PUBLIC-PRIVATE PARTNERSHIPS (PPPs) AS TOOLS FOR PRIVATISATION IN THE HEALTH SECTOR

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IN COLLABORATION WITH:

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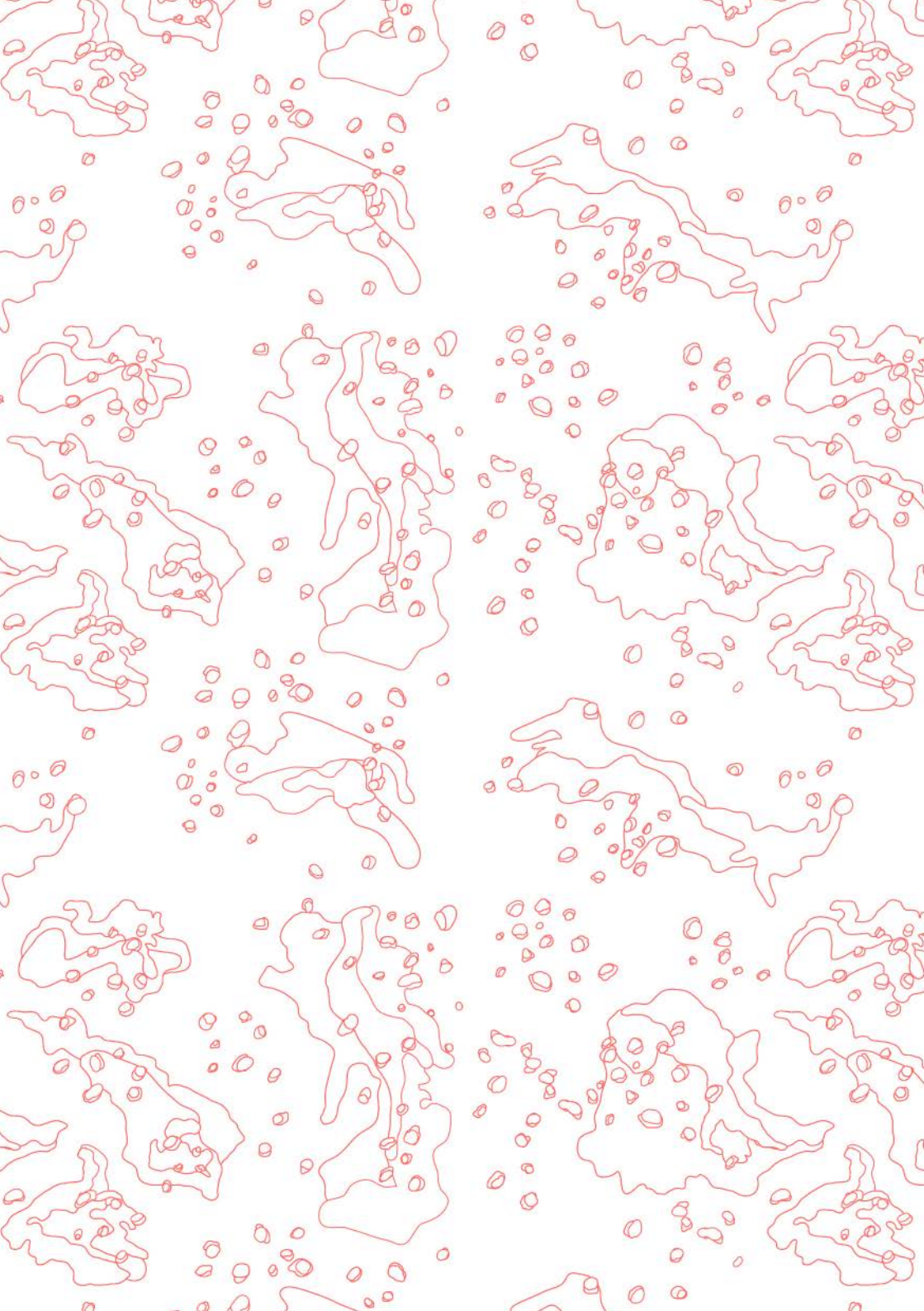

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1. Introduction

With the introduction of Public-Private Partnerships (PPPs), a new form of capitalist accumulation was established following decrease in profits caused by the oil and industrial crises of the 1970s. It attempted and still attempts to seize common goods and services belonging to societies, which were previously mostly in the hands of the State. An "accumulation by dispossession" of social wealth, according to D. Harvey[1].

This "dispossession" takes place through a collection of strategies implemented by the global network of connected and centralised companies which dominate most multinational institutions such as the World Bank (WB, which has promoted the "convenience" of transnational corporations in the health sector since 1987), the International Monetary Fund (IMF), the World Trade Organisation (WTO), the European Union (EU), States and the entire network of foundations, lobbies and think tanks that form the called "political planning network", through which they develop the "sciences" and "ideologies" which suit them, and to try to influence political and social decisions.

Public-Private Partnerships (PPPs) came into existence in 1992 in the United Kingdom as an accounting trick used to avoid government restrictions on public debt, a feature that remains their main attraction for governments and international institutions. As the rest of Europe and the world started to limit public debt with the application of austerity measures, PPPs took off as a component of privatisation policies and a way of balancing budgets through the concealment of debt.

Currently, we are experiencing a boom in the PPP model, which is becoming almost the only mechanism used to finance and/or manage our public goods and services. The mantra we hear again and again is that "the private" is more "effective" and "efficient" in the management of our productive and reproductive economy. Thus, the private sector should be invited into sectors that have traditionally been in the public domain (such as health, education, transportation, infrastructure etc.) and facilitate its participation therein.

It should be pointed out that the growth of public debt in the Spanish State has not stopped despite the implementation of strong austerity policies. Debt is a classic mechanism for the creation of wealth in capitalism and an old process of capital accumulation that, in the current financialisation phase of capitalism, has become one of the main tools by which holders of

1 Harvey, David. (2004). The new imperialism. Ediciones Akal. Madrid.

capital hold power over the public. Through this debt, and the prioritisation of its payment, neoliberalism subjects most of the investment decisions of a society to considerations that are not intended to improve people's lives, but to repay debts. Additionally, the cost overruns generated by PPP projects directly cause an increase in debt.

In practice, this means that governments develop policies aimed at depriving populations of their historically acquired rights and transferring funding from public providers to private ones, with the practical consequence that the collective rights of the many become incidental privileges for the few.

In the case of the public health system in the Spanish State, the application of neoliberal strategies in health services is guided by the so-called "Neoliberal Triad":

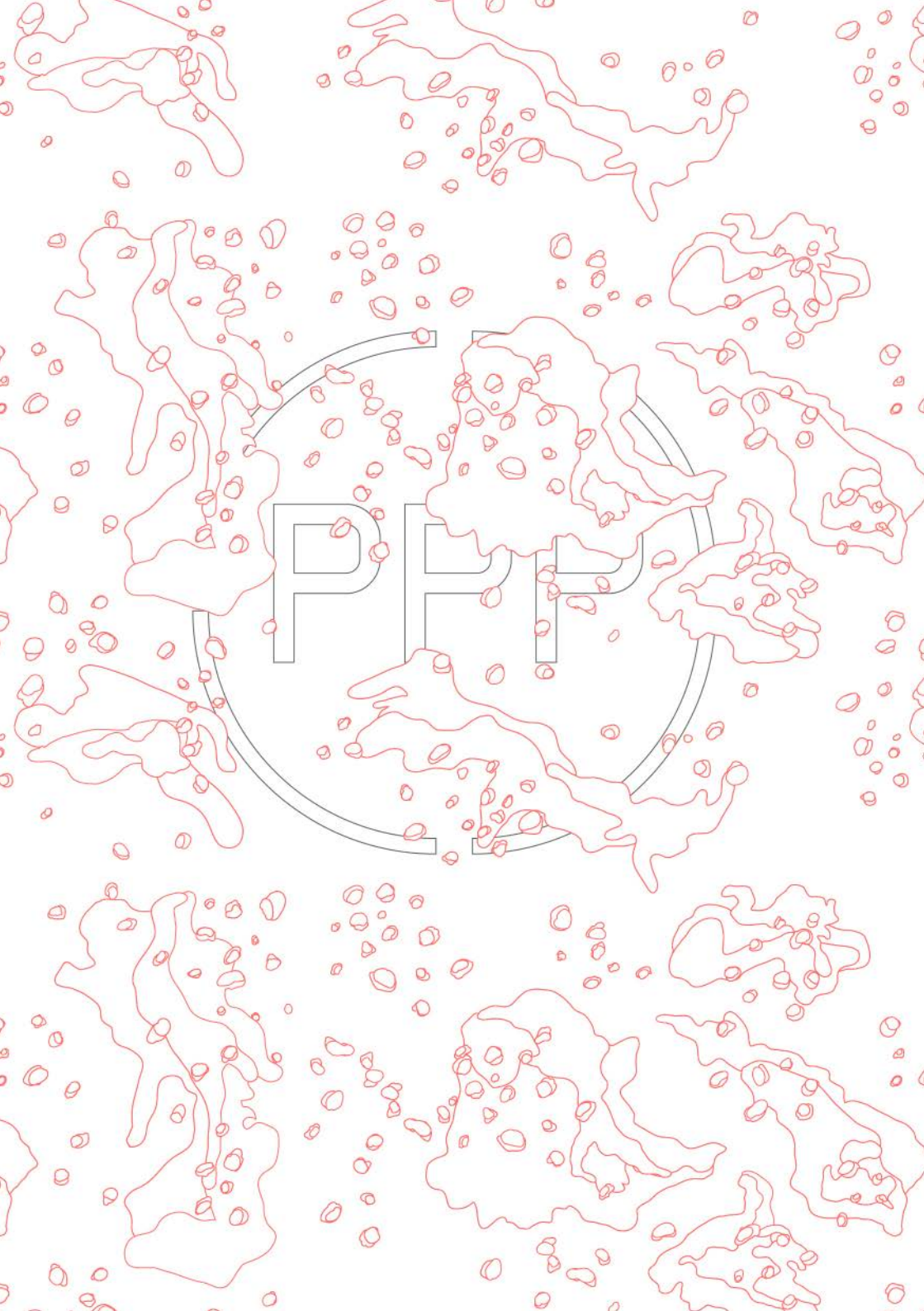
→ Reduction of the role of the State and introduction of co-payments/re-payments.

→ Expansion of the private sector in health systems (privatisation of health services) and

→ The deregulation of the public health sector (fragmentation, competition and internal markets).

Dismantling public health systems is a mechanism for restricting rights, transferring the cost of some health benefits to the public and the appropriation of medical insurance and public healthcare funds by multinationals.

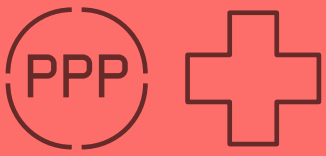
This report demonstrates that PPPs work very well for investors, the private sector and the ruling political class, while frequently draining public funds and often failing to respect the environment and respond to the needs of citizens. In this sense, the General Hospital de Villalba case in Madrid is an emblematic case and demonstrates the negative impacts that a PPP can have on healthcare.


PPP

2. MAIN RISKS OF PUBLIC-PRIVATE PARTNERSHIPS (PPPs)

PPPs vary by country and sector (ODG, 2018). They can range from informal and short-term collaborations to implement specific programs or projects, to more complex, formal and long-term contractual agreements in which the private sector collaborates in the supply of assets and services (Hall, 2015).

The experience of PPPs has been overwhelmingly negative and few have obtained positive results for the public interest, exposing the public to tremendous risks.



WHAT IS A PUBLIC-PRIVATE PARTNERSHIP?

The institutions which promote PPPs use very broad definitions, thus leaving room for PPPs to be used to achieve a wide variety of objectives in various sectors, such as transport, social housing and healthcare, and to be structured to adopt different approaches. The World Bank defines a PPP as an "agreement between the public sector and the private sector where some public services or tasks are provided by the private sector under an agreement of shared objectives for the provision of the service or infrastructure". The Organisation for Economic Cooperation and Development (OECD) defines PPPs as "long-term contractual agreements between the government and a private sector partner where the latter finances and provides a public service, using a capital asset and sharing the associated risks" (OECD, 2012). The European Commission defines PPPs as "collaboration between the public and private sector for the development of public infrastructure and / or the provision of a public service, either in the design, construction, financing, operation or maintenance phases (or in a combination of these phases) where the concessionary organisation receives payments from service users or from the public administration" (European Commission, 2004).

In practice, these broad definitions have been translated into policies and laws which allow various types of PPPs, through arrangements such as concessions, joint ventures or contractual PPPs. In the water supply and sanitation sector, for example, PPPs can range from a minor private sector involvement using a service contract to comprehensive privatisation.

There are three main types of PPPs:

A → **Concessions.** Where the private actor is authorised to charge the public for the use of the facilities, usually by paying a toll, a fee or a bill (for example, a water bill or road tolls). This can be complemented by subsidies paid by the government. The toll, fee or bill reimburses the private costs of the construction and operation of the facilities.

B → **Joint / mixed companies**, or institutional PPPs, where both the public and private sectors become shareholders of a third company.

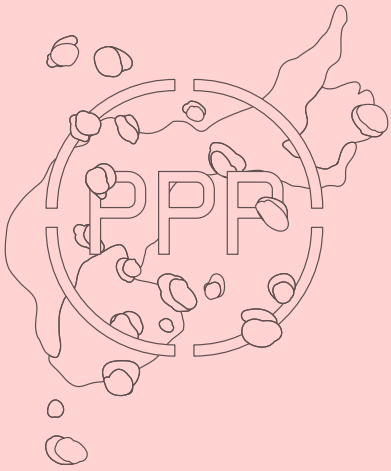
C → **Contractual PPPs**, where the relationship between the parties is governed by a contract. In the EU, the most common form of PPP is the "turnkey" contract for design, construction, financing, maintenance and operation. Here the private sector partner is entrusted with all phases of the project, from design to construction, operation and maintenance of the infrastructure, including fundraising (European Court of Auditors, 2018). In the Spanish State, two different models have been identified which fall under this category: one is the PFI (Private Finance Initiative) model and another is the PPP (Public Private Partnership) model, which are summarised in the section below.

The private party receives a return on its investment in two main ways. One is a **"user pays"** scheme, for example through tolls on the highway or through a fixed payment on the supply bill. The other is the **"Government pays"** formula. This means that payment to the private sector comes through regular payments from the public partner based on the level of service provided. Payments may depend on whether the good or service is provided according to the quality defined in the contract or on how many users the services are provided to, such as a 'hidden toll road' which is free for users although the government pays a fee per driver to the operator (ODG, 2018).

Taking into account the main characteristics that projects managed by PPPs have shown in practice, we can give the following definition:

DEFINITION OF PUBLIC-PRIVATE PARTNERSHIPS (PPPs)

PPPs are medium or long-term contracts between the public and private sectors. Backed by public guarantees, the private sector builds and / or manages goods or services traditionally provided by public institutions (whether national, regional or local), such as hospitals, schools, roads, railways, water, sanitation and energy infrastructure, amongst others. In this way, the project risk is shared between the public and the private sector or rests entirely with the public sector. The contract can cover the design, construction, financing, operation or maintenance phases, or all of them. The private actor receives payments from users or from the public administration.



THE MAIN RISKS OF PPPs

There is already a large body of literature demonstrating the risks that the PPP model may entail[2]. In summary, we identify four main risks:

1 → PPPs ARE MORE EXPENSIVE

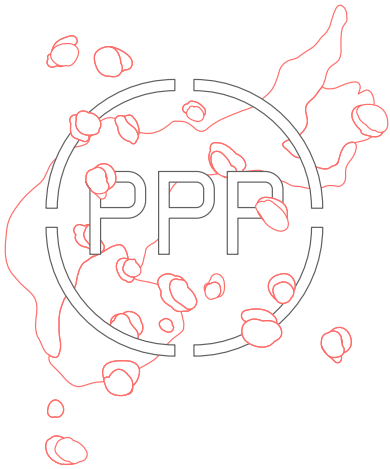
PPPs are, in most cases, the most expensive method of financing a project. They cost governments - and therefore citizens - significantly more in the long term than if the projects had been directly financed through public debt. This is due, amongst other reasons, to the higher interest rate for private financing operations compared to government loans, to the fact that private sector companies expect to obtain a profit from their investment increasing the overall cost of the investment, or to the increase in the final cost of a project due to renegotiation costs. The privileged position of the private sector company, the lack of experience of the public entity in these negotiations and the lack of transparency means that renegotiation generally significantly increases the cost of the project (ODG, 2017b). However, PPPs may be politically profitable for the ruling political class, since they offer the possibility of doing “great things” in a short period of time (the 4 years until the next election). Short-term policies are often beneficial in the electoral realm, but not in the long term for public coffers.

2 → PPPs MOVE RISKS TO THE PUBLIC DOMAIN

In principle, in a PPP project, risks should be assigned to the party that is best able to manage them, in order to achieve the optimal balance between the displacement of risk and the compensation of the party that assumes it (European Court of Auditors, 2018). The private sector partner is often responsible for the risks associated with the design, construction, financing, operation and maintenance of the infrastructure, while the public sector partner generally assumes regulatory and political risks. However, experience has shown that when these risks are assumed by the public entity they often result in **contingent liabilities**. These are hidden costs, payments that governments may have to make for assuming risks if a future uncertain event occurs which is outside the control of the government, such as if the demand falls below a specific level (demand risk).

2 See for example: ODG (2017b), International Manifesto (2017), European Court of Auditors (2018), EURODAD (2018), ODG (2018), EURODAD (2019).

Current PPP accounting practices allow governments to keep the project out of their accounts, since it is the private sector and not the government that holds the loan that finances the project. This can be called “creative accounting”, where the real cost of a project is hidden “off the balance sheet” and therefore not transparent or auditable. Therefore, there is a complete lack of information on public guarantees in PPP projects. Currently, it is not possible to calculate exactly how much public debt could be created through the PPP model if the public sector has to save a private investment, converting private debt into public debt. These practices expose public finances to excessive risks, and many of these “bailouts” can be described as illegitimate debts.



WHAT IS AN ILLEGITIMATE DEBT?

In international law, a debt is illegitimate if:

- → It comes from loans that, because of how they were granted or managed or what they financed, directly or indirectly threaten the dignity of the life of citizens and endanger peaceful coexistence among peoples.
- → It is debt that derives from financial agreements that (either in the contracting or renegotiation phases, or in what they establish, in what they finance or in the impacts they cause) violate human rights or the principles of international law recognized by the nations of the world which govern relations between states and between peoples.
- → External debt can also be considered illegitimate in its entirety, as a mechanism of domination and impoverishment which perpetuates unfair and unequal South-North relations and responds fundamentally to the interests of creditors: in particular, the economic elites (in the Global North and South).
- → A debt whose funds are used to acquire means and weapons for the repression of the population or for other questionable purposes, such as buying warships, submarines, fighter jets and combat helicopters.
- → Debts incurred behind the backs of citizens, in contravention of their rights, or which contribute to deteriorating or destroying the environment.
- → Bank bailouts are also included, because they do not fulfil the aims for which they were conceived but instead enable the private financial sector to get rid of toxic assets, to pay part of its debts and to restructure obtaining large profits.

An illegitimate debt is therefore a debt that the borrower cannot be forced to pay.

"Illegitimate debt" is not a technical or legal notion, but a political concept that evolves depending on the territorial context. That is, it must be the citizens themselves who democratically define what illegitimate debt is at a certain historical moment[3].

The definition of a debt as illegitimate is independent of the political organization of the State that contracts it, be it a dictatorship or a government constitutionally elected at the polls. The non-payment of such a debt is not due to legal issues, but to the unjust and morally illegitimate nature of a debt that generates great inequalities and goes against the common good.

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3 For example, definition of the Public Debt Audit Platform (PACD), citizen platform of the Spanish State that emerged from the 15M movement in 2011: https://auditoriaciudadana.net/2013/04/11/lo-que-quiere-decir-la -pacd-when-talks-about-citizen-audit-of-debt-and-illegitimate-castcat /

3 → PPPs THREATEN DEMOCRACY THROUGH LACK OF TRANSPARENCY AND CORRUPTION

PPPs often suffer from a lack of transparency and limited public scrutiny, which in many cases leads to poor decision-making due to reduced supervision and increased opportunities for corrupt behaviour (ODG, 2017b). The lack of transparency is a consequence of poor fiscal transparency and opaque decision-making processes. Many countries do not publicly disclose the full details of the guarantees and contingent liabilities associated with PPPs, or the conditions which generated them or their contracts, which are of vital importance for public scrutiny. This makes fiscal policy decisions less informed and encourages governments to move forward with projects even when they can create fiscal problems in the future.

In addition, PPP contracts often undermine the right and obligation of the State to regulate in the public interest. PPPs can limit the ability of governments to enact new policies - for example, reinforced environmental or social regulations - if they affect specific projects. It could be said that PPPs mortgage the future, reducing opportunities for future governments to implement progressive policies.

4 → PPPs CAUSE SOCIAL, ENVIRONMENTAL AND GENDER IMPACTS

PPPs can result in social, environmental and human rights abuses. In many cases, the private sector selects a small number of the most profitable projects and convinces governments to give priority to investment in these projects, not taking into account the distortion this causes in the provision of public services or its impacts on human rights and the environment. The final service does not matter, economic profitability matters: the "business of building." In the case of infrastructure, this has created a tendency to finance mega-projects according to the Big-Big-Big paradigm: big projects, big investments, big corporations (XSE, 2018). A paradigmatic example in the Spanish State is the failed Castor project, which is currently pending resolution, and has generated a strong social resistance[4].

The construction of large projects under the PPP model - such as dams, power grids, oil rigs, gas pipelines, mines, ports, railroads and highways - produces violations of fundamental human rights. Large infrastructure projects or corridors (such as the Belt and Road Initiative in China) are destroying territories and ecosystems, and displacing entire communities, especially in the Global South, where they also face violence and repression by corporations.

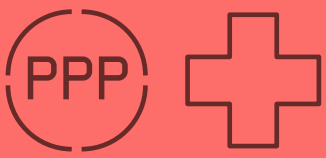
The PPP mega-project model has a devastating climate impact, which endangers future communities and generations which will be affected by climate change, especially in the Global South. Mega-projects designed worldwide are based primarily on high carbon transport (airports, highways) and energy infrastructure (including fossil fuels).

4 The Castor Case is a citizen action in the form of a criminal complaint, promoted by the ODG, Xnet and the IDHC. Its objective is to identify those responsible and end the fraud and impunity generated around the Castor project; a gas storage facility that has not operated for a single day, executed by EscalUGS of ACS, with the complicity of the PP and the PSOE. The cost of the controversial compensation to the company was initially charged to gas consumers, and has now slowed down but is pending final resolution:
https://casocastor.net/

The PPP model exacerbates gender inequality. First, the search for profits by the private sector restricts access to services for the most vulnerable people, often women, migrant women etc. For example, a change in public transport prices especially affects women, as they are the main users, either going to work or to perform care work. In addition, the more governments pay private companies, the less they can spend on essential social services with a gender perspective, such as universal social protection, vital to the realisation of women's rights. Finally, the objective of the private investor to obtain profits limits the provision of decent work for women in PPP projects. For example, there is a growing tendency to use international agencies to outsource workers with flexible contracts (Graham, 2010). Outsourcing erodes working conditions, especially with regard to the prevention of occupational hazards.

3. THE PRIVATISATION PROCESS IN HEALTHCARE SYSTEMS: THE GLOBAL CONTEXT

The application of neoliberal strategies in health services is guided by the so-called "Neoliberal Triad": the reduction of the role of the State and introduction of co-payments; the expansion of the private sector in healthcare systems (the privatisation of healthcare services); and the deregulation of the public health sector (fragmentation, competition and internal markets).



The World Bank's strategy: in its 1987 report on "Financing of health services: a reform program", the Bank recommends four measures to be applied to government health systems worldwide. These are to transfer costs to the users of public healthcare systems; introduce private insurance to cover main health risks; promote the use of private services paid for by public funds and decentralise and fragment public health systems to promote internal competition within healthcare providers.

In 1993 the World Bank published its "World Development Report" which proposed both the introduction of the market into healthcare systems (to promote competition between public and private providers) and resource cuts and outsourcing (privatisation) of services, promoting interventions of high effectiveness and low cost.

The concession to the private sector of public services implies the valuation of healthcare services at their exchange value instead of their use value, transforming the conception of healthcare services from instruments to meet the health needs of the population to an area of business. This strategic-ideological reorientation is aimed at introducing the market into spaces that were previously reserved for the State.

The objective of the World Trade Organization (WTO), in its various rounds of negotiations, is the complete liberalisation of the services sector, for which it is necessary to eradicate or minimise public systems and limit State interventions as far as possible.

The WTO attributes a decisive role to States in facilitating private sector access to public services through the reform of the legal framework that regulates contracting by the public administration of services, investment funds and private products. The assault on public systems has been designed to the last detail.

Structural reforms are being carried out in all areas: financial cuts; fragmentation of activities, contracts and subcontracts; reductions in personnel and increased precariousness of work; degradation of public services infrastructure and, above all, the promotion of economic profitability to a supreme law. This degrades the character of public services, supports claims that the Social State (the so-called Welfare State) is infeasible and must be dismantled, and promotes the healthcare agenda of the 21st century: partnerships, public-private collaboration, minimising and deregulating public services and increasing co-payments.

Dismantling public health systems is a mechanism for restricting rights, transferring the cost of some health services to the public and the appropriation of medical insurance and public healthcare funds by multinationals.

The public healthcare service sector has seen the slow, surreptitious introduction of a strategy that has the following dimensions:

The economic dimension is characterised on the one hand by the slow but progressive privatisation of public services through budget cuts and an increase in the mandatory economic contribution of citizens and, on the other hand, by the creation of incentives for private investors to increase both the proportion of global health expenditure which occurs through the private sector and the role of the market and consumption in satisfying the population's health needs.

The healthcare dimension is characterised by:

- → Prioritising treatment measures over preventative or rehabilitative measures.
- → Prioritising cost reductions over quality and the satisfaction of needs.
- → The breakdown of mandatory universal insurance which generates adverse selection of risks, increased inequality, decreased public resources, the breakdown of solidarity and increased health expenditure.
- → The privatisation of service provision with an increase in private provision and the deregulation of public health systems by creating a legal framework that has enabled measures such as the separation of the functions of financing, purchase and provision of services, the privatisation of the management of public facilities (leading to the creation of Public Companies, Consortiums, Public Foundations or Clinical Institutes), the promotion of public financing of private services, the political reorganisation of public facilities and the establishment of new working methods through Clinical Management and the introduction of competitiveness and market mechanisms.
- → Using personnel policy to introduce greater flexibility and precariousness in employment, to change staffing arrangements (part-time or agency staffing through private service companies) and to promote the restructuring the role of professionals.

→ In professional deontology, we have threats based on the subordination of professional practice to conveniences of private interests that health professionals are not in a position to contest[5], as well as the introduction of counterproductive health management practices[6].

Finally, there is a redistribution of power with the maintenance of a concentration of power in the medical industry: pharmaceuticals, medical appliances, computer technology and health insurance, which reinforces the role of technological infrastructure and political parties but leaves the role of communities and the public very limited.

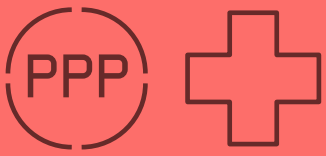
The sociocultural dimension focuses on the creation of a perception that sickness is result of individual responsibility, blaming the individual for unleashing the disease whilst exonerating the surrounding socioeconomic structure (which is considered irrelevant to the sickness) as well as using the usual marketing instruments to stimulate the consumption of goods, services and technological products which are wildly profitable for industries in the sector but not always scientifically justified for the prolongation of life. Ultimately, inequality in healthcare access and health status is increased.

5 https://www.eldiario.es/economia/tribunal-Quiron-manipulara-trabajador-despedido_0_919008901.html

6 https://mondiplo.com/riase-esta-siendo-explotado

4. THE PRIVATISATION PROCESS IN THE SPANISH PUBLIC HEALTH SYSTEM

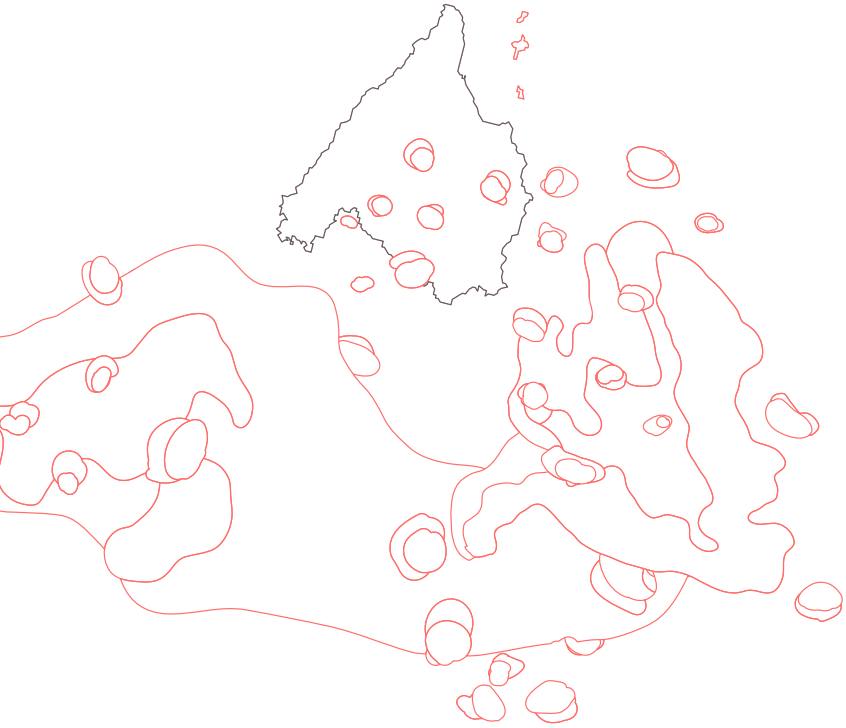
As we have seen, the cuts in the public health system since 1991 did not happen in isolation in the Spanish State, but are framed by a global offensive against public services, which has its origin in applied neoliberal policies. These respond to the demands of capital and the interests of the powerful financial sectors, backed by international organizations (the World Bank, the International Monetary Fund, the Organization for Economic Cooperation and Development and the World Trade Organization) and aim to liberalise the public sector, open it up to the market, and convert healthcare into a profitable product and financial asset.



In the Spanish State over the past three decades there has been a progressive infiltration of neoliberal dogma and the invasion of global transnational interests with respect to “rights”, solidarity, the value of public services and the supposed greater efficiency of the private sector.

Commodification and privatisation are being used to destroy national universal health care systems. Commodification refers to the introduction of commercial criteria into the operation and management of public administrations. We define “privatisation” as “the transfer or displacement, partial or total, of public functions or assets to the private sector”.

The European Observatory on Health Systems and Policy defines privatisation in health systems as “the process of transferring ownership and governmental functions from public to private entities (whether organisations with or without profit)”. This transfer process can affect financing, provision, management or investment.



In the Spanish State this took the form of a change of healthcare model, whose growth was excused by the crisis, which involves:

1 → STATE BUDGET CUTS WITH POLICIES TO CONTROL AND RESTRICT INVESTMENT AND PUBLIC SPENDING WITH INSUFFICIENT FUNDING FOR THE PUBLIC HEALTH SECTOR.

The EU demands compliance with the Stability and Growth Plan, causing budgetary restrictions and increasing the gap between available public facilities and the health needs of the population. Along these lines, it has been agreed to reduce the percentage of public health spending from 6.4% of GDP to 5.5% of GDP between 2012-2018, which puts the country at the same levels as the last century. It amounts to between 15,000 and 21,000 million euros over a period of 10 years. A central political project was the Economic and Financial Stability Plan through the approval of Organic Law 2/2012, of April 27, on Budget Stability and Financial Sustainability.

After the electoral victory of the Popular Party (PP) a great offensive began against the public health model. Insufficient funding increased deficits and debt and therefore provided the justification for gradually dismantling the public health system.

2 → CHANGES IN THE HEALTH MODEL AGREED UPON BY THE STATE.

Through:

The passing of amendments to laws and the constitutional framework to deregulate the Public Health System. The most significant were the Abril Martorell Report of 1991, whose recommendations have been gradually applied. Among the first to be adopted, the separation of the functions of purchase, provision and financing was of great impact. Subsequently came Law 15/97 on new forms of Public Services Management and the amendment in August 2011 of article 135 of the Constitution which established the priority of the repayment of debt and interest over any other public expenditure, the result of an agreement between the PSOE government, chaired by Rodríguez Zapatero, and the Popular Party.

Considering the Autonomous Communities, for example the Community of Madrid, the PP government, in its recent long-term privatisation plan for the sector, launched a full-fledged offensive against the Public Health System in October 2012 that appears in the draft the Budget Law of 2013 with the intention to progressively privatise all public hospitals.

3 → THE LIMITATION OF THE SCOPE OF THE RIGHT TO HEALTH CARE OF CITIZENS RESIDING IN THE COUNTRY ACCORDING TO VARIOUS CRITERIA AND CATEGORIES.

The Royal Decree 16/2012 of 20 April containing urgent measures to guarantee the Sustainability of the National Health System changed the universal accessibility of the Public System to every resident, an important recent social and historical event, to prevent access to the system to people who do not meet the "insurance" criteria. In fact, it means liquidating the Public Health System in which insured status was not vitally important when considering the right to healthcare and replacing it with the old insurance model which had been surpassed, in theory, by the General Health Law.

This promotes the social and healthcare exclusion of a very vulnerable sector of society and damages their health. Recently, after the change of government in the Spanish State, the PSOE approved a new RDL 7/2018 on Universal Access to Healthcare which aims to reverse the situation, but still leaves certain barriers to the recognition of the universality of healthcare.

4 → THE RESTRICTION OF THE SCOPE OF HEALTH BENEFITS INCLUDED IN THE PUBLIC HEALTH SYSTEM.

This involves limiting comprehensive health care and encouraging those who have private insurance to seek excluded services in the private sector (dental care, for example) or increase direct payments for non-basic benefits (for example, non-funded medicines, or increased re-payments)[7]. RD 16/2012 establishes different categories of benefits that will or will not be included. Three types of service portfolio are defined: basic, complementary and ancillary.

7 Clarification: The term re-payment is used instead of co-payment. The term co-payment aims to dislodge citizens' image of totally free health care, when it is they who finance the National Health System through their taxes. It is, however, not a co-payment, but a re-payment, since it entails a double taxation intended to finance the system by re-introducing costs into a health system that until now was based on health needs and values such as universality, equity, as well as public financing and forecasting.

5 → THINNING OF THE PUBLIC HEALTH SECTOR WITH A DECREASE IN THE WORKFORCE AND INCREASED JOB INSECURITY.

In the years of the crisis, budget cuts sharpened the progressive increase in the relative weight of employment in private healthcare compared to that in public health, from 30.8% in 2002 to 38.6% in 2014. This entails a displacement of activity from the public to the private sector motivated mainly by privatisations.

In addition, an extremely flexible staffing policy in the public health system was established, with high percentages of precarious work (around 40% of all health workers in many Health Services).

We have also seen forced retirements, a fall of up to 10% in replacement rates for a large sector of workers in the health sector leading to increased work hours and overloading, insufficient replenishment of materials and resources, low investment in new resources and the progressive introduction of Public-Private Partnerships for new investments or outsourcing of service provision in their place. Thus we can see how the Madrid Health Service (SERMAS) lost 6,000 health professionals in the crisis, of which it has recovered less than 3,000.

6 → INCREASING THE WEIGHT AND INFLUENCE OF THE PRIVATE SECTOR AND OF ECONOMIC AND FINANCIAL AGENTS IN THE HEALTH SERVICES SECTOR THROUGH:

A. Fragmentation of the public health network.

B. Transfer of ownership, privatisation of provision and subcontracting, administrative concessions of services, the privatisation of management and the commercialisation of resource management centres.

C. Participation in investment financing.

D. The “New Public Management” (NPM) theoretical trend in the management of public administrations expanded in the eighties in OECD countries and defends the need to de-bureaucratise the public sphere and introduce the private sector and competition mechanisms into the public services to soften the rigidities of the system and resolve its inherent inefficiency. It is interestedly biased towards private interests and ways of thinking, whilst being dysfunctional and counterproductive in many ways.

E. In the field of healthcare, it is argued that the separation of the purchase and provision of services enhances competition between suppliers and improves the overall efficiency of the system.

This despite the fact that in the healthcare area it has been shown that private for-profit institutions are more inefficient (they only show better results in terms of comfort and waiting times).

F. Favouring the creation of health lobbies and promoting their influence on public health.

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7 → **DESTROYING UNIVERSAL INSURANCE.**

This means encouraging and promoting private insurance complementary to the public system with the possibility of tax relief in the first instance, but with the explicit intention of breaking the emerging model of the National Health System and giving greater prominence to the private sector and the defence of citizens' freedom of choice. An example is that of the civil service mutual insurance companies[8] which are anomalously maintained to the advantage of a certain sector of the population.

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8 → **GREATER CONTRIBUTION BY THE POPULATION TO THE FINANCING OF THE PUBLIC HEALTH SYSTEM.**

This is done by transferring of a greater part of the health bill to society and increasing the contribution of workers to the income of the State. In the last decade the percentage of private health expenditure has increased from 20% to 35% of total health expenditure. Regressive fiscal policies with greater contributions from the middle and working classes are also applied.

We also include the increased contribution of citizens in the payment of services and in the financing of the public system itself through fees and repayments for certain benefits such as medicines, transport and prostheses.

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8 The three civil service mutual insurance companies are: Mutual of Officials of the Civil Administration of the State (MUFACE), General Judicial Mutuality (MUGEJU) and Social Institute of the Armed Forces (ISFAS).

9 → CURTAILING OR LIMITING THE RIGHT OF CITIZENS TO COMMUNITY PARTICIPATION IN THE PLANNING AND CONTROL OF BOTH THE SYSTEM AS A WHOLE AND INDIVIDUAL SERVICES.

For example, participation and monitoring mechanisms for healthcare services have been eliminated. In parallel, the term and practice of "free choice of the user" regarding professionals, services and health centres with which he wants to be treated is prioritised.

10 → DISCREDITATION AND DELEGITIMISATION OF PUBLIC SERVICE THROUGH VARIOUS STRATEGIES:

A. Dissemination of a health ideology based on a biomedical, hospital-centred, medicalising and individualistic paradigm. Promotion of the idea of "health = technology" and the medicalisation of everyday life. A consumerist trend is evident.

B. The implication that the patients themselves are the causes of the disease and their health problems, and of wasteful and unreasonable spending. This focus on the individual dilutes the responsibility of professionals and the administration, and makes the role of the social determinants of health invisible. An individualist trend is evident.

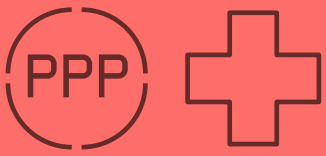
C. Characterising and stigmatising public services as uncompetitive, inefficient and wasteful, noting that there are not enough resources for everyone and that the most rational spending is through business-oriented management. An economy-focused trend is evident.

D. Commodifying and privatising resources making the processes of ownership, management and control of public services more and more opaque. A privatisation trend is evident.

E. Pushing the wealthy classes into the private sector, creating one healthcare system for the rich and another for the poor[9].

9 See: Olof Palme: A service for the poor is a poor service.

5. CASE STUDY: THE GENERAL HOSPITAL OF VILLALBA (MADRID)



INTRODUCTION

The privatisation process of the hospitals of the Madrid Health Service (SERMAS after the Spanish acronym) began in 2004 with the Infrastructure Plan 2004-2007, developed by the Popular Party (PP) government chaired by Esperanza Aguirre, which awarded concessions for the construction and 30-year operation of seven hospitals under the PFI (Private Finance Initiative) model and one under the PPP (Public-Private Partnership) model.

In 2007, the second Health Infrastructure Plan 2007-2011 was launched, which planned the construction of four[10] new hospitals under the PPP model.

The seven hospitals that were built under the PFI model designation were: Infanta Leonor Hospital in Vallecas, Infanta Sofía Hospital in San Sebastián de los Reyes, Hospital del Henares in Coslada, Hospital del Tajo in Aranjuez, Hospital del Sureste in Arganda, Hospital Infanta Cristina in Parla and the new Puerta de Hierro Hospital in Majadahonda.

The model is that private companies, most of which are construction companies, and many of which are now involved in legal proceedings for involvement in corruption schemes[11], would execute and finance the construction of hospitals under public works concession contracts (Law 13/2003[12]), in exchange for receiving an annual fee for the lease of the building and, for the first time, the provision of non-healthcare services for 30 years.

10 In principle, the construction of a PPP model hospital in the Carabanchel district (Madrid) was planned, but in the end, it was not built due to problems with the ground.

11 If there is one party most hit by corruption cases in recent years, it is the Popular Party. The Gürtel case, Bárcenas' papers, the Lezo case, the Púnica case and the Son Espases hospital are some examples. One of the most involved companies is OHL and its founder, Juan Miguel Villar Mir, who has been charged in several of these cases for allegedly making donations and paying commissions. FCC, Sacyr and ACS have also participated in the investigations of the Púnica case. ACS President Florentino Pérez has also had to testify in the case of the Son Espases hospital (PFI model): https://www.eleconomista.es/empresas-finanzas/noticias/6973573/09/15/Matas-ordeno-adjudicar-el-hospital-Son-Espases-a-Florentino-Perez.html

12 To see the Law: https://www.boe.es/buscar/pdf/2003/BOE-A-2003-10463-consolidado.pdf

In the case of hospitals built under the PPP model, the difference with respect to PFI is that the management of both health services and the so-called "non-healthcare" services[13] are managed by the private company.

With these long-term concessions, the companies are paid through a per capita compensation from the Administration depending on the catchment area and an "additional" payment for patients from outside the catchment area who want to be treated through the hospital's free choice system; patients to whom the provisions of Law 4/2000, of January 11, on the rights and freedoms of foreigners in Spain apply; and patients displaced from other Autonomous Communities.

The PPP model hospitals were built in the Spanish State without the existence of specific legislation for this type of contracting, but they were supported by more general guidelines such as the General Health Law of 1986, the Public Procurement Law, European Union (EU) legislation and especially Law 15/1997. On April 25, 1997, Law 15/1997[14] on Enabling New Forms of Management of the National Health System was passed, which involved the privatisation of public health management.[15]

At no time did they present a "Report" that showed that this type of financing and management applied to hospitals was the most economical or efficient. In fact, they justified it because in this way the Public Administration did not incur a public deficit[16].

13 "Non-healthcare" services are understood as cleaning, laundry, gardening, maintenance, file management, internal transportation personnel, etc., connected to the hospital.

14 To access Law 15/97 on Enabling New Forms of Management: https://www.boe.es/buscar/pdf/1997/BOE-A-1997-9021-consolidado.pdf

15 Those responsible for the implementation of the Plan were the Minister of Health, Manuel Lamela, the Deputy Minister, Arturo Canalda, and the General Director of the Single Public Healthcare Network, Elena de Mingo.

16 The EU accounting framework (ESA 2010) allows public participation in PPPs, under certain conditions, to be recorded off the balance sheet. This encourages their use by reinforcing compliance with the convergence criteria of the euro, also known as the Maastricht criteria. Together they try to promote health privatisation by squeezing out the public sector.

VILLALBA GENERAL HOSPITAL

Located in the municipality of Collado Villalba in the Community of Madrid, built on a plot of 55,688 square metres, protected by various regulations and ceded by the City Council of Collado Villalba to the Ministry of Health, the General Hospital of Villalba has been surrounded by all kinds of irregularities and bad practices that have damaged its public image despite the efforts of the Popular Party of Madrid to present it as a model of success.

In accordance with the PPP model, the chosen companies[17] were:

Ibérica de Diagnóstico y Cirugía SL (IDC),
Ghesa Ingeniería y Tecnología SA,
Hospital Sur SLU and
F. Forwart SLP.

In accordance with the Specification of Particular Administrative Clauses, it was established that the winning companies were required to establish a corporation prior to signing the contract, which in this case was called Capio Villalba SA.

Capio Villalba SA changed its name to IDC Salud Villalba SA, remaining the same company. In turn, IDC Salud Villalba SA[18] is a 100% subsidiary of IDC Salud. To avoid confusion, in this chapter we will call the company IDC Salud.

At the planning level, the hospital was constructed in the protected area of La Chopera[19], and the unions Madrid Association of Nursing (AME) and the Health Workers Assembly Movement (MATS) recently denounced to the Anti-Corruption Prosecutor's Office that pedestrian access to the hospital was paid for by the City Council of Collado Villalba instead of the concessionaire, as indicated by the specifications.

17 Official Gazette of the Community of Madrid (BOCM): http://www.bocm.es/boletin/CM_Orden_BOCM/2010/09/28/BOCM-20100928-29.PDF

18 For all purposes, the acquiring company is subrogated in the contracts, rights and obligations of the acquired company.

19 Ecologists in Action report that the new Villalba Hospital will be placed in an unhygienic area. See links in "Diario Crítico":

https://www.diariocritico.com/noticia/104266/noticias/ecologistas-denuncian-que-el-nuevo-hospital-de-villalba-se-hara-en-zona-insalubre.html

And in "El Faro de Guadarrama": https://www.elfarodelguadarrama.com/noticia/15944/collado-villalba/los-ecologistas-llevan-ante-el-fiscal-de-medio-ambiente-la-ubicacion-del-futuro-hospital-de-collado-villalba.html

ILLEGITIMATE DEBTS IDENTIFIED IN THE VILLALBA HOSPITAL CASE

The construction of the Villalba Hospital began in December 2010, while Esperanza Aguirre was president of the Community of Madrid. It was completed in December 2012. The Community of Madrid, presided over at that time by Ignacio González, decided to keep the hospital closed until October 2014 alleging cuts policies. During the time that the hospital remained closed without giving any kind of health benefit to citizens, the Ministry of Health paid IDC Salud (formerly Capio) the amount of 938,465[20] euros per month for 22 months.

That means that there was an expense of about 21 million euros which, from the perspective of the Citizen Audit of Health Debt[21], can be considered as illegitimate debt, as it has exclusively benefited the economic elites, in this case, IDC Salud, and not citizens, who did not receive any kind of service during the time the hospital was closed.

In addition there were extra costs in the construction of the hospital. Originally an investment of 108 million euros was planned but, in the end, the figure was 201 million euros[22].

However, one of the obligations[23] of the concessionary company, Capio Villalba SA, was to assume the costs and execution of access to the hospital. Although the contract included this obligation in the Specific Administrative Clauses, the pedestrian access works were financed with municipal funds.

20 IDC Health (formerly Capio), received 775,591 euros (with VAT, 938,465 euros) apparently for security, disinfection and pest control, cleaning, maintenance of roads and gardens, repair, insurance, supplies, taxes, amortisation and financial costs, as stated in the fourth clause of the Addendum to the Contract dated October 1, 2010, signed on October 1, 2012. This expense has not yet been properly audited.

21 Citizen Audit of Health Debt: https://auditoriaciudadana.net/tag/sanidad/

22 To see the final cost of the construction of the Villalba hospital see: https://www.elmundo.es/madrid/2016/03/23/56f19557268e3e44118b45ab.html

23 See point 9 of the Administrative Terms and Conditions: “Obligations of the winning Entity”.

In 2017, the Governing Board of the City Council of Collado Villalba agreed, to award the execution of the pedestrian access works to another company, "Urvios, Construcción y Servicios, SL", for an amount of 212,718 euros[24].

From the Citizen Audit of the Health Debt, it is understood that the amount of 212,718 euros is a clear illegitimate debt since, in accordance with section 9 of the Administrative Terms and Conditions, it should have been assumed by Capio Villalba SA instead of the City Council of Collado Villalba who could have used this amount to improve the basic services of the inhabitants of the municipality of Collado Villalba.

Another fact to take into account is that this type of hospitals are built on public land belonging to the city councils of the places they are located, constituting a transfer of land without any financial consideration to a private company that will profit from a public service that is granted for 30 years.

The construction of this hospital under the PPP model was not justified with any report about the suitability of this model, or the need for new beds. In the area there were already second level hospitals such as El Escorial Hospital, medium-stay hospitals such as Guadarrama Hospital and third level hospitals such as Puerta de Hierro Hospital. So the construction of the Villalba Hospital under the PPP model meant and still means a net transfer of public funds to the concessionaire, and the subsequent loss of funds for public hospitals in the area.

24 To see the cost of pedestrian access awarded by the City Council of Collado Villalba to the company Urvios, Construcción y Servicios, SL go to the link: https://cadenaser.com/emisora/2018/11/09/radio_madrid/1541781393_454165.html

Other possible causes of illegitimate debt generation at the Villalba Hospital could be:

1 The financing mechanism of this model for its construction and commissioning[25].

2 The annual fee on a per capita basis[26] and the term of the concession for 30 years[27].

25 There is sufficient literature from the United Kingdom and in the Spanish State that shows that the financing mechanism for the PPP model is between 6 and 7 times more expensive than if the hospital had been built with public resources.

See references in articles by Allyson Pollock and the Anti-privatisation Coordinator of Health Madrid (CAS Madrid).

26 Per capita funding is a system that consists of allocating an amount of money for each person included within the protected population, during a given period (usually one year) to the group of health care providers of a given geographical area. This amount is characterised as:

· Equivalent to the theoretical expenditure on health services for a person during the defined period.

· Adjusted according to certain socio-demographic and health characteristics of the population of said geographical area.

· Independent of the level of utilization of health services that occurs during the determined period of time.

It is in the latter case, where we believe an significant illegitimate debt is generated. The concessionaire is paid per capita regardless of whether or not the health service is used.

27 The annual per capita fee and the term of the concession for 30 years is found in the Contract signed between the Ministry of Health and Capio on October 1, 2010.

The annual per capita fee, calculated as shown in the footnote, also implies:

1 That, above and beyond these payments and on a large scale, the concessionaire will receive an amount per treatment for attention provided to patients from outside the catchment area who want to receive treatment at this hospital exercising their right to free choice.

2 Treatment provided to the population to which the provisions of Law 4/2000, of January 11, on the rights and freedoms of foreigners in Spain and their social integration are also financed outside of the per capita payment and per treatment.

3 The treatment of patients displaced from other autonomous communities (for emergency treatment) are also paid for per treatment.

These last three modalities are included in the section called free choice which causes confusion in this and other cases, since in its application it exceeds the provisions of the legal regulations applicable in the Community of Madrid.

At the end of the year, it is expected that, prior to the performance of an audit, the corresponding settlement will be made.

This settlement is made based on so-called inter-centre billing in which the cost of healthcare provided to the population assigned to the Villalba Hospital by other centres (per treatment) is deducted from the cost of healthcare provided by the Villalba Hospital to patients from other centres.

PPP schemes, in the specific case of health care, require complex auditing by the Administration, in order to ensure not only that the care is provided in a timely manner, but also that the centre does not perform what is known as “adverse selection” involving the referral of high cost processes and procedures to public facilities, etc.

The need to implement and develop these auditing mechanisms is an extra cost compared to other models that has not been assessed. As an example, the cost of managing healthcare in the United States, which is largely private with minimal public representation, is one of the largest in OECD countries.

ANALYSIS OF OTHER POSSIBLE CAUSES OF DEBT: ECOLOGICAL AND SOCIAL DEBT

The Villalba Hospital was built on land designated as “Non-Developable Land of Special Protection for its natural and landscape value and for its status as a riverbank” by the General Urban Plan of Collado Villalba.

This circumstance motivated, among other things, that Ecologistas en Acción-CODA filed an appeal before the Superior Court of Justice of Madrid (TSJM after the Spanish acronym) in June 2010. Surprisingly, the TSJM did not issue a judgment[28] until six years later, specifically, on September 1, 2016, in which it partially considers the contentious appeal promoted by Ecologists in Action-CODA.

As a consequence, it can be confirmed that the Villalba Hospital was built illegally because the modification of the General Plan of Urban Planning of Collado Villalba which converted the “Non-Developable Land” into “Developable Land” was annulled; a clear case of ecological debt.

In relation to social debt, when various healthcare and labour indicators are investigated, substantial variations are observed when the data between public hospitals and hospitals managed by Quirónsalud (such as Hospital de Villalba) is compared.

The aforementioned social debt is manifested in two aspects:

In worsened working conditions - higher workloads (workers per bed), longer hours (especially in the night shift), fewer breaks and lower wages - and undue forms of pressure on workers.

Consequently, there is a lower quality of care.

28 The TSJM annulled the Agreement of the Government Council of the Community of Madrid of February 10, 2012, which definitively approved the Non-Substantial Specific Modification of the General Plan of Urban Planning of Collado Villalba for the construction of the new Hospital.

Table 1

Comparison of working hours (annual hours) between Villalba Hospital and Public Hospitals

ITEM	Villalba Hospital (Collado Villalba)	Public Hospitals (SERMAS)	Difference
DAY SHIFT (ANNUAL HOURS) (1)	1.680	1.643	38
NIGHT SHIFT (ANNUAL HOURS) (1)	1.680	1.460	220

Source: Collective Agreement of Hospitals, Healthcare Assistance, Consultations and Clinical Analysis Laboratories for the Community of Madrid (BOCM 19/5/2018) - Instructions on SERMAS working hours.

Table 2

Comparison of the Nurse / Bed Ratio between the Villalba Hospital (PPP model) and PFI model hospitals

ITEM	Nurse / bed ratio (2)
VILLALBA HOSPITAL (COLLADO VILLALBA) - MODELO CPP	1.212/209=1,01
INFANTA CRISTINA HOSPITAL (PARLA) - MODELO PFI	212/209=1,01
Difference	**-0,45**
VILLALBA HOSPITAL (COLLADO VILLALBA) - MODELO CPP	212/209=1,01
INFANTA CRISTINA HOSPITAL (PARLA) - MODELO PFI	247/132=1,87
Difference	**-0,86**

Source: SERMAS Hospital Records 2017.

Table 3

Comparison of the Nurse / Bed Ratio between the Villalba Hospital (PPP model) and PFI Model Hospitals

ITEM	Ratio of Auxiliary Nurses / bed (2)
Villalba Hospital (Collado Villalba) - Modelo CPP	146/209=0,69
Infanta Cristina Hospital (Parla) - Modelo PFI	216/188=1,14
Difference	**-0,45**
Villalba Hospital (Collado Villalba) - Modelo CPP	146/209=0,69
Infanta Cristina Hospital (Parla) - Modelo PFI	191/132=1,44
Difference	**-0,75**

Source: Memorias Hospitales del SERMAS 2017.

Tabla 4

Comparison of the Nurse / Bed Ratio between the Villalba Hospital (PPP model) and PFI Model Hospitals

ITEM	Doctor / bed ratio (2)
Villalba Hospital (Collado Villalba) - Modelo CPP	187/209=0,89
Infanta Cristina Hospital (Parla) - Modelo PFI	201/188=1,06
Difference	**-0,17**
Villalba Hospital (Collado Villalba) - Modelo CPP	187/209=0,89
Infanta Cristina Hospital (Parla) - Modelo PFI	206/132=1,56
Difference	**-0,67**

Finally, throughout the process of implementing the PPP hospital model in the Community of Madrid there has been a lack of transparency and democracy due to:

→ A lack of prior consultation with the population and socio-health professionals.

→ The exclusion of the population, as a user, from the strategic management of public health.

→ A lack of justification reports, impact studies and planning and design according to the needs of the population.

→ A proliferation of conflicts of interest involving public officials.

→ A lack of transparency, monitoring and evaluation throughout the entire process.

Source: Memorias Hospitales del SERMAS 2017.

ASPECTS OF ILLEGITIMATE, ECOLOGICAL AND SOCIAL DEBT IDENTIFIED IN THE CASE OF THE VILLALBA HOSPITAL.

In Tables 5 and 6 you can see an approximate quantification of the illegitimate debt identified as well as debts which have been identified but could not be quantified.

Table 5
Illegitimate debts identified

Amount	Details	Details
21.000.000€	Monthly payment to the Villalba Hospital, closed from December 2012 to October 2014	
93.000.000€	Cost overruns in the construction of the Hospital, routinely linked to bribes during the tendering process	
212.718€	Access works executed by the City Council of Collado Villalba which the contract obliged the concessionaire of the Hospital de Villalba to carry out.	
Quantity not estimated	Transfer without consideration of financial compensation, for 30 years, of public land owned by the City Council – in addition, illegally with respect to urban planning.	
Quantity not estimated	Absence of justification of the choice of model and of the construction of the Hospital itself, which constitutes a net transfer of public funds that we are not in a position to estimate at this time	

Source: Created by the authors based on the information collected.

Table 6
Illegitimate practices identified

Amount	Details	Details
	Proliferation of situations of conflict of interest, deferred payments to officials by health lobbies and corruption situations in tenders and public decisions which are not monitored and of which only some have been identified by the Courts of Justice.	The case of Manuel Lamela and many others.
	Absolute absence of reports on which public decisions are based (eg: demonstrating advantages of private healthcare...).	
	Concealment of data and reports on key issues.	Pressure applied to the Chamber of Accounts of the Community of Madrid leading to the concealment of the fact that referrals to private health are 6 times more expensive than those to the public health services.
	Use of protocols, from EU level to the Spanish State, to transfer public heritage and services to the global transnational oligarchy.	Exclusion of PPP and PFI protocols in deficit and public debt coefficients.
	Absence of vigilance in the fulfillment of public contracts (interested lack of auditing by the public authority).	Statutes and protocols of the European Central Bank (ECB) and the Bank of Spain (BE).
	Deliberate obstruction of justice by the judges and courts of justice themselves.	Failure to comply with the coefficients of staff attention and quality assurance in hospitals for dependents stipulated by the Community of Madrid. The TSJM taking 6 years to declare the illegality of the transfer and change of urban designation of the ceded land: waiting for the decision to be useless. Not stipulating a sentence.

Source: Created by the authors based on the information collected.

IDENTIFICATION OF THE ACTORS RESPONSIBLE

Among the different actors involved in the process of awarding the PFI and PPP model hospitals of the Infrastructure Plan 2004-2007 prepared by the Ministry of Health of the Community of Madrid are:

1 → **CONSEJERÍA DE SANIDAD:**

Esperanza Aguirre: President of the Community of Madrid in the period 2003-2012. The Central Operating Unit[29] (UCO after the Spanish acronym) of the Civil Guard attended the headquarters of the Ministry of Health in 2017 to request information about one of the star projects of Esperanza Aguirre: the 2004-2007 health infrastructure plan.

Manuel Lamela: Minister of Health and Consumption between 2003 and 2007. As a health advisor to the Community of Madrid, Lamela signed the contract whereby a consortium led by the former Constructora Hispánica[30] was awarded the service management concession of the Tajo hospital.

Once he ceased to be a Minister, he became part of the concessionary company responsible for the operation of the Tajo hospital (Aranjuez), through the company Assignia, heir of the broken Constructora Hispánica – a clear case of the "revolving door".

Arturo Canalda: Manager of the Canal de Isabel II water company between 2001 and 2003 whose management is being investigated in the Lezo case. From 2003 to 2006 he was Deputy Minister of Health. He was then the Ombudsman for Minors and from there he became President of the Chamber of Accounts[31], which is responsible for evaluating the reports of the Canal and other hospitals. Witness in the Gürtel case.

Elena de Mingo: General Director of the Red Sanitaria Única de Utilización Pública [Unified Public Healthcare Network] from 2004 to 2008 and then

29 See news in the "Cadena SER" of March 8, 2017: https://cadenaser.com/ser/2017/03/08/tribunales/1488964455_852323.html

30 Alfonso García Pozuelo, former president of Constructora Hispánica, was charged in the Gürtel case for payment of commissions.

31 Arturo Canalda resigned in December 2017 as President of the Chamber of Accounts of the Community of Madrid, after being summoned by the investigating judge of the Lezo corruption case investigating the purchase in 2001 of the Colombian company Inassa by Canal de Isabel II, the public water company of Madrid.

coordinated the General Directorate of Health Planning, Infrastructure and Equipment until July 2011.

She was hired in May 2012, by the company Antares Consulting[32], dedicated to "consulting in strategy, management and technology in the field of health, life sciences and social services and socio-health", in another clear case of the revolving door.

2 → COLLADO VILLALBA CITY COUNCIL:

José Pablo González Durán: Mayor of Collado Villalba with the PSOE in the period 1999-2011.

From the Mayor's Office he signed a protocol with the regional government for the construction of the Villalba Hospital in March 2007.

He was charged with alleged crimes of bribery, prevarication and influence peddling, in relation to the awarding of the construction of an underground car park in the municipality to UTE Cover - Ortiz Construcciones y Proyectos SA for 20 million euros, which would end up costing around 40 million euros.

Agustín Juárez López de la Coca: Mayor of Collado Villalba for the Popular Party. In 2014, he had to resign when he was investigated for allegedly charging illegal commissions in exchange for awards of public contracts in the Punic case.

Alberto Sánchez Caballero: deputy mayor of the Popular Party and councillor for works and services of the municipality. In 2018, he also had to resign for his alleged involvement[33] in the Punic case.

32 Elena de Mingo's entry also coincided with the start of the largest figurehead project in Brazil, a Public-Private Partnership (PPP) project in the health sector in the state of Bahia.

33 See article in "El País" of July 24, 2015: https://elpais.com/ccaa/2015/07/23/madrid/1437659136_059079.html

3 → THE POPULAR PARTY AND ITS WEB OF INTERESTS:

As previously mentioned, various cases of corruption discovered in the Community of Madrid[34] (Gürtel, Púnica, etc.) which have involved the PP and provided significant resources to illegally finance the party, its members or other interested persons can be demonstrated and can be considered as causing illegitimate debt.

4 → BUSINESS GROUPS THAT ARE BEHIND THE PRIVATISATION STRATEGY OF THE PUBLIC HEALTH SYSTEM:

This section will try to clarify certain merger and acquisition processes that have been very prevalent since the beginning of the crisis and the cuts beginning in 2011.

Corporate giants and investment funds are behind the health business. They have had a prominent role in the process of restructuring private healthcare in the Spanish State and in the transfer of segments of the system from the public domain.

This is the case of the company Quirónsalud[35] which was awarded three hospitals in the Community of Madrid over the past decade under the PPP model, while Esperanza Aguirre was the president of the PP government: the Infanta Elena Hospital in Valdemoro (in 2006), the Kind Juan Carlos University Hospital in Móstoles (in April 2010), and the Villalba Hospital (in September 2010). In addition, as will be indicated below, it has maintained a Singular Agreement with the Jiménez Díaz Foundation since 2006.

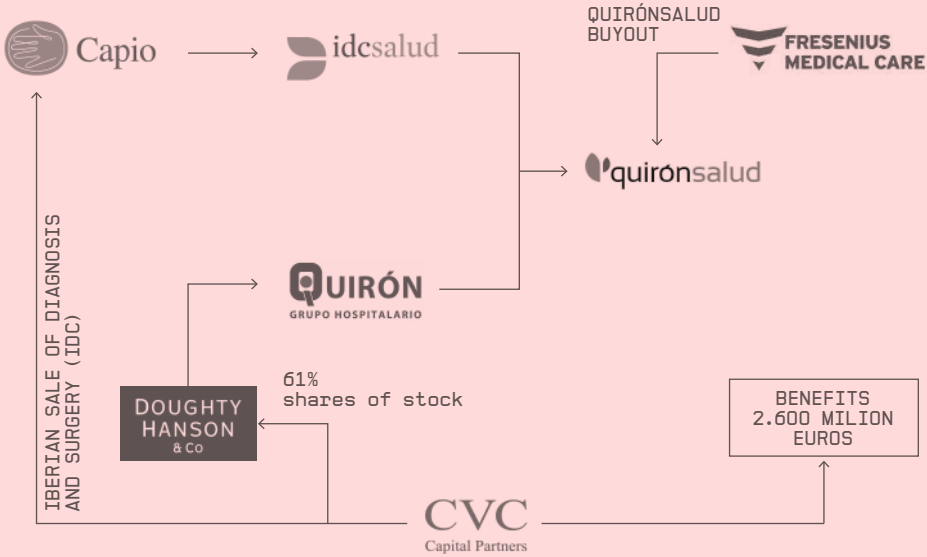
34 See article in “eldiario.es” of February 16, 2019: https://www.eldiario.es/politica/corrupcion-Comunidad-Madrid-gobierno-PP_0_867913613.html

35 Quirónsalud was born after the merger in 2014 of IDC Salud (former Capio) and Quirón, then the first and second operator in the Spanish State, respectively, with sales of 926 million (IDC) and 823 million (Quirón) annually.

On January 1, 2017, Fresenius, the main German private health group, purchased Quirónsalud, leader of private health in the Spanish State, in which it had a majority share, from the venture capital fund CVC Capital Partners2 for 5,760 million euros (see Figure 1).

In this way, Fresenius-Quirónsalud has become the first European health group to receive significant funding from the Madrid Health Service (SERMAS), at about 8% of the public health budget.

CREATION PROCESS OF QUIRÓNSALUD AND PURCHASE BY FRESENIUS-HELIOS FROM THE SHAREHOLDERS OF CVC CAPITAL



THE FRESENIUS GROUP

Fresenius, the group's 100% parent company, founded in 1912, was born in Germany and is the largest European health group, with more than 220,000 employees in 100 countries and a market capitalisation of around 36,000 million euros. Fresenius' activity is divided between the American (45%), European (39%) and Asian (10%) markets. It consists of four business branches: Fresenius Medical Care (formerly called Kidney Centers Holding), Fresenius Kabi, Fresenius Helios and Fresenius Vamed. The brand of Fresenius Medical Care dialysis services is NephroCare.

It is headquartered in Bad Homburg (Hesse, Germany), and is the largest publicly traded healthcare provider in Europe. The German giant, long considered number one in the sector in Europe, valued Quirónsalud as an international-level reference in the sector, as the Spanish company managed to consolidate its position among the best in the European continent very quickly.

Fresenius' main shareholder is the ElseKröner-Fresenius-Stiftung Foundation. This foundation has a 26.28% stake. The other shareholders are, mostly, global funds that make up the "superentity" of the global network of companies.

QUIRÓNSALUD

The private health giant of the Spanish State is also a leader in the management of publicly owned hospitals under concessions. Its short but intense and continuously rising trajectory began with the 2014 merger of IDC Salud (formerly Capio) - whose origin dates back to a small private clinic in Albacete - and Grupo Quirón - originally from Zaragoza.

With a market share of 14%, it is the fourth largest European operator and the leader in the Spanish State. During the company's existence the owners - Víctor Madera, for IDC, and the Quirón family - have carried out a concentration process taking advantage of the gradual deterioration in resources and the quality of care in the public health sector.

THE JIMÉNEZ DIAZ FOUNDATION (FJD AFTER ITS SPANISH ACRONYM): SINGULAR AGREEMENT MODEL

Even before the beginning of the implementation of the PPP model hospitals and even before the transfer of healthcare competencies to the Autonomous Community, there was already a Singular Agreement with the FJD. The FJD has always been a reference hospital, providing care to private patients.

Although the modifications intended to guarantee profit figures could be considered as part of the agreement signed in 2006 for a period of 10 years, the substantial change in the terms of the contract takes place in 2011, two months before the elections, extending the term of the previous one to 30 years. This means that the FJD has a contract signed until 2041.

This Agreement is tailored for advantageous conditions throughout the hospital's field of business. In recent years these conditions have passed through the hands of IDC, then Capio and in 2017 came the purchase of Quirónsalud by the German company Fresenius-Helios.

Since 2006 there have been changes in the Agreement signed by the Madrid Health Service (SERMAS) and the FJD that are beneficial for the Foundation. The highlights are:

→ The assigned population has increased, with a consequent increase in activity and, therefore, in funding.

→ The definitions of population areas have been modified in such a way that, in a very similar way to PPP hospitals, a concept of free choice is applied that exceeds the scope of the provisions of the law.

→ On the other hand, since they do not have a per capita financing contract, although the attention provided to the population included in this concept of "free choice" is paid per treatment, the attention provided by other centres to the population of its catchment area is not deducted.

This means that the termination of the contract, except for the legally established causes, would generate a compensation for loss of earnings that is probably unpayable.

6. Conclusions & Recommendations

In summary, the use of PPPs in public health has resulted in a process of under-financing of the public health system, which has therefore been underutilised, and the promotion of private initiatives without sufficient supervision. The healthcare lobbies like the PPP Forum (since 2017 Infrastructure Forum), IDIS Foundation, construction companies and private banking, have achieved an excessive and inopportune influence on decisions and strategies relating to public health heritage.

These strategies were designed to a large extent by private investors and transnational corporations that occupy the apex of global economic power. Their strategy is part of the programme of the global economic elite, and in fact funds such as the British CVC Capital Partners or the German Fresenius currently have signficant strategic influence over the Spanish healthcare system: the nerve centres of healthcare decisions are moving geographically and socially away from Spanish society.

In the process of privatisation of healthcare, corruption has been propitiated and payments have been deferred through “revolving doors” to politicians who have favoured private interests and have acted with hidden conflicts of interest. While public offices and business groups have been illicitly enriched, public health has been burdened with notable cost overruns, indebtedness and impoverishment in the quality of care for many users.

Through the analysis of the case of the Hospital de Villalba we can summarise:

- → In the process of privatisation of healthcare, corruption has been propitiated and payments have been deferred through “revolving doors” to politicians who have favoured private interests and have acted with hidden conflicts of interest.

- → We have seen the illicit enrichment of some public actors and beneficiary companies, while most citizens are being deprived of basic social rights.

- → We identify the generation of illegitimate debt and other possible causes of debt: ecological debt and social debt.

- → The healthcare lobbies (PPP Forum (since 2017 Infrastructure Forum), IDIS Foundation, construction companies and private banking) have achieved an excessive and inopportune influence on decisions and strategies relating to public health heritage.

- → The entry of investment funds such as the British CVC Capital Partners or as the German Fresenius into the Spanish health sector has been promoted, giving them strategic influence over Spanish healthcare.

We therefore recommend:

1 → QUESTIONING NEOLIBERAL POLICIES AND AUSTERITY MEASURES

The public sector is, above all, responsible for guaranteeing the economic, social, cultural and environmental rights (ESCRs) of citizens and should not put the interests of private investors above social policies. Public financing must be guaranteed via General State Budgets, through a progressive fiscal policy that guarantees the income necessary to cover social, economic, gender and environmental needs.

In this sense, the current article 135 of the Constitution must be repealed. With the modification of article 135 of the Constitution, the payment of debts is prioritised over any other expense including social expenditure. Debt has been, and still is, a mechanism for the domination of creditors over debtors, which has served as a lever to impose an economic model focused on neoliberalism. Through so-called austerity plans, debt causes the impoverishment of populations, the impairment of their economic, social and cultural rights and, finally, increased inequality.

Debt, as a justification for public service cuts, will prevent the dedication of the necessary public resources to the maintenance and improvement of the basic services for citizens and will justify the realisation of PPP projects.

At the same time, the European accounting policy that limits public finances with a comprehensive set of restrictions whilst granting laxity to the finances of private corporations must be abandoned. In this regard, we recommend reforming the European Accounting System (ESA 2010) to increase the public investment capacity of local, regional and national administrations throughout Europe, ending the rule that 100% of investments must be recorded on the date of implementation and replacing it with the usual annual depreciation practices.

2 → GUARANTEE THE RIGHT TO HEALTH AND HEALTH CARE AS A SERVICE AND COMMON GOOD FOR THE ENTIRE POPULATION LIVING IN A TERRITORY THROUGH PUBLIC AUTHORITIES AND PROHIBIT THE PPP MODEL IN SECTORS KEY TO GUARANTEEING ESCRS

Healthcare, education, transportation and infrastructure (among others), are common services and goods which the entire population living in a territory are entitled to. The right of access to these services must be shielded in the Constitution as a fundamental and protected right ahead of private interests.

Therefore, Law 15/97 on the authorisation of new forms of management of the Public Health System must be repealed. Point 2 of the single article of the Law says: "*The provision and management of health and socio-health services may be carried out, in addition to their own means, through agreements or contracts with persons or public or private entities, in the terms provided in the General Health Law*". This law opens the door to the privatisation of public healthcare and, among other things, the realisation of PPP agreements that are another form of privatisation. Repealing this law is essential.

3 → STRICT REGULATION, SUPERVISION, DEMOCRATIC MONITORING AND TRANSPARENCY WHILST MOVING TOWARDS A PUBLIC MODEL

While moving towards the prohibition of PPPs in sectors key to sustaining a healthy and dignified life, a set of legal measures must be implemented to guarantee the regulation, supervision, democratic monitoring and transparency of PPP projects. There is an urgent need to provide detailed and effective legislation and competent supervisory bodies to supervise and control the granting, execution and termination of PPPs, to avoid the serious failures of PPPs that are occurring in the short term, and in the longer term to move towards their prohibition.

→ The Independent Office of Regulation and Supervision of Public Procurement (**OIReScon**) should be endowed with real power to supervise and control PPP projects if necessary, taking into account public opinion through guaranteed participatory processes (see ODG publication "PPPs as tools for privatisation - The case of Spain").

→ A **multi-criteria evaluation of projects** must be carried out. Since PPPs can have economic, social environmental and gender impacts, they cannot be assessed only through an economic valuation. It is also necessary to take into account their social, environmental and gender dimensions, and therefore new evaluation criteria are needed. A multi-criteria analysis where these dimensions were taken into account would allow the comparison and evaluation of various forms of public financing against PPPs.

→ All r**isks to future public debt should be published explicitly and openly**, in order to ensure a proper risk assessment before a project begins.

→ Transparency: **All contracts, economic agreements, clauses and details, by law, must be made public and easily accessible for scrutiny by citizens**, through a transparency portal or other platform managed, for example, by OIReScon.

4 → DISCLOSURE OF THE REAL COSTS OF PPPs

Since PPPs are an expensive form of debt, responsible accounting practices should be adopted and the costs of PPPs should be included in national accounts, for example by publishing the clauses outlining the risks that the public administration assumes in each project that can turn into future public debts for society. These costs should be recognized as public debt and, therefore, would be part of the debt sustainability analysis.

5 → OFFICIAL AND CITIZEN AUDITING OF PPPs

In the case of failed projects - or those with serious financial, social, environmental and gender impacts - the public authority should be obliged to carry out an audit to assess the damage caused to public funds, society or the environment. In case of violation of the ESCRs by the private party, the public party should be obliged to claim compensation from the guilty parties. In any case, if an official audit is not carried out, we recommend that citizen audits be undertaken to assess possible illegitimate debts and promote their non-payment.

6 → PROMOTE FAIR, SOCIALLY AND ENVIRONMENTALLY SUSTAINABLE FORMS OF FINANCING AND MANAGING PUBLIC GOODS AND SERVICES

Public administrations can promote the creation of public-public **collaborations or concessions**, which are collaborations between a public body or a public authority and another non-profit organisation or organisation of general interest to provide services and / or facilities, aiming to transfer technical knowledge and experience. Although they are not yet sufficiently developed, these collaborations differ from PPPs in that they do not seek profitability but the transfer of knowledge and experience in the execution of projects. Through the **Public Sector Contracts Law**, commercial PPPs can be restricted and / or collaboration with **Social and Solidarity Economy (SEE)** entities can be promoted, whose objectives are social, environmental and gender sustainability. An alternative to public-private management of key services could be **public-community management**.

7 → PROPOSE CONCEPTS AND PROTOCOLS FOR THE MANAGEMENT AND LEADERSHIP OF HOSPITALS AND PUBLIC HEALTH THAT ARE ADVANCED AND CAPABLE OF CHALLENGING CAPITALIST SCHOOLS OF MANAGEMENT

The subordination of healthcare functions and staff organisation to criteria which are not related to healthcare or to correct professional practice (such as NPM and others) must be halted, and instead health and staff management codes and practices must be proposed which are consistent with good health practice, the good of the user community, which has a right to health, and professional ethics.

BOE (2000). *Ley Orgánica 4/2000, de 11 de enero, sobre derechos y libertades de los extranjeros en España y su integración social.* Jefatura del Estado, núm. 10, de 12/01/2000. Madrid.

BOE (2017). *Ley 9/2017, de 8 de noviembre, de Contratos del Sector Público.* Jefatura del Estado, núm. 272, de 9 /11/ 2017. Madrid.

Camacho, J., Orueta Díaz, F., Gadea M.E., Ginés, X., Lourés Seoane, M.L (2015): *Madrid: el agotamiento de un modelo urbano y la construcción de nuevas propuestas para una ciudad en transformación.* Quid 16, 5 pp.5-45.

Carroll, W. K. (2009). "Transnationalists and nacional networkers in the global corporate elite". Global Networks, 9 (3), 289-314.

CAS Madrid (comp) (2010): ¿Por nuestra salud? *La privatización de los servicios sanitarios.* Editorial Traficantes de Sueños. Madrid.

Comisión Europea (2004): *Libro verde. Sobre la colaboración publico-privada y el derecho comunitario en materia de contratación publica y concesiones.* Bruselas, 30.4.2004. 327 final.

Comisión Europea (2009). *Movilizar las inversiones públicas y privadas con vistas a la recuperación y el cambio estructural a largo plazo: desarrollo de la colaboración público-privada(CPP).* COM/2009/0615 final.

Comisión Europea (2011). *Libro verde. sobre la modernización de la política de contratación pública de la UE. Hacia un mercado europeo de la contratación pública más eficiente.* Bruselas, 27.1.2011, 15 final.

Comunidad de Madrid, Consejería de Sanidad (2010): *Contrato de gestión de servicio público en la modalidad de concesión firmado entre la Consejería de Sanidad y Capio Villalba SA.*
http://www.madrid.org/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobheadername1=Content-disposition&blobheadername2=cadena&blobheadervalue1=filename%3DContrato+Collado+Villalba.pdf&blobheadervalue2=language%3Des%26site%3DHospitalColladoVillalba&blobkey=id&blobtable=MungoBlobs&blobwhere=1352907056902&ssbinary=true

Comunidad de Madrid, Consejería de Sanidad (2010): *Pliego de Prescripciones Técnicas del Hospital de Villalba.*
http://www.madrid.org/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobheadername1=Content-disposition&blobheadername2=cadena&blobheadervalue1=filename%3DPPT+Villalba.pdf&blobheadervalue2=language%3Des%26site%3DHospitalColladoVillalba&blobkey=id&blobtable=MungoBlobs&blobwhere=1352905053715&ssbinary=true

Comunidad de Madrid, Consejería de Sanidad (2010): *Pliego de Cláusulas Administrativas del Hospital de Villalba*.
http://www.madrid.org/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobheadername1=Content-disposition&blobheadername2=cadena&blobheadervalue1=filename%3DPCAP+Villalba.pdf&blobheadervalue2=language%3Des%26site%3DHospitalColladoVillalba&blobkey=id&blobtable=MungoBlobs&blobwhere=1352905027379&ssbinary=true

Coordinadora Antiprivatización de la Sanidad Pública de Madrid (CAS Madrid) (2010). *¿Por nuestra salud? La privatización de los servicios sanitarios.* Traficantes de Sueños. Madrid.

Costas, A. (2014): Exceso de capitalismo concesional y rentista. El País, 23/02/2014.
https://elpais.com/economia/2014/02/21/actualidad/1392982265_238560.html

Eurodad (2018): *Historia repetida. Cómo fracasan las Colaboraciones Público-Privadas.* Informe coordinado por Eurodad. Barcelona.

Eurodad, FEMNET, Gender & Development Network (2019): *Can public-private-partnerships deliver gender equality?.* Briefing paper.

Gafo Álvarez, A. (2016): *La participación público-privada en los proyectos de inversión pública.* Tesis doctoral. Universidad de Cantabria.

Glattfelder, James and Battiston, Stefano. (2019). "The Architecture of Power: Patterns of Disruption and Stability in the Global Ownership Network" (January 12, 2019).
Disponible en SSRN: https://ssrn.com/abstract=3314648
o: http://dx.doi.org/10.2139/ssrn.3314648

Gómez Liébana, J.A. (Coord.) (2017): *Se vende Sanidad Pública. Todo lo que deberías saber sobre la privatización, pero nadie quiere contarte. Los Libros de la Catarata.* Madrid.

Hall, D. (2015): *¿Por qué las Colaboraciones Público-Privadas (CPPs) no funcionan? Las numerosas ventajas de la alternativa pública.* Public Services International Research Unit, Universidad de Greenwich, Reino Unido.

Harvey, David. (2004). *El nuevo imperialismo.* Ediciones Akal. Madrid.

Hernando Rydings, Mª (2012): *La Colaboración público-privada. Fórmulas Contractuales.* Madrid: Civitas.

Manifiesto internacional (2017): Las riesgosas Colaboraciones Público Privadas (CPP) activan las alarmas. Eurodad (entre otros).

Martínez-Alonso, J.L (2016): *"La Ley de racionalización y sostenibilidad de la Administración Local y su incidencia en los Sistemas de Bienestar"*. En Crisis, gobiernos locales y políticas urbanas. Ciudad y Territorio , XLVIII (188) (201-213).

Observatori del Deute en la Globalització (2013): *El fracaso del Consenso de Washington. La caída de su mejor alumno: Argentina.* Icaria. Barcelona.

Observatori del Deute en la Globalització (2017a): *Mega-infraestructura como mecanismo de endeudamiento. El riesgo de deuda ilegítima, ecológica y de género.* Barcelona.

Observatori del Deute en la Globalització (ODG) (2017b): *Colaboraciones o Concesiones Público-Privadas: el caso de las infraestructuras. Principales motivaciones y críticas después de dos décadas de CPPs*. Barcelona.

Observatori del Deute en la Globalització (ODG) (2018): *Los riesgos de las Concesiones Público Privadas en infraestructuras. El caso de Renace en Guatemala.* Barcelona.

OECD (2012): *Principles of Public Governance of Public-Private Partnerships.* Ed. OECD.

OMM (2007): *Madrid ¿la suma de todos? Globalización, territorio y desigualdad*. Madrid: Traficantes de Sueños.

Plataforma Auditoría Ciudadana de la Deuda ¡No debemos! ¡No pagamos! (PACD) (2013): ¿Por qué no debemos pagar la deuda? Razones y alternativas. Icaria Editorial SA. Barcelona.

Plataforma Auditoría Ciudadana de la Deuda ¡No debemos! ¡No pagamos! (PACD) (2014): Documento político colaborativo sobre ideas fuerza.

Rubio, M. (2014): *Tu salud, nuestro negocio. ¿Quién gana con el proceso de privatización de la Sanidad pública en España? La densa red de intereses económicos y políticos que amenaza el sistema público de Salud*. Ediciones Akal SA. Madrid.

Simón, Alfonso (2018): Blackstone afianza su cetro como mayor propietario inmobiliario de España. El País, 18/09/2018.
https://cincodias.elpais.com/cincodias/2018/09/17/companias/1537208709_558520.html

Tribunal de Cuentas Europeo (2018): *Colaboraciones público-privadas en la UE: Deficiencias generalizadas y beneficios limitados*. Informe especial 09/2018.

Vicente-Dávila, F. (2018): *Repensar la colaboración público-privada en los tiempos de crisis*. Observatorio de Contratación Pública.

Vitali, Stefania; Glattfelder, James, Battiston, Stefano. “The network of global corporate control”. En: http://arxiv.org/abs/1107.5728v2

World Bank Group. Public Private Partnership Legal Resource Centre. France: PPP Legislation and Regulation.

XSE (2018). *Tenimenergia! Reptes per transiciócap a la sobiraniaenergètica.* Xarxa per la Sobirania Energètica. Barcelona.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