

Response to call for input from the Office of the High Commissioner for Human Rights regarding its research on human rights-based pathways to achieving universal health coverage (UHC)

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The Human Rights and Privatization Project at CHRGJ is dedicated to advancing global understanding of the human rights impacts of privatization. This response has been prepared by the Project's Director, Rebecca Riddell, as well as CHRGJ Faculty Director and former UN Special Rapporteur on extreme poverty and human rights, Philip Alston.

The respondents commend the Office of the High Commissioner for examining human rights-based pathways to achieving universal health coverage. The topic is important and timely, given that not all paths taken in the name of achieving UHC are consistent with that goal, or rights-respecting.¹

In our response, we focus on the human rights risks associated with relying on the private sector to achieve universal health coverage.² We draw from our research on the rollout of universal health coverage in Kenya, and, in particular, seek to emphasize the risks of two common mechanisms for involving the private sector in healthcare: social health insurance schemes and public-private partnerships.

Human rights risks associated with reliance on the private sector

Private sector involvement in the financing and delivery of healthcare is often depicted as essential to achieving universal health coverage.³ Yet, relying on the private sector can instead undermine that goal.⁴ While in principle there may be rights-based pathways to achieving universal health coverage that involve a major role for the private sector, in practice the approach can result in a

¹ World Health Organization, *Making Fair Choices on the Path to Universal Health Coverage: Final Report of the WHO Consultative Group on Equity and Universal Health Coverage*, 2014, 37, <https://www.who.int/publications/i/item/9789241507158>; Helen Nygren-Krug, "The Right(s) Road to Universal Health Coverage," *Health and Human Rights Journal* 21 no. 2 (2019), 215-228, <https://www.hhrjournal.org/2019/12/the-rights-road-to-universal-health-coverage/>.

² Unless noted otherwise, the term "private," as used in this response, refers to for-profit private entities, and does not include not-for-profit or faith-based facilities.

³ See, e.g., Sofiat Akinola and Dessilava Dimitrova, "7 ways the private sector can contribute to universal health coverage," World Economic Forum, September 20, 2019, <https://www.weforum.org/agenda/2019/09/7-ways-the-private-sector-can-contribute-to-universal-health-coverage/>.

⁴ See, e.g., Sonja Kristine Kittelsen, Sakiko Fukuda-Parr and Katerini Tagmatarchi Storeng, "The Political Determinants of Health Inequities and Universal Health Coverage," *Globalization and Health* 15, no. 73 (2019): 1, <https://doi.org/10.1186/s12992-019-0514-6>.

healthcare system shaped by market forces that does not comply with a State's human rights obligations.⁵

In recent years, the Kenyan government and development actors have actively encouraged the growth of the private healthcare sector. National policies explicitly seek to expand the private sector's role,⁶ and former President Uhuru Kenyatta, cabinet members, and other high-level officials have referenced the central role of the private sector in achieving universal health coverage.⁷ While public facilities have traditionally provided most healthcare services, and still did so as of the most recent national survey on health utilization in 2018,⁸ as a result of government policy, the role of private healthcare providers is rapidly growing.⁹

However, as Kenya's experience illustrates, when a government increases the role of the private sector in health without due care, even if it does so under the auspices of seeking to achieve universal health coverage, it can exacerbate rather than alleviate problems like high costs, exclusion, and inequalities in access to care—and ultimately harm the enjoyment of the right to health. For example, our research in Kenya found that private healthcare facilities charge far more than the public sector for the same services, and we spoke with many individuals who had been pushed into debt to pay for expensive private care, or who had been turned away from private facilities or stopped care altogether due to their inability to pay.¹⁰ We also found that the private sector is disproportionately focused on the areas, patients, and services that generate the greatest revenue while neglecting important but less-profitable forms of care—such as immunizations, treatment for HIV/AIDS and services for survivors of sexual abuse. And despite the common association of the private sector with high quality care, the sector is actually highly heterogeneous; while a wealthy urban minority can often access high-quality private care, many people end up accessing healthcare at private facilities that are substandard, underregulated, and too often, unsafe.¹¹ Finally, although it is frequently depicted as alleviating a fiscal burden, the private sector

⁵ For a more extensive legal analysis, see Human Rights Centre Clinic at the University of Essex, The Global Initiative for Economic, Social and Cultural Rights (GI-ESCR), and the Initiative on Social and Economic Rights (ISER), *Private Actors in Health Services: Towards a Human Rights Impact Assessment Framework*, 2019, 27-30, <https://static1.squarespace.com/static/5a6e0958f6576ebde0e78c18/t/5dfb832f7894511787b02d52/1576764300874/Private+Actors+and+the+Right+to+Health+Report+-+December+2019.pdf>.

⁶ See, e.g., Kenya Health Sector Strategic Plan 2018-2023, which calls for expanding the role of private healthcare and financing through private insurance products, specialized private hospitals, and other public-private partnerships. Ministry of Health, *Kenya Health Sector Strategic Plan*, 2018, 53, 70, 71, 77, <https://www.health.go.ke/wp-content/uploads/2020/11/Kenya-Health-Sector-Strategic-Plan-2018-231.pdf>.

⁷ See, e.g., “Kenya Encourages Private Sector Investment in the Health Sector,” Ministry of Health, October 31, 2019, <https://www.health.go.ke/kenya-encourages-private-sector-investment-in-the-health-sector/>; John Muchangi, “Private Hospitals to Get UHC Cash,” *The Star*, September 6, 2019, <https://www.the-star.co.ke/news/2019-09-06-private-hospitals-to-get-uhc-cash/>.

⁸ A 2018 national survey found that 56.7% of outpatient visits occurred at government hospitals, health centers, and dispensaries, and that 51.7% of inpatient admissions occurred at government hospitals or health centers. Ministry of Health, *2018 Household Health Expenditure and Utilization Survey*, 2018, 21, 42, <https://pdfcoffee.com/2018-khheus-report-04072018-pdf-free.html>.

⁹ The Economic and Social Rights Centre-Hakijamii and CHRGI, *Wrong Prescription: The Impact of Privatizing Healthcare in Kenya*, 2021, 12, <https://chrgj.org/kenya-health/>.

¹⁰ Hakijamii and CHRGI, *Wrong Prescription*, 18-19, 33.

¹¹ Hakijamii and CHRGI, *Wrong Prescription*, 23-27.

actually relies heavily on public funding, raising questions about whether maximum available resources are being dedicated to the realization of the right to health.¹²

While the human rights risks associated with highly privatized and commercialized healthcare systems are certainly not new, the momentum behind involving the private sector in the achievement of universal health coverage gives the issue fresh urgency.

Social health insurance as a form of stealth privatization

Establishing or expanding social health insurance coverage that can be used at public and private health facilities has been presented as one way for countries to achieve universal health coverage. Kenya's experience demonstrates some of the potential human rights pitfalls of that approach. The country's flagship policy for achieving universal health coverage—making insurance coverage from the country's existing social health insurance entity, the National Hospital Insurance Fund (NHIF), mandatory nationwide—has the potential to transform the government from a provider to a purchaser of healthcare, without adequately addressing the human rights risks associated with private sector care.¹³

In 2017, Kenya's then-President Kenyatta committed his administration to the realization of universal health coverage. Following a pilot phase, the government announced it would deliver universal health coverage primarily by expanding insurance through the NHIF.¹⁴ The NHIF Amendment Act, which codifies this approach and which received presidential assent January 10, 2022, cements the NHIF as *the* primary route for pursuing universal health coverage.¹⁵ It represents a major departure from the pilot phase of UHC, which had eliminated fees at public facilities in four counties with considerable success.¹⁶

By choosing social health insurance as the primary vehicle for achieving UHC, rather than the existing public healthcare system, the government is much more deeply embedding the private sector's role in the healthcare system. Although the NHIF encompasses both private and public facilities, in recent years, its spending has rapidly shifted toward the private sector. Between 2010

¹² Hakijamii and CHRGI, *Wrong Prescription*, 24.

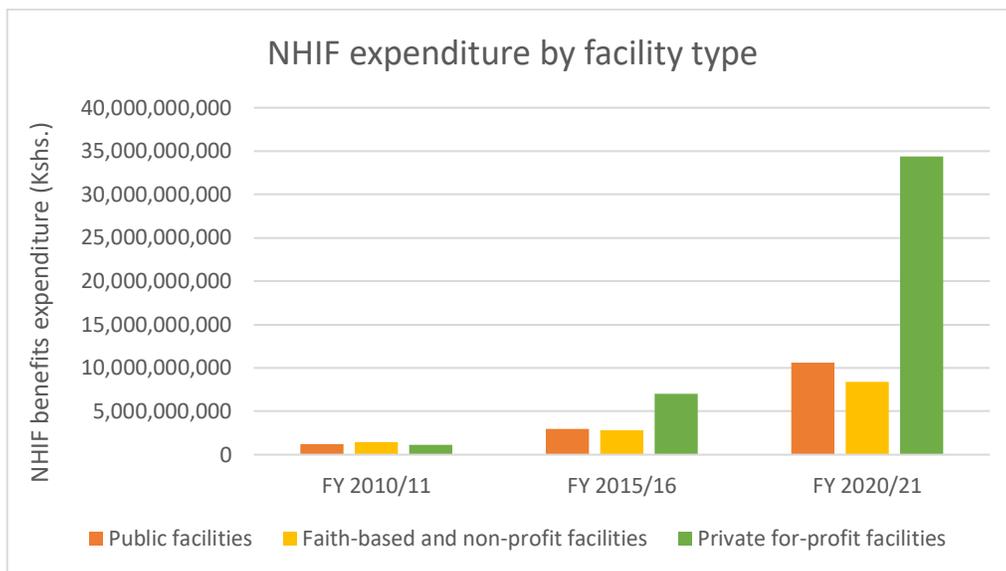
¹³ Bassam Khawaja and Rebecca Riddell, "Stealth privatization: Kenya's approach to universal health coverage is a private sector giveaway," *OpenGlobalRights*, May 20, 2022, <https://www.openglobalrights.org/stealth-privatization-kenyas-approach-to-universal-health-coverage-is-a-private-sector-giveaway/?lang=English>. There are additional concerns about the contributory social insurance approach, such as the risks of exclusion due to the cost of mandatory contributions, that are beyond the scope of the submission.

¹⁴ "Speech by His Excellency Hon. Uhuru Kenyatta, C.G.H.," Statements and Speeches, president.go.ke, October 31, 2020, <https://www.president.go.ke/2020/10/31/speech-by-h-e-uhuru-kenyatta-president-of-the-republic-of-kenya-and-commander-in-chief-of-the-kenya-defence-forces-during-the-launch-of-biometric-registration-for-universal-health-coverage-scheme-be/>.

¹⁵ See Kenya, The National Hospital Insurance Fund (Amendment) Act, 2022, http://kenyalaw.org/kl/fileadmin/pdfdownloads/Acts/2022/TheNationalHospitalInsuranceFund__Amendment_Act_No1of2022.pdf; see also "President Kenyatta Launches UHC National Roll Out," Presidential Strategic Communication Unit, February 7, 2022, <https://www.president.go.ke/2022/02/07/president-kenyatta-launches-uhc-national-roll-out/>.

¹⁶ Derrick Okubasu, "830K People Stranded as Governor Scraps Uhuru's Free Healthcare Project," *Kenyans.co.ke*, August 26, 2020, <https://www.kenyans.co.ke/news/56765-830k-people-stranded-governor-scraps-uhurus-free-healthcare-project>.

and 2021, the insurer’s payouts to for-profit private healthcare facilities rose more than 30-fold, vastly outstripping increases for public facilities. In 2011, 32 percent of total spending on benefits went to public facilities and 30 percent to private for-profits. Just 10 years later, payouts to for-profits had soared to 64 percent (about 289 million USD), while just 20 percent went to public facilities (see chart below).¹⁷



Unfortunately, the adoption of social health insurance does not, by itself, remedy many of the human rights risks associated with the private sector. In part this is because, absent stringent regulations, the private sector still has free reign to operate in ways that maximize profits, even if they undermine rights. For example, under current arrangements in Kenya, private facilities are able to charge patients on top of what the insurance covers, and often do so. In carrying out our research in Kenya, we spoke with many individuals who said they faced high and unaffordable costs at private providers and incurred debt to pay for care, despite having NHIF insurance coverage.¹⁸ Social insurance as currently structured also offers no incentives for private providers to shift their attention away from more profitable areas, services and patients.

It’s also not clear that the State gets good value for money. Instead, limited resources may be diverted to undue private profit. Although the insurer’s contracts with private facilities are—problematically—not publicly available, the NHIF has confirmed that it reimburses private facilities at higher rates than public facilities for the same services.¹⁹ According to media reports,

¹⁷ “Annex: Questions for the National Hospital Insurance Fund,” NHIF, March 12, 2022, <https://chrgj.org/wp-content/uploads/2022/03/NHIF-response-to-CHRGJ-query.pdf>.

¹⁸ Hakijamii and CHRGI, *Wrong Prescription*, 40.

¹⁹ “Annex: Questions for the National Hospital Insurance Fund,” NHIF, March 12, 2022, 4, <https://chrgj.org/wp-content/uploads/2022/03/NHIF-response-to-CHRGJ-query.pdf>. Limited information available in scholarship and media reports confirms that the NHIF reimburses private facilities at higher rates than public facilities for certain services. See, e.g., Gabriella Appleford and Edward Owino, *National Hospital Insurance Fund Tariffs: What are the Effects on Amua Franchisee Businesses?* (London: Marie Stopes International, 2018), 5, <https://hanshep.org/our-programmes/AHMEResources/case-study-national-hospital-insurance-fund-tariffs>.

the private sector blocked recent NHIF reforms meant to put it on a level playing field with the public sector, refusing to offer services if the reforms were implemented.²⁰

Supporters of social insurance often refer to countries where private providers deliver care under tightly regulated national social insurance programs. However, these programs are often highly context specific, have evolved over decades, and are not necessarily easy to duplicate.²¹ For example, Japan's social insurance program is strictly regulated, reimburses private and public providers equally, determines reimbursement rates through a rigorous and transparent process that firmly limits total expenditure, and generally prohibits private providers from billing patients.²² Importing social insurance models without strong safeguards, intensive regulation, participation, and transparency, could leave people vulnerable to widespread violations of the right to health.

Public-private partnerships carry considerable human rights risks

Public-private partnerships (PPPs) are one of the principal mechanisms for involving private actors in healthcare and are often presented as playing a critical role in the achievement of universal health coverage. PPPs are long-term contractual arrangements in which the private sector takes on a significant role in providing health infrastructure or services in return for revenue in the form of user fees, government funding, or some combination of the two.²³ Proponents sometimes argue the approach provides cash-strapped governments with an efficient, affordable route to UHC.²⁴

Unfortunately, the evidence shows that public-private partnerships often fail to deliver. A wide range of voices have raised concerns about public-private partnerships' failures to achieve development goals and to meet the needs of historically unserved and marginalized groups, including poor households, women, and people in rural areas.²⁵ Others have raised concerns about the costs of public-private partnerships, which are often more expensive over time than public

²⁰ The Star, "Private hospitals have jumped the gun on NHIF," January 2022, <https://www.the-star.co.ke/opinion/leader/2022-01-29-editorial-private-hospitals-have-jumped-the-gun-on-nhif/>; Capital FM, "Kenya: MPs to Meet With Private Hospitals, NHIF Over Stand-Off," February 3, 2022, <https://allafrica.com/stories/202202030438.html>.

²¹ Mary Suma Cardoso, et al., "How to Sustainably Finance Universal Health Care," *Inter Press Service*, August 10, 2021, www.ipsnews.net/2021/08/sustainably-finance-universal-health-care/.

²² See Naoki Ikegami, "Japan: Achieving UHC by Regulating Payment," *Globalization and Health* 15, no. 72 (2019), <https://doi.org/10.1186/s12992-019-0524-4>.

²³ There is no single universally accepted definition of a PPP. For additional background on varying definitions and analysis of the different forms of private sector participation, see World Bank, *Public-Private Partnerships: Reference Guide Version 3*, 2017, 6-12, <http://hdl.handle.net/10986/29052>.

²⁴ Dalene Van Greune and Fernando Faria, "The Triple Win: Rethinking public private partnerships for universal healthcare," KPMG, September 2017, <https://home.kpmg/xx/en/home/insights/2017/09/the-triple-win-rethinking-public-private-partnerships-for-universal-healthcare.html>; Nasrin Joudyian, et al., "Public-private partnerships in primary health care: a scoping review," *BMC Health Serv Res* 21, 4 (2021), <https://doi.org/10.1186/s12913-020-05979-9>.

²⁵ See, e.g., María José Romero and Julia Ravenscroft, eds., *History RePPPeated - How public-private partnerships are failing*, Eurodad, 2018, <https://www.eurodad.org/historyrepppeated>.

procurement.²⁶ They frequently entail significant, binding, and unpredictable costs, including fees for preparation, frequent renegotiations, subsidies, and guarantees to the private sector.²⁷

Kenya's experience offers a cautionary tale about the risks of overreliance on public-private partnerships to achieve UHC. Since 2013, Kenya, has undertaken a massive effort to get its PPP program off the ground, taking out US \$90 million in loans from the World Bank²⁸ and making major law and policy reforms.²⁹ The Kenyan PPP Directorate considers public-private partnerships in health to “have a number of benefits compared to ... traditional tax-funded arrangements,” including “efficiency” and “better value for money.”³⁰ However, the track record of PPPs in health stands as a stark rebuke to these claims.

One controversial PPP, known as Managed Equipment Services (MES), demonstrates the human rights risks of such deals—including due to its mismatch with healthcare needs, significant cost and poor value for money, and extreme lack of transparency. This high-profile, seven-year arrangement with five global companies to equip 119 public Kenyan hospitals with leased medical equipment was heralded as a success by some—including in industry-authored blogs published by the World Bank.³¹

However, it drew significant scrutiny from civil society organizations, officials, and others amidst widespread reports that some of the equipment was never delivered, substantially delayed, or was

²⁶ Timothy Irwin, et al., *How to Control the Fiscal Costs of Public-Private Partnerships*, International Monetary Fund, 2018, 1, <https://www.imf.org/en/Publications/Fiscal-Affairs-Department-How-To-Notes/Issues/2018/10/17/How-to-Control-the-Fiscal-Costs-of-Public-Private-Partnerships-46294>; James Leigland, “Public-Private Partnerships in Developing Countries: The Emerging Evidence-Based Critique,” *The World Bank Research Observer* 33, no. 1 (2018): 108, 123, <https://doi.org/10.1093/wbro/lkx008>; European Court of Auditors, *Public Private Partnerships in the EU: Widespread Shortcomings and Limited Benefits*, 2018, 10, https://www.eca.europa.eu/Lists/ECADocuments/SR18_09/SR_PPP_EN.pdf; European Court of Auditors, *Public Private Partnerships in the EU: Widespread Shortcomings and Limited Benefits*, 2018, 10, https://www.eca.europa.eu/Lists/ECADocuments/SR18_09/SR_PPP_EN.pdf.

²⁷ Kate Bayliss and Elisa Van Waeyenberge, “Unpacking the Public Private Partnership Revival,” *Journal of Development Studies* 54, no. 4 (2018), 586: <https://doi.org/10.1080/00220388.2017.1303671>; Alessandra Cepparulo, et al., “Public Private Partnership and Fiscal Illusion: A Systematic Review,” *Journal of Infrastructure Policy and Development* 3, no. 2 (2019): 299, <http://dx.doi.org/10.24294/jipd.v3i2.1157>; Leigland, “Public-Private Partnerships,” 110, 112; World Bank, *Public-Private Partnerships: Reference Guide*, 23-24.

²⁸ For more on the Infrastructure Finance and PPP Project, see World Bank, *Kenya: Enabling Private-Sector Participation in Infrastructure and Social Services*, April 2018, <https://www.worldbank.org/en/about/partners/brief/kenya-enabling-private-sector-participation-in-infrastructure-and-social-services>. See also “Kenya Infrastructure Finance/PPP project,” World Bank, accessed February 24, 2020, <https://projects.worldbank.org/en/projects-operations/project-detail/P121019>.

²⁹ See, e.g., Kenya, “Third Medium Term Plan 2018-2022,” 2018, p. vi, <http://vision2030.go.ke/wp-content/uploads/2019/01/THIRD-MEDIUM-TERM-PLAN-2018-2022.pdf>.

³⁰ PPP Directorate, email message, October 6, 2021, 2-3, <https://chrgj.org/wp-content/uploads/2021/11/Response-from-PPP-directorate.pdf>.

³¹ Monish Patolawala, “Transforming Kenya’s Healthcare System: A PPP Success Story,” *World Bank Blogs*, May 24, 2017, <https://blogs.worldbank.org/ppps/transforming-kenya-s-healthcare-system-ppp-success-story>; Cynthia Olotch, “How Managed Equipment Services in Kenya Help the Private Sector Contribute to Healthcare,” *World Bank Blogs*, January 4, 2018, <https://blogs.worldbank.org/ppps/how-managed-equipment-services-kenya-help-private-sector-contribute-healthcare>.

unusable due to lack of infrastructure and staff.³² A Kenyan Senate committee investigation largely confirmed these reports and concluded that five years into the project, despite making annual payments, some counties still lacked functioning equipment with key items like x-ray machines, CT scanners, and surgical theatres unavailable or nonfunctional in many places.³³

The deal was estimated to cost more than Kshs. 60 billion (over USD \$500 million).³⁴ This constitutes a significant portion of the government's limited resources: in the 2021/22 national budget, the government allocated 6 percent of its total health spending to the PPP, about half of what it allocated to the entire rollout of universal health coverage,³⁵ while counties also reported spending up to 14 percent of their annual health budgets on the deal.³⁶ Meanwhile, private actors have derived significant returns from the project, with CEOs of Philips and General Electric boasting about the deal on earnings calls.³⁷ It also appears that some of the equipment was significantly overpriced, with Ministry of Health records suggesting pieces of equipment were leased at many times their normal market price, and counties reporting they had procured similar equipment at a fraction of the lease cost.³⁸

An extreme lack of information about the public-private partnership has fundamentally challenged efforts at scrutiny and oversight by civil society, oversight bodies, county authorities, and even members of the cabinet.³⁹ County officials report being forced to sign off on the project before

³² See, e.g. Crystal Simeoni and Wangari Kinoti, *Medical Equipment Leasing in Kenya: Neocolonial Global Finance and Misplaced Health Priorities*, DAWN, 2020, https://dawnnet.org/wp-content/uploads/2021/01/Medical-Equipment-Leasing-in-Kenya_Neocolonial-Global-Finance-and-Misplaced-Health-Priorities_DAWN-discussion-paper-25.pdf; John Mutua, "Taxpayers Paid 6 Times More for GE Hospital Machine," *Business Daily*, November 25, 2019, <https://www.businessdailyafrica.com/economy/Taxpayers-paid-6-times-more-for-GE-hospital-machine/3946234-5362374-4j8ch0z/index.html>; Ibrahim Oruko, "Medical Kits 'Lying Idle' in 27 Counties," *The Nation*, October 22, 2019, <https://allafrica.com/stories/201910230354.html>; "Tana River's Sh800m Idle Medical Machines," *The Standard*, November 11, 2019, <https://www.standardmedia.co.ke/coast/article/2001348873/tana-river-s-sh800m-idle-medical-machines>; Roselyn Obala and Jacob Ng'etich, "How Sh63 Billion Health Project Bleeds Taxpayers," *The Standard*, December 1, 2018, [standardmedia.co.ke/health-science/article/2001304678/how-sh63-billion-health-project-bleeds-taxpayers](https://www.standardmedia.co.ke/health-science/article/2001304678/how-sh63-billion-health-project-bleeds-taxpayers); Angela Oketch and Samwel Owino, "How Uhuru's MES health care scheme went to the dogs," *The Nation*, October 4, 2020, <https://nation.africa/kenya/news/how-uhuru-s-mes-health-care-scheme-went-to-the-dogs-2456164>.

³³ Senate Ad-Hoc Committee to Investigate the Managed Equipment Services, *Report of the Investigation of the Managed Equipment Services*, September 2020, 203-205, 240-241, https://www.kelinkkenya.org/wp-content/uploads/2020/09/Final-Version-of-MES-Committee-Report-for-Tabling_08092020.pdf.

The report was ultimately not adopted by the Senate.

³⁴ John Mutua and Noah Wamalwa, *Leasing of Medical Equipment Project in Kenya: Value for Money Assessment*, Institute of Economic Affairs, 2020, 6, 13-15, <https://ieakenya.or.ke/download/leasing-of-medical-equipment-project-in-kenya-value-for-money-assessment/>.

³⁵ Parliamentary Budget Office, *Unpacking the Estimates of Revenue and Expenditure for 2021/2022 and the Medium Term*, May 2021, 11-12, [http://www.parliament.go.ke/sites/default/files/2021-05/Unpacking of the FY 2021-22 budget.pdf](http://www.parliament.go.ke/sites/default/files/2021-05/Unpacking%20of%20the%20FY%2021-22%20budget.pdf).

³⁶ Mutua and Wamalwa, *Leasing of Medical Equipment Project in Kenya*, 18.

³⁷ General Electric Co., *Edited Transcript: GE - Q2 2015 General Electric Co Earnings Call*, 2015, 3, 6, https://www.ge.com/sites/default/files/ge_webcast_transcript_07172015_1.pdf; Philips, *Edited Transcript: Q1 2015, Koninklijke Philips NV Earnings, April 28, 2015*, 2015, <https://www.results.philips.com/publications/q115/downloads/files/en/philips-first-quarter-results-2015-transcript.pdf?v=20210726183841>.

³⁸ Senate Ad-Hoc Committee, *Report of the Investigation of the Managed Equipment Services*, 101-02.

³⁹ Mutua and Wamalwa, *Leasing of Medical Equipment Project in Kenya*, 11.

they could review the terms of the contracts and not knowing what equipment they would receive.⁴⁰ Even the former Attorney General said his office was denied access to the contracts, despite his responsibility for scrutinizing and approving them to ensure their compliance with the Constitution and other relevant laws.⁴¹

Another recent proposed PPP—which would have established a for-profit, user-fee funded private hospital on the campus of Kenya’s premier public hospital—was quickly condemned by civil society actors and medical professionals, who expressed concerns that it would entrench, rather than address, inequality in access to healthcare and ignore urgent public health needs.⁴² According to 2019 bidding documents, the private sector operator would have had near complete discretion over what services it would offer and what fees it would charge.⁴³ The Kenya Medical Practitioners Pharmacists and Dentists Union sued the Ministry of Health and the hospital board, alleging that the new private hospital would lead to discrimination in healthcare provision.⁴⁴ As of October 2021, the project appeared on hold, with the PPP authority reporting that the officials were considering restructuring the deal due to a non-responsive tender process.⁴⁵

Many of these issues—including concerns about who benefits, high costs to the state, and lack of transparency—are not unique to these deals or to Kenya. Many have been observed in other contexts as well.⁴⁶ While some promote public-private partnerships as a win-win approach for delivering universal health coverage, the suitability of PPPs for achieving UHC or delivering on the right to health is far from proven.

In closing

Our experience is that much of the advice offered to policymakers treats private sector goals as inherently aligned with the achievement of universal health coverage. The reality is that relying on the private sector to deliver UHC is, at best, extremely tricky to get right. Kenya’s attempt to achieve UHC largely by relying on the private sector is a cautionary tale. The country’s experience

⁴⁰ Joy Kirigia, “Public Disservice, Kenya: Shiny New Useless Machines,” *Africa Uncensored*, July 3, 2019, <https://africauncensored.online/public-disservice-kenya/>.

⁴¹ Rawlings Otieno, “Former AG Faults CS Macharia on Multi-Billion Medical Leasing Deal,” *The Standard*, July 23, 2020, <https://www.standardmedia.co.ke/business/article/2001379751/former-ag-faults-cs-macharia-on-multi-billion-medical-leasing-deal>.

⁴² See Lukoye Atwoli, “KNH Deal is a Scam; Thought You Should Know,” *The Nation*, October 19, 2019, <https://nation.africa/kenya/blogs-opinion/opinion/knh-deal-is-a-scam-thought-you-should-know-214688>.

⁴³ Kenyatta National Hospital Board, *Clarification No 1*, November 2019, 2, https://knh.or.ke/wp-content/uploads/2019/12/Clarification-No.-1-KNH-PPP_RFQ_01_2019-2020-29Nov2019.pdf; Kenyatta National Hospital, *The Proposed KNH Private Hospital PPP*, 31.

⁴⁴ Kenya Medical Practitioners Pharmacists and Dentists Union v. Kenyatta National Hospital Board & Others, petition 452 (High Court of Kenya, Constitution and Human Rights Division 2019), para. 24.

⁴⁵ PPP Directorate, email message, October 6, 2021, 1, <https://chrgj.org/wp-content/uploads/2021/11/Response-from-PPP-directorate.pdf>.

⁴⁶ See, e.g., ISER, *Achieving Equity in Health: Are Public Private Partnerships the Solution?*, 2019, <https://iser-uganda.org/publication/achieving-equity-in-health-are-public-private-partnerships-the-solution/>; María José Romero and Bodo Ellmers, “The Financial and Social Cost of Public–Private Partnerships,” in *Sovereign Debt and Human Rights*, eds. Ilias Bantekas and Cephias Lumina (Oxford: Oxford University Press, 2019), DOI: 10.1093/oso/9780198810445.003.0007; Mariateresa Torchia, Andrea Calabrò and Michèle Morner, “Public–Private Partnerships in the Health Care Sector: A systematic review of the literature,” *Public Management Review*, 17:2, 2015, 236-261, DOI: 10.1080/14719037.2013.792380.

shows that two common approaches for involving the private sector—social health insurance and public-private partnerships—leave healthcare systems vulnerable to the pitfalls of privatization and commodification, and can place human rights at risk. If the private sector is to be involved in the push to achieve UHC, such involvement must be exceedingly carefully designed and managed to ensure that it will meet the basic requirements of universal health coverage and fulfill a state’s human rights obligations. Alternatives, such as using tax revenue to fund a public healthcare system that is free at point of use, may be more progressive and financially sustainable, and more likely to ensure the right to health.⁴⁷

The respondents thank the Office of the High Commissioner for its consideration.

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⁴⁷ See, e.g., Vincent Okungu, Jane Chuma, and Di McIntyre, “The Cost of Free Health Care for All Kenyans: Assessing the Financial Sustainability of Contributory and Non-Contributory Financing Mechanisms,” *International Journal for Equity in Health* 16, no. 39 (2017), <https://doi.org/10.1186/s12939-017-0535-9>.