt;90%</td>
</tr>
</tbody>
</table>

**Source:** EsSalud, 2017. Prepared by author.
Of the 13 quality and outcome indicators that do not meet their goals, six directly affect women’s health, and their numbers are far from the proposed targets, deepening the health gaps that affect women.

5.3. Working Conditions and their Impact on Women Workers

The Barton PPP contract specifies that the OC should be subject to the rules that regulate the labour relations of workers in the private sector. It was also supposed to apply the special labour regimes, but this was not complied with.

According to the information collected from the social networks of key informants, among the labour conditions, an annual compensatory role was implemented that:

- infringed upon the right to a continuous working day;
- did not account for overtime;
- infringed upon the right to a maximum of 150 hours of work per month for technical nurses and care assistants.

This was detrimental to the workers, because it not only reduced their income, but also made it impossible for them to reconcile their family time and their working lives. In addition, it hindered their possibility of training or supplementing their income, so they were forced to join a union in order to assert their rights.

In May 2020, during the Covid-19 pandemic, the union denounced the lack of personal protection equipment (PPE) and requested that it be distributed without discrimination (because official masks were being distributed to administrative staff and lower quality masks to health care personnel). They also denounced the lack of recruitment of personnel with decent salaries in accordance with the current market.

These conditions are detrimental to the health of the staff, the majority of whom are women, generating work overloads and widening the salary gap between men and women.

6. Transparency

Transparency implies “the social visibility of the acts” (Figueroa, 2015: p. 6) and the stability of the legal regulations. Both factors are fundamental for citizen vigilance, to generate equal opportunities in the public processes, and to have evidence upon which to formulate adequate public policies.
Although the contract and addenda to the Barton PPP are available on the EsSalud websites, the information that supports the decisions made and the documents that allow for the monitoring of the operation phase are not available: the only report on the indicators was published in 2017.

On the other hand, the process regulated in D.L. 1012 generates advantages for the consortium that develops the proposal declared to be of interest, since it has previous knowledge both of the contract and of the project, which limits the competitive conditions of the processes.

The continuous modifications to the legal regulations also reduces the transparency. In the case of the addenda, the rules of D.L. 1012 (D.S. No. 146-2008-EF) established that no addenda to the contract could be made during the first three years from the date of its execution. After that period, if the proposed addendum exceeded 15 per cent of the total cost of the PPP project, the entity would evaluate the convenience of carrying out a new selection process (Art. 9). However, this article was modified by D.S. No. 144-2009-EF, which established the various grounds for which addenda could be signed during the first three years. This is exactly what happened with the Barton PPP, generating cost overruns for the state and high possibilities of corruption.

6.1. Follow-up and Evaluation of the Contract

The Contract and Operations Supervisor is responsible for carrying out technical inspection activities on service indicators and minimum standards of care, preparing monthly reports on its activities and the application of penalties, among others.

The contract states that: “Each time the penalties reach ten per cent (10%) of the Reference Projected Investment, EsSalud will be entitled to proceed to the termination of the contract or to agree to the continuity of its execution with the imposition of new penalties” (EsSalud, 2010a: p. 170).

The supervisor should also perform:

- The validation of normative, procedural and computer tools;
- The application of procedures and tools for control, monitoring, and follow-up, as well as the issuance of monthly reports;
- The monitoring of indicators, and monthly and annual reports with recommendations.
Gaps in the contract (EsSalud, 2019), in terms of defining penalties, and in the periodicity for monitoring indicators and for their modification are, among others, detrimental to effective monitoring and to the quality of the service that the users should receive.

The lack of transparency, since neither the tools nor the supervisor's reports are published on EsSalud’s website, prevents civil society from following up and monitoring. This happens because it does not have evidence of the progress of the PPP, and therefore it is not possible to report or demand the termination of the contract. This, as has been observed, creates a breeding ground for corrupt practice, to the detriment of the quality of the services that should be received by the insured.

7. RESISTANCE

The social movement has, for decades, been resisting the privatisation of public services, and denouncing the various strategies that seek to privatise the Social Security Health (EsSalud); PPPs, as well as the outsourcing of services, are considered to be obvious mechanisms that lead to the privatisation of health, in addition to being sources of corruption.

7.1. Internal Resistance

When the Barton PPP began its operations, it appeared to comply with the labour rights of its personnel, but over time, the labour situation deteriorated. One worker describes it this way:

“This company started off very well by complying with its workers in everything. However, today everything is upside down for us, the staff. With the annual role, is terrible to work in these conditions. To come in the morning and return for the evening. To work tired and stressed out from the traffic. Terrible.” (Ramirez, 2018)

In turn, the OC began to condition labour stability on the signing of agreements that harmed women workers’ rights, as one worker relates:

“That happened years ago: in admission, we started with 6-hour rotating schedules and then they imposed the 9-hour schedule on us. They still forced us to sign and so far, we can’t return to the schedule of the beginning of the contract. This company is used to working with fear.” (Polo, 2018)

In view of this situation and despite the hostilities of the OC, in March 2018, the United Union of Healthcare Workers Callao Salud (SUTACAS, for its acronym in Spanish)
was formed. Its first board is headed by a female worker and composed of seven women and one man.

Among their claims, they declared themselves to be against the annual compensatory role, as well as against the work overload. This was because procedures that should govern medical technologists were included in the nursing and care technician procedures. In both cases, their rights were recognised.

They have campaigned against anti-union practices, and entered into negotiations with the authorities of *EsSalud* and the Ministry of Health to lend legal support to their demands.

Their leaders have also warned about PPPs on the social media, via Twitter:

“Mr. Vizcarra, no more PPPs. Don’t allow the waste of money on someone who not only curtails our labour rights but also imposes a foreign model that goes against our professional laws. Our laws are not privatised. No more abuse!” (Luna, 2018)

The strategy most used by SUTACAS to exert pressure is through sit-ins in front of the Barton Hospital, as well as the use of the social media Facebook and Twitter to spread its campaign.

### 7.2. The Participation of Social Organisations

The opposition of the unions to the implementation of PPPs in the health sector has expressed itself in various ways. For example, in 2010, the National Medical Union of Social Security of Peru (SINAMSSOP, for its acronym in Spanish) stated that “ESSALUD commits itself not to implement privatisation or public-private partnerships” (*EsSalud*, 2010a). However, in the commitment act with *EsSalud*, it was stated that, “they have not reached agreements (...) regarding Public-Private Partnerships and Administrative Contracting of Services” (*EsSalud*, 2010c).

They also spoke out requesting the unconstitutionality of D.L. 1012, because they considered PPPs to be the basis of the privatisation of *EsSalud*. (SINAMSSOP, 2010b)

The General Confederation of Workers of Peru has included this battle in various struggle platforms; for example, in 2014, it declared: “Defence of health and public education, increase in budget according to the National Agreement. Defence of social security (*EsSalud*), autonomous from the MEF and FONAFE and without privatisation of its services. No to privatisations through Public-Private Partnerships.” (CGTP, 2014) Moreover,
in the platform of the national strike of 9 July 2015, it stated: “No to privatisations or Public-Private Partnerships of strategic state enterprises and public services.” (CGTP, 2015)

In the presentation of its Master Plan 2013-2021, *EsSalud* states that it prioritises, among others, “the use of contracting processes of private entities and public-private partnerships for new investments and for the management of health units” (*EsSalud*, 2014). Moreover, the Front for the Defence of the Right to Health and Social Security was formed by nine *EsSalud* unions, who:

“The reaffirmed that the National Public Health System has sufficient installed capacity, in many cases idle, and the state and *EsSalud* have sufficient budget and resources to promote a strong investment in repowering the hospitals, polyclinics and assistance centres (...) without the need to count on the participation of the Public Private Partnerships (PPPs), which in the end represent a millionaire business of resources and privileges behind the backs of the people.” (SINAMSSOP, 2014)

The Federation Workers’ Union Centre of the Social Health Insurance of Peru (FED-CUT, 2015), under the title, “PPP contracts harmful to ESSALUD and the country”, denounced that the Central Manager of Health Benefits had been forced to resign for proposing to review the contracts of the Kaelin and Barton PPPs, considering them to be harmful to *EsSalud*.

The Doctors’ National Union of *EsSalud* (SINAMES, 2015) published a statement in which it rejected a fragmented, segmented, and under-funded health system that objectifies the human person and commodifies health. It also opposes privatisation (via outsourcing and PPPs) because it is neither equitable nor inclusive, and because, in its view, it also deepens the health crisis.

In 2017, when the Committee for the Promotion of Private Investment of *EsSalud* (CPIP, for its acronym in Spanish) was created to carry out private investment projects through Public Private Partnerships and Projects in Assets, several institutions took a stand against this: the National Union of Nurses of the Social Health Insurance, stated that:

“Under the argument of giving coverage to the insured and their beneficiaries, the intention is to leave the health services that are paid for with the money of the insured in private hands. This modality implies a risk, as it leaves the commitment to the health care and quality deserved by the insured population in the hands of third parties.” (SINESSS, 2017)
In addition, it alerted civil society to the cost that EsSalud incurs in the PPPs of the Alberto Barton and Guillermo Kaelin hospitals, as well as the implementation of two new PPPs in Piura and Chimbote, while no resources are allocated to address the lack of healthcare professionals, the maintenance and acquisition of equipment, or the obsolete infrastructure.

The journalist Martin Sarmiento (2017) reported that the Peruvian Medical Association had asked EsSalud to demonstrate with technical studies that public-private alliances are able to promote good results in the health sector, and that, if these alliances are formed, the state will have to place limits on the economic profits of the private sector. He also reported that the Social Security medical union had stated that “there is no need for PPPs in the health sector, since the budget it has is sufficient to build hospitals, buy equipment and hire more doctors”.

For its part, the Civil Society Forum on Health - Forosalud, a national movement that works from the perspectives of human rights, gender, and interculturality - has, on various occasions, expressed its views against the privatisation of health and on the negative consequences that the application of the modality of public-private partnerships in the health sector will have for the population (Lazo, 2020).

The most used strategies are denunciations or protests by alternative means (since the commercial media generally do not broadcast them), communications on the social media, and the inclusion of their opposition to PPPs on the various struggle platforms.

Despite the existence of a consensus in the social movement about the problems and disadvantages of PPPs in public services, it has not succeeded in establishing a unified, solid and alternative movement in opposition to PPPs.

**SUMMARY AND RECOMMENDATIONS**

Since the 1990s, in Peru there has been a process of privatisation of public services and promotion of private investment in public infrastructure projects. The Peruvian state has generated a transversal system not only at all levels of government but also at the highest level to promote private investment in PPPs supported and advised by international organisations. In the face of this, the social movement has, for decades, resisted the privatisation of public services and denounced the various strategies - including PPPs - aimed at privatising health care.
The legislation on PPPs and its continuous modifications limit the competitive conditions of the processes. This, coupled with the lack of transparency and mechanisms for civil-society participation, creates a breeding ground for corrupt practices.

The Barton PPP has resulted in a higher cost than traditional public investment, both in terms of the investment and the operation costs. The increasing and inflexible cost of the annual remuneration that *EsSalud* will have to pay for the next 30 years is not in line with the Level II services that it provides and compromises investment in other health services.

The Barton PPP is a complex project and the gaps in the contract are detrimental to the effective supervision and the quality of service that the users should receive. The coverage and quality of services are not guaranteed. In addition to the weakness of the agreed standards and indicators, the OC does not meet the quality goals or the results established, nor does it respect the labour rights of the workers.

**Recommendations in relation to PPPs**

- The elimination of the modality of private initiative PPPs and consideration only of public initiative PPPs that are included within the framework of the National System of Strategic Planning.
- The generation of mechanisms for the participation of civil society in the different phases of the projects.
- The incorporation of environmental and gender equality criteria in the different phases of the projects.
- The generation of mechanisms to comply with the principle of transparency in information:
  - The obligation that the public entity’s website has the documents that support the decision-making with respect to the contracts.
  - The obligation to publish the contract proposal before it is signed in order to receive remarks or suggestions.
  - The obligation to publish the monitoring and evaluation reports of the Contract Supervisor.
- The generation of mechanisms to make the processes transparent and competitive.
- *Ex ante* and *ex post* evaluations of the projects.
• The *ex-ante* evaluation should include: the evaluation of environmental impact, the gender impact, and the cultural impact.

• Application prior to the consultation processes during the *ex-ante* evaluation when dealing with projects that may affect communities.

• The guarantee of the application of the Value for Money Principle to all projects, and a methodology for applying the Public-Private Comparator.

• Strict regulation of re-negotiations and the use of the addenda for all contracts, and publication of the documents that support them.

• Public information on: indicators, minimum standards, and unit costs that allow civil society to make observations and follow up on projects.

**Recommendations regarding resistance to PPPs**

• Joint efforts to prevent the voices of civil society that oppose PPPs from being diluted in the face of the aggressive PPP promotion strategies implemented by the government.

• Strategic Actions:
  
  o The demand that no new PPP contracts be made until a transparent evaluation of the PPPs in operation has been carried out.
  
  o The carrying out of sustained dissemination campaigns on the SNPIP and the results of the PPPs.
  
  o Follow up on and dissemination of reports of corruption.
  
  o Incorporation of all demands based upon the law of transparency in information that allow for the follow-up of contracts and, if necessary, to have mechanisms to request their resolution.

• Strengthening:
  
  o The generation of training spaces on the SNPIP and the PPP legislation, which allow for a comprehensive view.
  
  o The generation of spaces for the exchange of experiences in: follow-up to contracts, dissemination, and advocacy campaigns.

• Knowledge management to transform it into intellectual capital that generates a current of opinion and strengthens the social movement that resists PPPs and privatisation.
The identification, collection and organisation of the existing knowledge about Peruvian PPPs.

The promotion of the creation of new knowledge, deepening the study of the legal and tax aspects, the transaction costs, and the promotion costs, among others, as well as case studies.

Notes

1 Peru has a decentralized healthcare system that consists of a combination of governmental and non-governmental coverage. World Health Organization (WHO), available at: https://www.who.int/workforcealliance/countries/per/es/, last accessed 19 January 2021.

See, also, the official website of EsSalud, at: http://portal.essalud.gob.pe.

2 The Multi-year Macroeconomic Framework, the most relevant document in economic matters, contains the macroeconomic and fiscal projections, as well as the assumptions upon which they are based, for a period of four years.

3 In Spanish, this is “Obras por impuestos”, which is a system by which the money private sector invests in public works is recovered through the legal non-payment of taxes.

4 This system, whose governing body is the General Directorate of Public Investment of the Ministry of Economy and Finance, was created by Legislative Decree No. 1252 of 1 December 2016.

5 For information on gender gaps in Peru, see INEI, 2019.

6 Peruvian Institute of Social Security, which later through Law No. 27056, becomes the Social Health Insurance (EsSalud).


8 See OECD, 2020.

9 “We understand social movement as a process of politicized collective action aimed at fighting against forms of accumulation and colonization that reproduce injustice and that has an alternative vision of society and development.” Bebbington (2008).

10 The investment plan is not available on the EsSalud website in the Planning and Organisation section, see http://www.essalud.gob.pe/transparencia/index.html, last accessed 21 September 2020, nor is the cost-benefit analysis of current PPP contracts on the ESSSALUD website, see http://www.essalud.gob.pe/asiacion-publico-privada-contratos-vigentes, last accessed 21 September 2020.

11 The legal entity constituted by the successful bidder who signs the PPP contract with EsSalud.

12 See what corresponds to each group in the PPP contract (EsSalud, 2010a: p. 67).

13 On 1 March, 2011 the GST dropped to 18%.

14 Approximately 90 million USD (average bank exchange rate for the 2019 period: 3.34).

15 Approximately 173,000 USD (average bank exchange rate for the 2019 period: 3.34).

16 Highlighted in brown.

17 The annual compensatory role adds up the working hours for the entire year and distributes them arbitrarily, not taking into account the legally established daily or monthly working hours.
References


Federation Workers’ Union Centre of the Social Health Insurance of Peru, (2015). “Contratos APP son lesivos para ESSALUD y el País. Informativo 06 CDN FED CUT”,


National Union of Nurses of the Social Health Insurance (2017). “Gestión de EsSalud busca traspasar a empresas extranjeras el servicio a la salud por el que pagan millones de


PROINVERSIÓN, see Private Investment Promotion Agency.


**Legal Regulations of Peru**

**Laws**


**Legislative Decrees**


**Supreme Decrees**


