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ORIGINAL PAPER

Healthcare financialisation in the Global South: examining the role of the World Bank Group in promoting public private partnerships in health in Africa

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Abstract
In recent development policy discourse, an ambition to deliver comprehensive healthcare to all citizens in the Global South via publicly financed provisioning systems has been replaced by calls for universal health coverage (UHC). At the heart of today's promotion of UHC in the Global South is a strategy to involve private actors as providers and financiers of healthcare. This is presented as an apt approach to overcome an acute financing gap to achieve the Sustainable Development Goals (SDGs), including SDG 3 on attaining UHC. As part of these efforts, public private partnerships (PPPs) are celebrated as an efficient way of mobilising private sector resources and expertise, including in Africa. The World Bank Group (WBG), as a lead actor in international development, is at the forefront of promoting such a policy solution, despite mounting evidence of the pernicious implications of the increased prevalence of health PPPs across both Global North and South. Our contribution to this Special Issue on healthcare financialisation is twofold. First, we demonstrate how health PPPs can act as vehicles of healthcare financialisation, posing significant threats to equitable healthcare delivery. Second, we examine the WBG's role in promoting health PPPs in Africa. By doing so, we shed light on the ways in which health PPPs can serve as an important channel for the advancement of financial actors, instruments and practices in national healthcare systems. The WBG's use of diverse tools in support of health PPPs significantly impacts African healthcare systems, highlighting the scope for 'financialisation by development policies'.

Keywords Health · Healthcare · Financialisation · Public private partnerships · World Bank Group · Africa

JEL Classification H41 · H51 · I13 · I14 · I18

Extended author information available on the last page of the article

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1 Introduction

The promotion of universal health coverage (UHC) sits at the heart of the 2030 Agenda for Sustainable Development. However, while universalism may have once implied healthcare provision that is public, integrated, free or subsidised and equitably accessible, today's focus is on assuring UHC and guaranteeing access regardless of how services are provided and financed (Yi et al. 2017; Fischer 2018). Contemporary national UHC reform processes, including across African countries, take many different forms, often relying on the private sector as provider and financier of healthcare services (Stuckler et al. 2010; MacGregor 2017; Fischer 2018; Nabyonga-Orem et al. 2019; Gideon and Bayliss 2024).

Indeed, the adoption of the Sustainable Development Goals (SDGs), in 2015, has fuelled a 'private turn' in development finance and has generated increased attention on 'impact finance' (Van Waeyenberge 2015; Romero 2016; Chiapello 2023). This private turn extends to the sphere of health (Chiapello 2017; Hunter and Murray 2019; Bayliss 2022; Mosciaro et al. 2022; Hunter 2023), for which a 'financing gap' to attain the health-related Sustainable Development Goal (SDG 3) has been estimated to be of the order of US$ 371 billion a year (Stenberg et al. 2017). This highlights an insufficiency of public resources in a fiscally constrained world, while at the same time elevates the potential role of private finance. Attaining UHC now serves as 'justification for the activities of development finance institutions to promote equity investments and loans in the healthcare sector' (Hunter and Murray 2019, p. 1275).

In light of this, public private partnerships (PPPs), which are long-term contractual arrangements between the private and the public sector, are increasingly presented as an alternative to entirely privatised healthcare systems and an adequate strategy to facilitate universal access to healthcare. Research, however, shows that health PPPs contain several risks. These include high costs for national governments; a diversion of development aid towards the private sector (through risk-mitigation or other forms of blended finance); adverse effects on public sector administrative capacity; and limited transparency and a weakening of democratic accountability (Roehrich et al. 2014; Romero 2015; Jomo et al. 2016; Languille 2017; Bayliss and Van Waeyenberge 2018; Eurodad 2018; Hellowell 2019; Parker et al. 2019; Romero and Gideon 2020; Gianella et al. 2021; Borsa et al. 2023). At the same time, PPPs can act as conduits (and accelerators) of the financialisation of healthcare, when the roll-out of health PPPs extends beyond the mere privatisation of national healthcare delivery systems to enable the involvement of financial actors, instruments and practices (Stein and Sridhar 2018; Romero and Van Waeyenberge 2020; Hernández-Álvarez et al. 2020; Cordilha 2022a; Stafford et al. 2022). Furthermore, PPPs (including in health) often draw on public (domestic and international) resources to support the transformation of public services into private assets (Hunter and Murray 2019; Romero and Van Waeyenberge 2020; Bayliss 2022; Hunter 2023; Marriott 2023). This occurs to the detriment of alternative practices and notions of strengthening public social service delivery systems framed by the imperatives of access and quality for all.

It is against this background that this article seeks to add insights to the scholarly literature on drivers and mechanisms of how global finance penetrates national healthcare systems in the Global South. It unpacks in detail how the promotion of a particular policy practice, here PPPs, by a lead development agency, here the World Bank Group (WBG),[1] furthers the financialisation of healthcare in the Global South. In that way, it documents a specific dimension of 'financialisation by development policies' (Chiapello et al. 2023, p. 1).

While such trends can be observed across the Global South, this article pays particular attention to these dynamics in the African context.[2] Although only few large-scale health PPP projects are currently operational in Africa, the shortfall in domestic public funding for healthcare—estimated of the order of US$ 66 billion—is particularly pronounced for the African region (UNECA 2019). Notably, high levels of indebtedness and the dominance of fiscal consolidation imperatives characterise African economies. This results in underfunding of healthcare delivery systems and makes the continent particularly susceptible to WBG policy priorities (UNCTAD 2024). Furthermore, the ever-growing dominance of private finance exacerbates a 'core-periphery divide in the global financial system', presenting a further disadvantage of the African region to develop sustainably (Lysandrou and Ranjbaran 2021, p. 590).

This paper proceeds as follows. We first demonstrate, in Sect. 2, how PPPs enable the financialisation of healthcare in the Global South. We situate them among a broader spectrum of vectors of healthcare financialisation and highlight how they often combine a multiplicity of such mechanisms. Subsequently, we examine, in Sect. 3, how the WBG is at the forefront of brokering and fostering the promotion of health PPPs in the Global South, including in Africa. We argue how this reflects the WBG's ideological disposition towards a Wall Street Consensus characterised by Gabor (2021, p. 430) as the ambition to 'create investible development projects that can attract global investors'.

To analyse the different approaches and instruments of the WBG in enabling the proliferation of health PPPs across Africa, we draw on multiple data sources: WBG project databases; a database compiled by the Dutch non-governmental organisation Wemos, updated and extended by Romero (2024), that tracks health projects supported by the WBG's International Finance Corporation (IFC), the private sector

[1] The World Bank Group (WBG) consists of five institutions that support both public and private sector projects. The two WBG's public sector arms are: the International Bank for Reconstruction and Development (IBRD), which extends loans to low- and middle-income countries, and the International Development Association (IDA), which provides concessional finance to low-income countries. Together, they make up the World Bank. The three additional organisations are the International Finance Corporation (IFC), which supports private sector companies, the Multilateral Investment Guarantee Agency (MIGA), which provides non-commercial risk insurance to private companies, and the International Centre for Settlement of Investment Disputes (ICSID), which offers international facilities for conciliation and arbitration of investment disputes.

[2] For WBG promotion of health PPPs in other regions of the Global South, see Yilmaz (2017); Romero and Gideon (2020); Gianella et al. (2024); Bayliss et al. (2021); Chakravarthi et al. (2023); Marriott (2023); and Taneja and Sarkar (2023). These studies carefully document problems and risks associated with health PPPs for the specific contexts of Turkey, Peru, Brazil and India.

arm of the WBG; information drawn from investor databases (notably, IJ Global and InfraPPP); national PPP laws and policies, national health policies and health financing strategies; and media articles. Relevant scholarly and grey literature on the promotion, planning, financing and implementation of PPPs in health across 54 African countries was also reviewed.[3] Our mapping of the significance of WBG PPP-related interventions for health policy in Africa, in Sect. 3, emerged in response to a specific set of questions, including the following: which African countries have a PPP law/policy in place and what has been the nature of the WBG's involvement? Which African countries refer to health PPPs in their national health strategies or policies? What are the WBG's modalities of promoting health PPPs in a specific country? A detailed overview of our research protocol is provided in Appendix Table 1.

We conclude, in Sect. 4, by arguing that, with PPPs conceptualised as a key potential channel of healthcare financialisation, WBG efforts possibly expose national healthcare systems to the vagaries of globalised finance, including by creating opportunities for financial private actors (such as investment banks and equity funds), with likely detrimental impacts on health equity.

2 Situating PPPs as vectors of healthcare financialisation in the Global South

The private provision of healthcare, which can take the form of private hospitals and healthcare centres, reliance on user fees to pay for healthcare or the outsourcing of activities such as transport to healthcare centres or medical equipment (see, e.g., Birn et al. 2016), is not a new phenomenon. Widespread pleas for greater involvement of the private sector in healthcare started in the 1980s and accelerated throughout the 1990s, notably with the publication of the landmark World Development Report 1993, *Investing in Health* (World Bank 1993). However, since the 2000s, the nature of the private sector that is attracted into healthcare systems has evolved to include not only non-financial private actors (such as corporate hospitals or clinics) but also financial institutions such as investment and private equity funds (Dentico 2019; PSI 2021; Cordilha 2022a; Sriram et al. 2024). This shift has been accelerated by the private turn in development finance, including in health (Hunter and Murray 2019), and draws attention to the heterogeneity of the private sector in health. Traditionally, the latter has been defined as 'all health providers not owned or directly controlled by government' including 'for-profit and not-for-profit, formal and informal, and domestic and foreign entities'.[4] Cordilha (2022b), however, stresses that there is a need to make a further distinction, between financial and non-financial private actors. This is necessary as *financial*

[3] We have excluded Western Sahara from our country desk-review exercise as it is difficult to find information on the country.

[4] See UHC2030 Private Sector Constituency: https://www.uhc2030.org/fileadmin/uploads/uhc2030/Documents/Key_Issues/Private_Sector/UHC2030_Private_Sector_Constituency_Joint_Statement_on_UHC_FINAL.pdf (Accessed: 7 March 2024).

private actors have become increasingly prevalent in national healthcare systems (Dentico 2019, 2021), raising the spectre of financialisation.

2.1 Demarcating healthcare financialisation from healthcare privatisation

Broadly speaking, financialisation can be understood as the 'the increasing dominance of financial actors, markets, practices, measurements and narratives at various scales, resulting in a structural transformation of economies, firms (including financial institutions), states and households' (Aalbers 2016, p. 2). Yet, definitions of financialisation vary and hinge on the 'object' of financialisation (in our case, healthcare) as well as on the expected effect that financialisation has on certain aspects of everyday life (in our case, healthcare access and health equity) (Stockhammer et al. 2021). We deem Aalbers' definition of financialisation particularly pertinent in the context of healthcare financialisation, given that the escalating significance of global finance incorporates the sphere of social reproduction. This is illustrated by an increasingly important role for financial actors or practices across various key sectors of social reproduction and everyday life, including health (Chiapello 2017; Vural 2017; Hunter and Murray 2019; Hernández-Álvarez et al. 2020; Bayliss 2022; Mosciaro et al. 2022; Hunter 2023). While there are diverging views on how privatisation can be demarcated from financialisation, we consider financialisation to be a continuation of privatisation, now extending the reach of *financial* private actors and incorporating financial instruments and practices (see Fig. 1). In the context of health, such an understanding mirrors Cordilha (2022b), who emphasises the interconnected nature of healthcare privatisation and financialisation.

For Cordilha (2022b, p. 6), healthcare financialisation encapsulates the process of 'transforming health financing and provision into financial investments and the correlated participation of financial actors in the sector'. This reflects Hunter and Murray's (2019, p. 1264) perspective on healthcare financialisation as the 'last emerging phase of health system change—that of the transformation of healthcare into saleable and tradeable assets for global investors'. Similarly, Dentico (2019) highlights the increasingly important role of financial institutions in healthcare sectors as a continuation of policies of privatisation in place since the 1990s. This translates into a reality where financial players are powerful enough to influence the types of healthcare available to people in need (Stein and Sridhar 2018). For Bayliss (2022, p. 481), financialisation of healthcare 'is associated with a growing role for financial actors … [that] seek new profit opportunities' and, as such, healthcare becomes another sphere through which global finance can extend its value capture with significant implications for inequalities. Building on these contributions, we define healthcare financialisation as the transformation of health financing and provision into financial investment opportunities and/or the inclusion of financial actors, instruments and practices (or logics) in national healthcare systems.

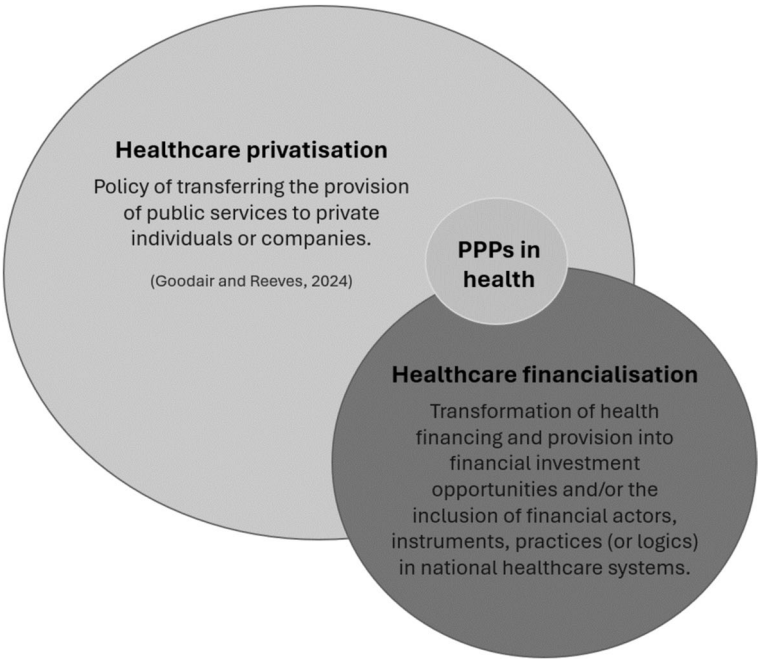

Fig. 1 Healthcare privatisation and financialisation. Source: Authors' illustration

2.2 PPPs as channels of healthcare financialisation

There are a range of avenues through which the financialisation of healthcare can proceed, including in the Global South. These cover, among other, changes in ownership structures of privately owned healthcare providers to the benefit of financial investors, such as private equity funds (Borsa et al. 2023); the increased prevalence of financialised logics in the behaviour of privately owned healthcare providers (for instance by maximising shareholder value through share buy-backs) (Vural 2017; Hunter and Murray 2019; Bayliss 2022); increases in household debt as a result of insufficient access to health via a publicly funded system, where this debt becomes the basis for the creation of new asset classes (Gouzoulis and Galanis 2021; Cordilha 2022a; Lavinas et al. 2022); the collateralisation of cash transfers as an important social policy instrument across countries in the Global South to enable access to healthcare (Lavinas 2018, 2020); the transformation of patents of new drugs into speculative financial products (Tulum et al. 2022); or the emergence of private health financing mechanisms that pool and invest funds, like the Pandemic Emergency Financing Facility (PEF) (Stein and Sridhar 2018). Our focus here is on the mobilisation of private finance via health PPPs and we illustrate how PPPs combine *simultaneously* different vectors of financialisation.

Health PPPs imply a long-term contractual agreement between the public sector (national or sub-national governments or line Ministries such as the Ministry of Health) and a private entity for major public infrastructure projects such as hospitals

or to assure the functionality of healthcare service delivery in publicly administered facilities. The private entity, a private firm or a consortium of private firms, commonly constituted in a special purpose vehicle (SPV), is contracted to perform clearly defined tasks (such as constructing, operating and/or managing a healthcare facility) for which it receives a payment via a pre-defined revenue stream (drawing on user fees and/or government payments). While the (stated) aim of PPPs is to shift risk and management responsibility to the private sector, governments remain ultimately accountable for public services (Stafford et al. 2022).

Health PPPs are often categorised on the basis of the respective responsibilities of public versus private agents (see Montagu and Harding 2012; PwC 2018). For Romero and Van Waeyenberge (2020), however, different definitions and typologies of health PPPs tend to distract from the role PPPs play in the transformation of healthcare provision and infrastructure into private assets that yield revenue streams for investors as well as from the importance of public sector actors (domestic and international) in enabling this transformation.

There are several specific ways in which health PPPs can act as conduits for healthcare financialisation. The rest of this section unpacks these mechanisms. Where appropriate, our analysis draws on the specific example of a health PPP project that was enabled by the WBG, namely the construction and management of the Queen Mamohato Memorial Hospital (QMMH) in the Lesotho capital, anticipating the relevance of our analysis in Sect. 3 below. The QMMH PPP project was the first of its kind in Africa, marketed by the WBG's private sector affiliate, the IFC, as a 'flagship' and 'model' healthcare PPP on the continent (Marriott 2014; Webster 2015).[5] While it has received considerable attention (Marriott 2014; Webster 2015; Hildyard 2016; Hellowell 2019), it presents an emblematic case, allowing us to showcase different avenues via which a health PPP can foster healthcare financialisation.

First, a common characteristic of health PPPs is that they invite financial actors, such as private equity (PE) funds, insurance companies or banks, into national healthcare systems. These actors obey financialised logics, as they pursue strategies such as maximising shareholder value through share buy-backs, deploy financial engineering techniques via high gearing ratios, property sales and lease-back, or seek tax breaks on debt interest payments (Vural 2017; Hunter and Murray 2019; Bayliss 2022). In the case of the QMMH, for example, a majority of the shareholders of the South African company Netcare, the main shareholder of the consortium that had entered into the PPP arrangement with the Lesotho government in 2008, were financial private sector actors, mostly based in South Africa, including banks,

[5] The QMMH PPP was borne out of a contract signed in 2008 between the Government of Lesotho and a private consortium named Tsepong. It obliged the consortium to construct a 425-bed hospital in Lesotho's capital, Maseru, and subsequently to manage it and three healthcare clinics until December 2026 (Eurodad 2018; Hellowell 2019). In 2021, however, the PPP contract was prematurely terminated by the Government of Lesotho. A major reason relates to fact that the monetary transfers from the Government to the private sector increased significantly, putting undue pressure onto the country's national health sector budget (Marriott 2014; Hildyard 2016; World Bank 2018; Hellowell 2019).

insurance companies, investment and pension funds and medical aid societies (Hildyard 2016; PSI 2021).

Second, the consortium of private investors, usually brought together as shareholders in a SPV, often engages in thin capitalisation practices. This is a common practice in financialised corporate structures. It makes the SPV reliant on large amounts of debt—generating high debt/equity ratios—and accentuates its dependence on payments from the public sector (or user fees) to meet its financial obligations. This means that while a government often takes out a loan to provide its share to the up-front payment of a PPP project, there is effectively little finance that is mobilised from the private sector directly via equity contributions. For the QMMH, the private consortium provided less than 1% of total up-front capital cost compared to 34.3 provided by the Government of Lesotho (Hildyard 2016; Hellowell 2019). This effectively meant a minimisation of risk for the private sector, while making the daily operations of the hospital highly dependent on recurrent payments from the public sector. Yet, while the equity investment of the main shareholders was minimal, annual returns on their investments were reported to range between 17 and 25% (Hildyard 2016; Hellowell 2019; PSI 2021).

Third, private companies—financial and non-financial—in a SPV consortium are often based in tax havens, which allows companies to shift profits offshore to avoid paying taxes and public scrutiny. This mechanism facilitates value capture by private finance, undermining government budgets and, thus, the financing of alternative forms of public provision of healthcare. For instance, among the shareholders of Netcare (the main shareholder in the QMMH SPV) are financial services firms and investment management funds such as Franklin Resources, Capital Research and Management Company (a subsidiary of Capital Group) and BlackRock.[6] The negative impact on governments' public budgets due to forgoing tax income from multinational corporations, including global investment funds, pursuing tax optimisation strategies is well documented (Marian 2016; Olbert and Severin 2020; Tax Justice Network 2023).

Fourth, because of thin capitalisation practices, private sector consortia in PPP arrangements often have recourse to loans from public bodies, such as development banks, and, regularly, the public sector underwrites the repayment of the private consortium's loans via public sector guarantees, de facto transforming public sector funds into collateral. In Lesotho, thin capitalisation implied the need for the private consortium to take on loans to complement necessary capital funding. The consortium received a loan from the Development Bank of Southern Africa to pay for the main share of its contribution to the PPP, which required public sector guarantees and resulted in interest payments in excess of 10% (Hellowell 2019). The consortium's significant debt obligations meant that in case the Government of Lesotho was not able to pay its annual obligations, the consortium would default on its payments, which in turn would further increase costs for the Government, liable for interest and penalty payments. This situation quickly materialised as the annual 'unitary fee'

[6] Information on Netcare's ownership structure is available here: https://simplywall.st/stocks/za/healthcare/jse-ntc/netcare-shares/ownership (Accessed: 23 August 2024).

paid by the government to the consortium increased because the number of patients treated was much higher than expected. Moreover, the inflation risk had been fully transferred to the Government of Lesotho, which bloated annual payments by 68% between 2008 and 2016 (Hellowell 2019; PSI 2021).

Fifth, regularly, the private party to the PPP takes on loans not only from development finance institutions (DFIs) but from its own shareholders, i.e. intra-company loans from consortium members, and/or outsources parts of its contractual duties to them (or their shareholders). These intra-company loans, alongside a reliance on managements fees which the government needs to pay to the main contractor, allow private investors in a PPP consortium to extract high profits and, once more, minimise tax liabilities and undermine the state's general capacity to fund public services. This was the case for the QMMH in Lesotho, for which the consortium took a loan from its main shareholder Netcare, resulting in high interest payments to Netcare (Hellowell 2019).

Sixth, loans and equity investments provided to finance the PPP project, including from DFIs, can be securitised, and sold on to other investors (Whitfield 2016).

Seventh, if user fees are part and parcel of the PPP contract, households may accrue unsustainable levels of debt if they are not able to access free or subsidised healthcare services via a publicly funded system. Such household debt then possibly becomes the basis for the creation of new asset classes and financial instruments further enabling income redistributions via 'rent capture' or value extraction (Gouzoulis and Galanis 2021; Cordilha 2022a; Lavinas et al. 2022).

Figure 2 sums up our account of the way in which PPPs combine different vectors of financialisation as they offer multiple avenues for the expansion of financial

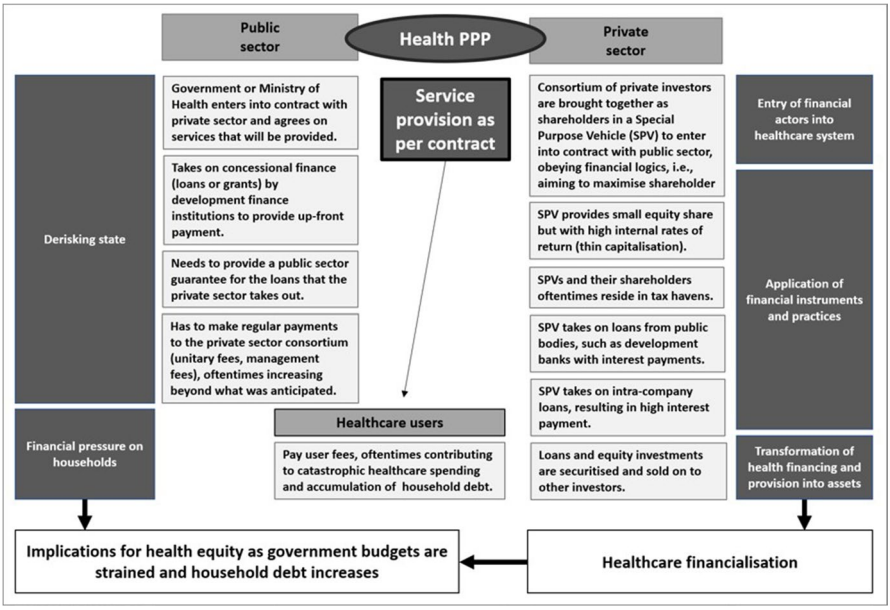

Fig. 2 Mechanisms of healthcare financialisation via a health PPP. Source: Authors' illustration

agents, practices and instruments enabled by the particular contractual relations between public and private sectors. For Bayliss and Van Waeyenberge (2018), their vigorous promotion by the international community, including the WBG, reflects the increased prevalence of financial agents in public service provisioning in the Global South, in particular driven by the rise of institutional investor interest in social and economic infrastructures. Gabor (2021) complements this analysis by drawing attention to the specific policy paradigm, the Wall Street Consensus, that furthers the expansion of these interests.

The next section unpacks in greater detail the way in which this consensus has been put in practice to promote health PPPs in Africa. To date, Africa remains the region where healthcare service coverage is worst and the share of people with impoverishing out-of-pocket health spending is highest (WHO and World Bank 2023). African countries, furthermore, are faced with considerable budget constraints, worsened by austerity measures and fiscal consolidation imperatives (Stubbs et al. 2023). Insufficient access to quality healthcare is reflected in poor health outcomes, with maternal and child mortality rates across a majority of African countries lying by far above global averages (WHO 2024).

3 Promoting health PPPs in Africa: the role of the World Bank Group

Since the late 1960s, the WBG has become the leading agency in guiding development policymaking globally (Van Waeyenberge and Fine 2011). Over the years, the WBG has increasingly promoted the expansion of the private sector in national healthcare systems (Noy 2017; Romero 2024), with the promotion of PPPs as an off-budget financing strategy accelerating since the 2000s (Gideon and Unterhalter 2020; Bayliss et al. 2021). In this context, the WBG has been vocal about the need for countries to undergo structural reforms that enable the participation of private financial and non-financial actors in health, including via PPPs (Mariotti and Romero 2022).

This section analyses the role the WBG plays in promoting health PPPs in the Global South, with a focus on Africa. It does so by, first, briefly expanding on the WBG's current policy paradigm, the Wall Street Consensus, and second, highlighting the different ways in which the WBG promotes health PPPs in Africa.

3.1 The Wall Street Consensus as the WBG's new normal

Throughout its 80 years of existence, the WBG has become an increasingly influential actor in the field of social policy. It has been a leading force in the global process of narrowing the scope of social policy (Adésínà 2015; Chukwuma 2021), while promoting an increasing role of private finance as a way of delivering on social goals, including in healthcare. Its attachment to the private sector dates back to the 1970s, when concepts of state failure started to emerge in mainstream economics and, subsequently, in the WBG's policy analysis. Rent-seeking theories (Krueger 1974) as well as public choice and rational choice theories (Bates 1988) became

prominent, pointing to the state's bureaucratic apparatus as well as incentives of people in power to maximise their own interests as causes for slow economic development. In 1981, a key World Bank report stated that 'although internal constraints and changes in the world economy are heavily implicated in Africa's slow economic growth, domestic policy deficiencies and administrative constraints have also been important—in many cases, decisive—and will continue to block economic progress unless changes are made' (World Bank 1981, p. 24). Inadequate governance systems and poor policymaking of African governments were thus singled out to account for African countries' limited economic growth performance.

Since then, the WBG remains attached to a growth-oriented and instrumentalist approach to social policy, considering private sector involvement in social policy essential with the latter conceptualised 'as a means to achieve economic growth and to manage socio-economic risks of the poor' (Chukwuma 2021, p. 20). Meanwhile, the World Bank's attachment to fiscal consolidation implies that, de facto, African countries do not have the fiscal space to increase health spending, despite their widespread commitment to UHC (Stubbs et al. 2023). According to WHO data, in 2021, only three African countries (Cabo Verde, South Africa and Botswana) narrowly met the Abuja Declaration target of allocating at least 15% of the public budget to health. Thus, the WBG's narrow vision of social policy and its emphasis on budget discipline, reflective of mainstream economic theory, is squarely at odds with a view that advocates for a human rights-based approach to the different dimensions of well-being, including healthcare (Sabates-Wheeler and Devereux 2007).

After the 2008 Global Financial Crisis (GFC), the WBG's role in social (and health) policy further intensified, when a 'private turn' and a push for 'impact finance' came to dominate the development cooperation field (Van Waeyenberge 2015; Chiapello 2023). Since then, WBG's narratives, ideas and tools have come to reflect what Gabor (2021) terms the Wall Street Consensus (Romero 2024). According to Gabor (2021, p. 429), this Consensus seeks to 'reorganise development interventions around partnerships with global finance' and to promote a 'de-risking' role for the state. The 'de-risking state', as Gabor (2021, p. 436) calls it, can be understood as a project that seeks to extend the infrastructural dependence of the state on private finance—and thus the infrastructural power of the latter—from its two traditional domains of monetary and fiscal policy to other arenas of the government. These can include energy, transport, education and health, among others, which 'can be transformed in asset classes, a code for creating de-risking partnerships' (Gabor 2021, p. 436). In other words, the state relies on private finance to deliver physical and social infrastructure, and development more broadly. As a result, national and global healthcare systems have increasingly become dominated by particular norms, cultures and practices centred around serving private financial sector interests (Hunter and Murray 2019; Romero 2024). This includes the promotion, financing and provision of advice in support of health PPPs, which despite their different concrete forms foster the increased participation of the private (financial) sector in healthcare provisioning, reflecting increased efforts to transform broader swaths of social and economic infrastructure into revenue-yielding assets.

3.2 The WBG's modalities of promoting health PPPs

Over the last two decades, the WBG has used different tools to promote health PPPs across countries of the Global South, and African countries, in particular. Indeed, the WBG has increasingly played a significant role in fostering and shaping the regulatory framework across African countries to make the implementation of PPPs, including in healthcare, possible. One key platform for the promotion of PPPs in general, hosted and administered by the WBG, with important effects for enabling health PPPs, is the Public–Private Infrastructure Advisory Facility (PPIAF). The PPIAF is a multi-donor technical assistance facility, currently supported by various governments, including the USA, the UK, Germany and the Netherlands. It aims 'at helping developing countries improve the quality of their infrastructure through private sector involvement' and administers interventions that foster PPP legal frameworks and policies (PPIAF 2000, p. n/a). In some cases, these governments have played a leading role in exporting PPPs in healthcare, driven by the interest of their own private sector, and the opportunities that these have offered to expand their markets (Holden 2013; Lethbridge 2016; Wemos 2022).

In 2024, the PPIAF reports that it supported 131 countries and funded more than 1700 development projects, which range from the provision of technical assistance to specific projects to the production of knowledge materials such as PPP Reference Guides, Guidance on PPP Legal Frameworks and a PPP Certification programme.[7] These outputs have informed African governments' practices (43 of 54 of which are beneficiaries of PPIAF support). We established in our mapping of African countries' progress relating to health PPPs that at least 33 of 54 African countries (60%) had been (or currently are being) supported by the WBG in their efforts to put into place a regulatory framework that enables PPPs, including in healthcare (see Fig. 3). As illustrated in Fig. 4, as of July 2024, only six countries on the continent have no PPP law or policy in place, of which two countries—Algeria and Somalia—are currently in the process of developing a law (the latter with the support of the WBG).[8] This leaves Equatorial Guinea, Eritrea, Libya and South Sudan as the only four countries on the continent where we were not able to establish that the adoption of a PPP law or policy is imminent (see Appendix Table 2).

Moreover, our review finds clear evidence of the WBG's large-scale promotion of PPPs in the realm of healthcare. In our analysis, we establish that the WBG has used a variety of avenues explicitly to promote health PPPs in two-thirds of African countries (36 out of 54 countries). The organisation uses a range of different modalities of involvement (see Appendix Table 3 for a detailed list of interventions at country-level). These can broadly be grouped into five categories.

[7] See PPIAF website: https://www.ppiaf.org/results (Accessed: 5 April 2024).

[8] A similar exercise was conducted by the African Legal Support Facility (ALSF) that finds that 42 of the 54 African countries have a law on PPPs (ALSF 2024). However, several countries they list as not having a PPP law have either adopted PPP laws recently, have other forms of legislation in place that cover PPPs and/or have developed a PPP policy.

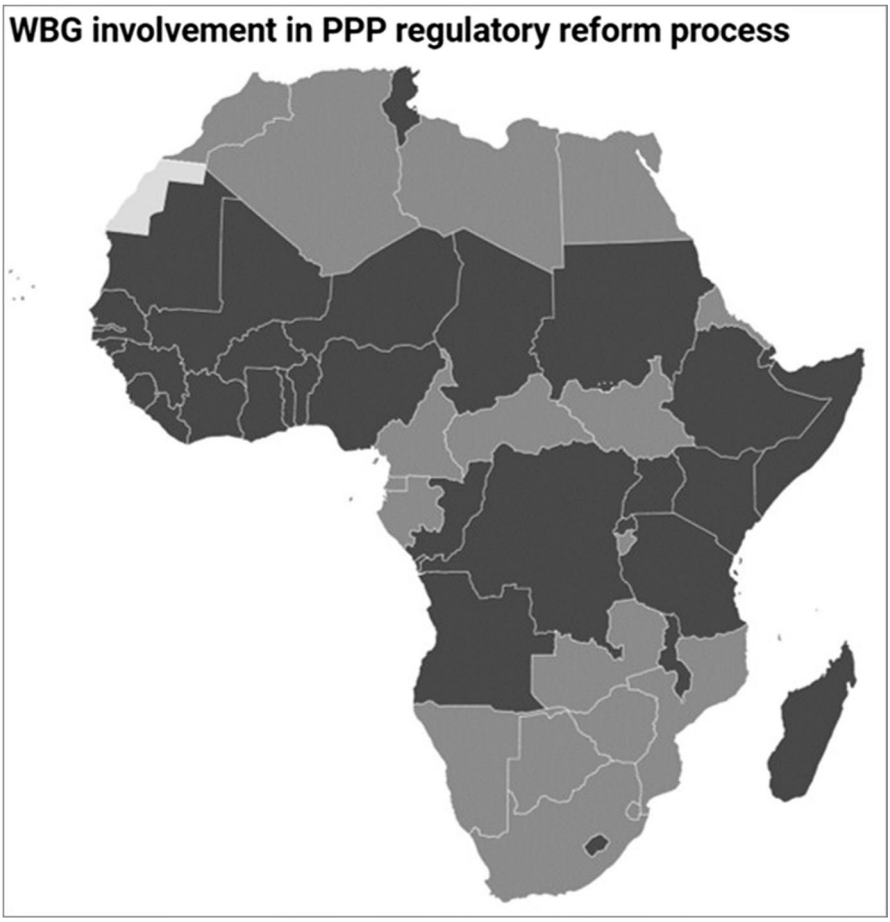

Fig. 3 WBG involvement in PPP regulatory reform process across African countries. Source: Authors' illustration; notes: dark areas, WBG involvement established; light areas, WBG involvement unclear; no data for Western Sahara

First, the WBG—via its private sector affiliate, the IFC—provides direct project support to selected health PPPs, either in the form of a financial investment or advisory services. Traditionally, the public sector arms of the WBG, the International Bank for Reconstruction and Development (IBRD) and the International Development Association (IDA), were the main development partners of national governments, providing financial and technical support to governments in the Global South. However, since the 1980s, the IFC, with a mandate to strengthen the reach and capacity of private sector actors, has become increasingly influential in transforming and impacting social and economic landscapes across the Global South (Dreher et al. 2019). Today, the IFC remains at the forefront of promoting and

Fig. 4 Countries in Africa with PPP laws or policies in place. Source: Authors' illustration; notes: dark areas, PPP law in place; areas with horizontal stripes, PPP policy in place, but no law; areas with diagonal stripes, no PPP law in place, but in preparation; light areas, no PPP law or policy in place; no data for Western Sahara

facilitating the creation of new investment opportunities for global financial actors hereby advancing financialisation dynamics (Funke 2022).

In the 1980s and early 1990s, the IFC approved investment projects in the health sector amounting to US$20.94 million, increasing its commitments more than 20-fold between 1997 and 2007 to US$ 522 million, with a focus on direct and indirect support to the private provision of healthcare (Romero 2024). From 2008 onwards, the IFC further expanded its activities in the healthcare sector, including investment projects in support of private sector companies, advisory service for

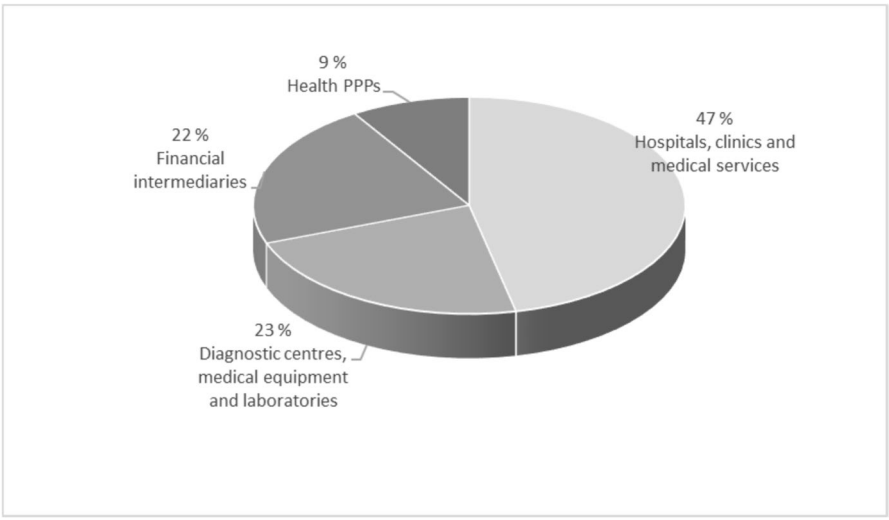

Fig. 5 Distribution of IFC investment projects in healthcare (direct and indirect), 2008–2022 (% of the total amount). Source: Romero (2024)

market creation (including for health PPP projects) and tailored analytical work to identify business opportunities in the health sector. This involved direct financial investments, but also implied a broader scope for IFC healthcare-related activities. Between 2008 and 2022, the IFC invested US$ 3.9 billion in healthcare projects, representing an exponential increase compared to the previous decade (Romero 2024). Out of this, US$553 million were invested in Africa. Yet, IFC financial support to PPPs in health was relatively small, representing 9% of all IFC investment in healthcare between 2008 and 2022 (see Fig. 5).

At the same time, the IFC has become the global lead advisor in the field of health PPPs. Indeed, in the period 2008–2022, the IFC delivered 72 advisory service projects that supported healthcare companies and governments activities in the health sector in 27 countries, which amounted to at least US$56.6 million.[9] Fifty-one of these projects—or 71%—are to deliver health PPPs across the Global South, including in Benin, Ghana, Nigeria, Lesotho and Togo (Romero 2024).

By way of examples, in 2012, the IFC advised on a project to structure and implement a PPP to build, equip, operate and maintain a diagnostics centre within the Korle-Bu University Hospital in Accra, Ghana, and to structure and implement a PPP for a laboratory and diagnostic imaging services for the Ekiti State Teaching Hospital, in Nigeria. In 2013, the IFC provided support for contract management capacity to the Government of Lesotho for the QMM PPP Hospital (see above), and in 2022, it provided support to the Government of Togo to develop and implement a

[9] The exact amount of all IFC advisory service in health is not possible to quantify as the IFC does not disclose this information for all projects.

PPP to deliver medical imaging services in public hospitals. Moreover, in February 2024, the IFC announced that it will support the government of Côte d'Ivoire in its efforts to structure and implement health PPPs for laboratory and imaging services at 14 hospitals in the Abidjan and Abengourou regions of the country.[10] According to the investor database *IJ Global*, the IFC was also involved in a nursery facility PPP project in Morocco (in 2020). Furthermore, certain countries have benefited from IFC support via the Health in Africa (HiA) Fund, but it is not clear to what extent this support extends to health PPPs, even if, for instance, we found evidence that in Burkina Faso and South Sudan this is the case.

Second, the WBG—via its public sector arms, the IDA and the IBRD—financially supports (through both loans and grants) the implementation of specific projects pertaining to the health sector. We established that, in many instances, the World Bank's project documents emphasise the potential of health PPPs as an innovative health financing mechanism (e.g. in Congo, Eswatini, Kenya and Niger). Moreover, we note that health PPPs are often promoted in projects that seek to introduce or improve performance-based financing (e.g. in Benin and Cameroon). We also find evidence of the promotion of health PPPs in emergency-related project documents. For example, in Libya, the WBG encouraged health PPPs as part of its 'Rapid Damage and Needs Assessment' that followed the 2023 floods. Moreover, the promotion of health PPPs does not only occur in the context of health-related projects. In Angola, the World Bank's promotion of health PPPs features in its document outlining its support for the country's privatisation programme. Similarly, health PPPs are a feature of the World Bank's support in Nigeria for a loan entitled 'Public Private Partnerships Adaptable Program Lending'.

Third, the influence of the WBG is evident in global health PPPs, such as the Global Financing Facility for Women, Children and Adolescents (GFF). In this context, the WBG provides both funding and exercises a global leadership (or convening) role (Harman 2009; Clinton and Sridhar 2017; Tichenor et al. 2021). For instance, the WBG has been involved in 25 global health PPPs and in six multi-donor trust funds, which have been instrumental in moving forward the WBG's strategy in health (Independent Evaluation Group 2018). As of 2020, the WBG was represented on the committees or governing bodies of 22 out of 25 global health partnerships, and in nine of these programmes, the WBG is represented at the highest level (Independent Evaluation Group 2020). As Tichenor et al. (2021, p. 8) argue, 'this has provided the Bank with a distinct, influential network of high-level national and international stakeholders'. For example, we find that the WBG via the GFF has been able to promote health PPPs in Chad, Ethiopia, Kenya, Niger and Somalia.

Fourth, the promotion of health PPPs as an opportune health financing strategy that African governments should pursue is at the heart of a variety of technical documents that were prepared by the WBG or by national governments and ministries with WBG support. In Zimbabwe, Malawi and Tanzania, health PPPs feature in health financing policies and strategies, which were elaborated with the support

[10] The press release is available here: https://pressroom.ifc.org/all/pages/PressDetail.aspx?ID=28022 (Accessed: 4 April 2024).

of the WBG. In Namibia, Seychelles and the Comoros, WBG-led public health expenditure reviews highlight the need to establish health PPPs as a way to mobilise additional resources for health. And, in Mauretania, Ghana, Uganda and the Democratic Republic of the Congo, health sector assessment reports, drafted by the WBG, highlight the need for health PPPs.

Lastly, the WBG's production and active dissemination of knowledge, or its 'thought leadership role', is a critical component of its promotion of health PPPs across African countries (Romero 2024). It influences health policymaking with its managerial economic ideas, and economic language and methods to the detriment of rights-based discourses and practices (Ruger 2005; Adams 2016; Clinton and Sridhar 2017; Shawar and Ruger 2018; Whiteside 2020). It deploys a host of platforms to that effect, ranging from a PPP certification programme (e.g. actively encouraged in Angola), to its involvement in the establishment of country-level alliances for the promotion of health PPPs (as is the case in Mali), the use of blog posts (e.g. in Morocco) or the organisation of workshops (e.g. in Cabo Verde). More broadly, the WBG uses different outlets such as short story awards, webisodes, newsletters and briefing papers to amplify the voices of advisory companies and investors in health PPPs.[11]

Finally, WBG promotion of health PPPs has contributed to the normalisation of a narrative that private finance is the best financing option for African governments to attain UHC. Unsurprisingly, then, 43 out of 54 African countries (80%) mention health PPPs explicitly in their national health strategies, policies and plans (see Fig. 6 and Appendix Table 4). Therefore, while the actual footprint of health PPPs on the African continent remains relatively small, ongoing narratives, trends, changing regulatory frameworks and policies indicate that health PPPs are widely considered as an important financing option and are likely to appear more regularly across African countries.

4 Conclusion

Today, healthcare sectors are presented as a new frontier for global financial shareholders. The latter are argued to 'do good' while (financially) supporting efforts to improve service delivery and access to healthcare.[12] This resonates with the current rhetoric in international development of private finance being necessary for the attainment of the SDGs, including SDG3. It also reflects the 'new

[11] See Webisode 'Investing and growing a private health system in Africa': https://www.ifc.org/wps/wcm/connect/industry_ext_content/ifc_external_corporate_site/health/events/webisodes/health_webisode_s1_e2 and Blog post 'IFC Kenya Transforming Kenya's healthcare system: a PPP success story': https://blogs.worldbank.org/ppps/transforming-kenya-s-healthcare-system-ppp-success-story (Accessed: 5 April 2024).

[12] See, for example, the websites of PharmAccess and Market Access Africa: https://publications.pharmaccess.org/progress-report-2022/making-inclusive-health-markets-a-reality and https://www.marketaccess.africa/about (Accessed: 14 April 2024).

Fig. 6 Countries in Africa with national health policies, strategies and plans explicitly encouraging health PPPs. Source: Authors' illustration; notes: dark areas, health PPPs promoted; light areas, health PPPs not promoted, or unclear whether they are being promoted; no data for Western Sahara

normal' at the WBG whose narratives, ideas and tools have come to reflect the premises of the Wall Street Consensus.

According to the WBG, health PPPs are an opportune vehicle to channel private finance into healthcare systems. It is argued that by using public funds to leverage private finance, governments can expand service delivery (e.g. via the construction of new hospitals) while adhering to fiscal consolidation principles. However, the negative implications for health equity of PPPs are well documented and health PPPs allow global finance to penetrate national healthcare systems, furthering their financialisation. At the same time, health PPPs facilitate the

diversion of public sector resources, earmarked for healthcare, to the advantage of private (and financial) agents. Such siphoning away of public funds, including development aid, towards the private sector is particularly concerning in the African context, where public health budgets are constrained, including because of higher borrowing costs and crippling debt burdens (UNCTAD 2024).

Despite these concerns, the WBG remains a strong advocate of health PPPs. And, while health PPPs are not yet the norm in practice across African countries, WBG support for policy frameworks that enable the proliferation of PPPs are starting to pay off. In 2024, few African countries do not have (or are not working towards) a PPP law or policy. The large majority of African countries (43 out of 54) explicitly encourage health PPPs in their national health plans, policies and/or strategies, and for many of these (36 out of 54), we found clear evidence that the WBG supports health PPP development in one form or another.

We identified a range of modalities of WBG support for health PPPs. These include the following: direct financial support (in particular via the WGB's private sector affiliate); technical assistance and transaction advice; promoting health PPPs in technical documents such as health sector assessments and public expenditure reviews; integrating support for health PPPs into projects that receive WBG grants or credits; promoting health PPPs as part of projects funded via the GFF; and playing a 'thought leadership role' by, e.g. publishing blogs on the topic of health PPPs in a particular countries, organising workshops and/or participating in and encouraging the establishment of private health sector alliances. By having investigated the different modalities of the WBG's promotion of health PPPs, we have unpacked a specific dimension of 'financialisation by development policies' (Chiapello et al. 2023).

Thus, while we are yet to witness a massive roll-out of health PPPs in Africa, the legal and regulatory conditions in their support have been successfully created on the ground. This ambition to accelerate the prevalence of private finance, including via health PPPs, in national health systems however requires caution, as it risks deepening the exposure of national health systems to the pernicious implications of financialised logics.

Appendix

Table 1 Table 2 Table 3 Table 4

Table 1 Research protocol for the mapping of the advancement of health PPPs in Africa

Objective	Research strategy
Identify which African countries have a PPP law or policy in place and what was the nature of WBG involvement	Establish whether country has a PPP law or policy in place, and since when
	Establish whether country has a dedicated PPP unit in place
	Establish whether PPP law or policy makes explicit reference to health
	Establish whether the WBG was involved in the development of the PPP law or policy without any doubt
Identify which African countries refer to health PPPs in their national health strategies or policies	Establish whether country's vision for health financing includes reference to private sector finance
	Establish whether country's vision for health financing explicitly includes PPPs
Identify in which African countries—and using which modalities—the WBG is promoting health PPPs	Establish the WBG's role in promoting health system reform that enables health PPPs within the country

Sources:

- World Bank PPP Country Profiles: https://ppp.worldbank.org/public-private-partnership/country-profile-sub-saharan-africa-ssa
- World Bank Group webpages: https://projects.worldbank.org/en/projects-operations/project-country and https://projects.worldbank.org/en/projects-operations/projects-list?os=0&qterm=public%20private%20partnerships
- World Bank Public–Private Infrastructure Advisory Facility webpage: https://www.ppiaf.org/
- IFC webpage: https://disclosures.ifc.org/
- Economist Intelligence Unit webpage: https://infrascope.eiu.com/
- World Health Organisation webpage: https://extranet.who.int/mindbank/collection/country
- Wemos database: https://www.wemos.org/en/database-with-health-related-projects-of-the-international-financial-corporation/
- IJ Global webpage: https://hub.ijglobal.com/
- InfraPPP webpage: https://www.infrapppworld.com/
- Webpages of relevant official institutions and national Ministries of Health

Table 2 WBG involvement in the PPP regulatory reform process

Country (in alphabetical order)	Is there a PPP law/policy in place in the country?	Since when is a PPP law/policy in place?	Is/was the WBG involved in the PPP regulatory reform process?	Does/has the WBG via PPIAF support/ed PPP regulatory reforms?
Algeria	No (in preparation)	n/a	Unclear	No
Angola	Yes	2019	Yes	Yes
Benin	Yes	2016	Yes	Yes
Botswana	(Yes)—policy, no law	2009	Unclear	No
Burkina Faso	Yes	2013 (revised in 2021)	Yes	Yes
Burundi	Yes	2015 (revised in 2019)	Unclear	No
Cameroon	Yes	2006	Unclear	Yes
Cape Verde	Yes	2015	Unclear	Yes
Central African Republic	Yes	2019	Unclear	Yes
Chad	Yes	2017	Yes	Yes
Comoros	Yes	2018	Unclear	No
Congo	Yes	2022	Yes	Yes
Côte d'Ivoire	Yes	2012	Yes	Yes
Djibouti	Yes	2017	Yes	Yes
DR Congo	Yes	2018	Yes	Yes
Egypt	Yes	2010	Unclear	Yes
Equatorial Guinea	No	n/a	Unclear	No
Eritrea	No	n/a	Unclear	No
Eswatini	(Yes)—policy, no law	2009	Unclear	No
Ethiopia	Yes	2018	Yes	Yes
Gabon	Yes	2016	Unclear	Yes
Gambia	(Yes)—policy, no law	2015	Yes	Yes
Ghana	Yes	2020	Yes	Yes
Guinea	Yes	2017	Yes	Yes

Table 2 (continued)

Country (in alphabetical order)	Is there a PPP law/policy in place in the country?	Since when is a PPP law/policy in place?	Is/was the WBG involved in the PPP regulatory reform process?	Does/has the WBG via PPIAF support/ed PPP regulatory reforms?
Guinea-Bissau	Yes	2021	Yes	Yes
Kenya	Yes	2013 (revised in 2021)	Yes	Yes
Lesotho	(Yes) - policy, no law	2017	Yes	Yes
Liberia	Yes	2010	Yes	Yes
Libya	No	n/a	Unclear	No
Madagascar	Yes	2015	Yes	Yes
Malawi	Yes	2011 (revised in 2022)	Yes	Yes
Mali	Yes	2016	Yes	Yes
Mauritania	Yes	2017	Yes	Yes
Mauritius	Yes	2004 (revised in 2008)	Yes	Yes
Morocco	Yes	2015 (revised in 2020)	Unclear	Yes
Mozambique	Yes	2011	Unclear	Yes
Namibia	Yes	2017	Unclear	No
Niger	Yes	2011 (revised in 2018)	Yes	Yes
Nigeria	Yes	2005	Yes	Yes
Rwanda	Yes	2016	Yes	Yes
São Tomé and Príncipe	Yes	2018	Unclear	No
Senegal	Yes	2014 (revised in 2021)	Yes	Yes
Seychelles	Yes	2017	Yes	Yes
Sierra Leone	Yes	2010 (revised in 2014)	Yes	Yes
Somalia	No (in preparation)	n/a	Yes	Yes
South Africa	(Yes) – not exclusively dedicated to PPPs	1999	Unclear	Yes
South Sudan	No	n/a	Unclear	No

Table 2 (continued)

Country (in alphabetical order)	Is there a PPP law/policy in place in the country?	Since when is a PPP law/policy in place?	Is/was the WBG involved in the PPP regulatory reform process?	Does/has the WBG via PPIAF support/ed PPP regulatory reforms?
Sudan	Yes	2021	Yes	Yes
Tanzania	Yes	2010 (revised in 2023)	Yes	Yes
Togo	Yes	2021	Yes	Yes
Tunisia	Yes	2015	Yes	Yes
Uganda	Yes	2015	Yes	Yes
Zambia	Yes	2009	Unclear	Yes
Zimbabwe	Yes	2015 (revised in 2020)	Unclear	No

Table 3 Examples of WBG involvement in the promotion of health PPPs

Country	What are the WBG's modalities of promoting health PPPs in the country?
Angola	WBG support to a privatisation programme (PROPRIV) which promotes health PPPs in health; WBG support to send Government officials to certify in the management of PPPs (including in social sectors)
Benin	WBG promotion of health PPPs as part of performance-based financing reform and via its technical support to a platform encouraging private sector participation in health
Burkina Faso	WBG promotion of health PPPs as part of its strategy for improved 'fiscal management, sustainable growth and health service delivery development policy operation' and via the Health in Africa Fund to which the IFC contributes
Cameroon	WBG promotion of health PPPs via the funding of projects that enable performance-based financing of health
Cape Verde	WBG promotion of health PPPs during workshop which it organised as part of a COVID-19 emergency project
Chad	WBG promotion of health PPPs via its support for the 'Scaling up Performance-Based Financing for better health service delivery' project and via the Global Financing Facility
Comoros	WBG promotion of health PPPs in its 2022 Public Expenditure Review document, provides a list of different types of PPPs in health that Comoros could engage in
Congo	WBG promotion of health PPPs in health system restructuring project document and study assessing the role of the private healthcare sector in Congo
Côte d'Ivoire	IFC announcement in 2024 to support the Ministry of Health to design, structure, and competitively contract two PPPs for laboratory and imaging services in 14 public hospitals
DR Congo	WBG engaged Abt Associates to assess the role of the private sector in improving health system performance, which included a recommendation to develop of a list with potential health PPP opportunities
Egypt	WBG promotion of health PPPs in its policy report 'A roadmap to achieve social justice in health care in Egypt', IFC transaction advice for the Alexandria University hospitals PPP and IFC funding of cataract care/ophthalmology services
Eritrea	WBG promotion of health PPPs in its 1997 'Health Project'
Eswatini	WBG promotion of health PPPs via its 'Health System Strengthening for Human Capital Development in Eswatini Project (2020)'
Ethiopia	WBG promotion of health PPPs via the GFF and support for the development of a 'Healthcare Financing Strategy (2020–2024)'
Ghana	WBG promotion of health PPPs as part of its health sector assessment report
Kenya	WBG promotion of health PPPs via the GFF and its 'Transforming Health Systems for Universal Care Project (2016)'
Lesotho	IFC funding to Queen Mamohato Memorial Hospital in Maseru
Liberia	WBG study into PPPs, including in health and support to the Government to structure a health PPP to improve laboratory and imaging services at the JFK Medical Center (IFC funding)
Libya	WBG promotion of health PPPs in 'Rapid Damage and Needs Assessment' following the 2023 floods
Malawi	WBG promotion of health PPPs in 'Fiscal Space for Health in Malawi and Revenue Potential for Innovative Financing' document
Mali	WBG support to establish a country-level alliance for the promotion of health PPPs
Mauritania	WBG promotion of health PPPs as part of its 'Primary Health Care Performance Initiative Assessment'
Morocco	WBG promotion of health PPPs via Linkedin blog by WBG Senior Consultant

Table 3 (continued)

Country	What are the WBG's modalities of promoting health PPPs in the country?
Namibia	WBG promotion of health PPPs in the 'Health Sector Public Expenditure Review (2019)'
Niger	WBG promotion of health PPPs via the Global Funding Facility and its 'Population and Health Support Project'
Nigeria	WBG support (IDA credit) provided to Nigeria in 2011 for 'Public Private Partnerships Adaptable Program Lending' which promotes health PPPs
Rwanda	WBG promotion of health PPPs in its strategy document entitled 'Opportunities abound: Public Private Partnerships for Laboratory Services in East Africa'
Senegal	WBG promotion of health PPP in a maternal and child health investment project, which includes support to establish an alliance of private health sector actors and activities to better manage and track financial resources for health
Seychelles	WBG promotion of PPPs in its 'Seychelles Programmatic Public Expenditure Review Policy Notes—Health Education & Investment Management (2014)'
Sierra Leone	WBG promotion of health PPPs in its 'Quality Essential Health Services and Systems Support Project'
Somalia	WBG promotion of health PPPs via the GFF (Investment Case for the Somali Health Sector 2022–2027)
South Sudan	WBG promotion of health PPPs via its involvement in 'Health in Africa'
Tanzania	WBG promotion of health PPPs via its involvement in the development of the 'Tanzania Health Financing Strategy 2016–2026' and in its 'Private Health Sector Assessment in Tanzania' study
Togo	IFC provision of advisory services for an imaging health PPP; WBG promotion of health PPPs in its 'Country Partnership Framework' as well as in project that supports performance-based financing
Uganda	WBG promotion of health PPPs via the GFF and the Health in Africa initiative as well as in its 'Uganda Private Sector Assessment' and a PPP Diagnostic report
Zimbabwe	WBG promotion of health PPPs via its involvement in the development of the 'Zimbabwe National Health Financing Policy'

Table 4 Countries with national health strategies and policies promoting health PPPs

Country	Is private sector finance mentioned as part of country's health strategies or policies?	Are health PPPs explicitly mentioned as part of country's health strategies or policies?
Algeria	Yes	No
Angola	Yes	Yes
Benin	Yes	Yes
Botswana	Yes	Yes
Burkina Faso	Yes	Yes
Burundi	Yes	Yes
Cameroon	Yes	Yes
Cape Verde	Yes	Yes
Central African Republic	Yes	Yes
Chad	Yes	Yes
Comoros	Yes	Yes
Congo	Yes	Yes
Côte d'Ivoire	Yes	Yes
Djibouti	Yes	Yes
DR Congo	Yes	Yes
Egypt	Yes	Yes
Equatorial Guinea	Yes	No
Eritrea	No	No
Eswatini	Yes	Yes
Ethiopia	Yes	Yes
Gabon	Health policy not online available	Health policy not online available
Gambia	Yes	Yes
Ghana	Yes	Yes
Guinea	Yes	Yes
Guinea-Bissau	Yes	No
Kenya	Yes	Yes
Lesotho	Yes	Yes
Liberia	Yes	Yes
Libya	Health policy not online available	Health policy not online available
Madagascar	No	No
Malawi	Yes	Yes
Mali	Yes	Yes
Mauritania	Yes	Yes
Mauritius	Yes	Yes
Morocco	Yes	No
Mozambique	Yes	Yes
Namibia	Yes	Yes
Niger	Yes	Yes
Nigeria	Yes	Yes
Rwanda	Yes	Yes
São Tomé and Príncipe	Yes	Yes

Table 4 (continued)

Country	Is private sector finance mentioned as part of country's health strategies or policies?	Are health PPPs explicitly mentioned as part of country's health strategies or policies?
Senegal	Yes	Yes
Seychelles	Yes	Yes
Sierra Leone	Yes	Yes
Somalia	Yes	Yes
South Africa	Yes	Yes
South Sudan	Yes	Yes
Sudan	No	No
Tanzania	Yes	Yes
Togo	Yes	Yes
Tunisia	No	No
Uganda	Yes	Yes
Zambia	Yes	Yes
Zimbabwe	Yes	No

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Data Availability All data is taken from publicly available sources.

Declarations

Competing interests The authors declare no competing interests.

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