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Public - Private Partnerships in Healthcare: A Literature Review

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Abstract

As fiscal pressures intensify and healthcare needs continue to rise, public-private partnerships have evolved into a central policy response to close enduring gaps in infrastructure, financing, and service efficiency. This paper presents an integrative literature review of PPPs in healthcare sector, exploring their theoretical foundations and examining their conceptual underpinnings and the empirical results. Based on evidence from scholarly publications, institutional analyses, and international policy sources, the review highlights findings across diverse contexts from both advanced and developing economies.

Findings reveal that PPPs can markedly advance healthcare access, efficiency, and quality when backed by strong institutional capacities, clear governance mechanisms, and fair risk sharing. While case studies from Morocco, Iran, and Lesotho demonstrate the positive impact of PPPs on hospital functioning and patient care, other studies underscore persistent challenges such as budgetary exposure, governance deficits, and the growing financialisation of the healthcare sector.

According to the study, PPPs should not be viewed as a universal solution but rather as a governance approach whose success relies on robust state capacity, sound regulatory frameworks, and consistent policy alignment. When thoughtfully designed and efficiently implemented, PPPs

can enhance the pursuit of equitable, efficient, and durable healthcare systems, notably within settings facing fiscal and infrastructural constraints.

Keywords: Public private partnerships, Healthcare Governance, Institutional Capacity, Health Service Performance

Introduction

Global health systems are increasingly challenged to sustain equitable, efficient, and resilient service delivery in light of demographic transitions, epidemiological shifts, and fiscal austerity. The combined effects of expanding healthcare demand, technological progress, and limited public budgets have driven health spending to unprecedented levels. According to the World Health Organization low- and middle-income nations face an annual shortfall exceeding USD 371 billion to reach the Sustainable Development Goals (SDGs) related to health. These systemic challenges have encouraged policymakers to adopt innovative funding and governance models that can leverage additional investment without undermining the principle of universal healthcare access.

In this context, PPPs have gained prominence as a strategic approach to modernizing healthcare systems, expanding access to care, and improving institutional efficiency. By integrating public oversight with private financing and managerial capabilities, PPPs seek to address funding shortfalls and stimulate innovation in health service delivery. Over the last three decades, many countries including the United Kingdom, Australia, Morocco, Iran and South Africa have embraced PPP arrangements to fund hospitals, diagnostic platforms, and specialized treatment centres. Their rationale rests on principles of shared risk, improved accountability, and value-for-money outcomes. Nevertheless, empirical evidence remains ambivalent: while many evaluations reveal significant improvements in infrastructure and service quality, others expose challenges linked to fiscal exposure, lack of transparency, and the increasing commodification of healthcare.

The diversity of PPP outcomes has revitalised theoretical discussions on the determinants of their capacity to create public value. Various theoretical frameworks have been widely used to explain performance variations; however, comparative research across institutional environments remains underdeveloped, particularly in developing and emerging economies, where institutional and legal settings diverge markedly from those of industrialised economies. Moreover, critical perspectives warn that when regulatory oversight is weak, PPPs may alter the nature of healthcare provision, prioritising profit generation over social welfare and thus jeopardising both equity and accountability.

Within this framework, the study undertakes an integrative review that unifies theoretical debates and empirical evidence on PPPs within the health sector. It investigates how governance structures, institutional strength, and contractual configurations affect the ability of PPPs to deliver health services, emphasising experiences in emerging economies. By combining global evidence with locally grounded analysis, the paper contributes to a more balanced understanding of PPPs as situational governance mechanisms whose effectiveness relies on strong state oversight, financial resilience, and alignment with national health policy priorities.

This article contributes to the existing literature in several ways. First, it provides an integrative synthesis that combines conventional theoretical approaches to public–private partnerships, such as agency theory, transaction cost economics, and incomplete contract theory, with critical perspectives rooted in financialisation and political economy. Second, the review places particular emphasis on emerging and developing economies, with specific attention to the MENA region, which remains underrepresented in the empirical literature on healthcare PPPs. Third, by conceptualizing PPPs not merely as financing instruments but as hybrid governance mechanisms, the paper offers a nuanced framework for understanding how institutional capacity, regulatory quality, and contractual design jointly shape healthcare outcomes. This approach allows for a more balanced assessment of PPPs beyond ideological polarization, highlighting the conditions under which they can contribute to sustainable and equitable health systems.

Theoretical background

The participation of private actors in healthcare through the management of hospitals and clinics, reliance on user charges, and the outsourcing of auxiliary services including patient transport, infrastructure maintenance, and equipment management (Birn et al., 2016), has long formed an integral part of national health systems, rather than a contemporary novelty. Calls to expand private participation began in the 1980s and accelerated throughout the 1990s, notably following the release of the World Development Report 1993: *Investing in Health* (World Bank, 1993), which framed private engagement as a pathway to greater efficiency, innovation, and fiscal sustainability in health financing.

Since the early 2000s, private-sector engagement in healthcare has undergone a profound structural transformation. Whereas the sector was previously dominated by non-financial actors—such as corporate hospital networks, clinical service providers, and philanthropic organisations—it has increasingly attracted financial investors, including private equity firms, pension funds, investment funds, and specialised financial vehicles (Dentico, 2019; PSI, 2021; Cordilha, 2022a; Sriram et al., 2024). This shift reflects a

transition from traditional service provision toward financial intermediation, whereby healthcare assets are increasingly treated as investment products capable of generating stable long-term returns. As healthcare becomes progressively financialised, the boundaries between public obligation and private profit grow blurred, giving rise to renewed debates over equity, accountability, and the governance of health services. Fueled by the global "private turn" in development finance, this reorientation embeds health systems within a policy agenda that emphasises mobilising private capital for the provision of public goods (Hunter & Murray, 2019).

Health public–private partnerships are generally described as long-term agreements between public authorities, including central governments, local administrations, and ministries such as Health. These agreements generally focus on large-scale public assets, including hospital construction, facility management, and the provision of non-clinical services essential to maintaining continuity of care in public institutions. and private partners for the development, funding, and management of essential healthcare facilities and services. The private partner, either a single company or a consortium formed into a special purpose vehicle (SPV), is assigned specific responsibilities that may include design, construction, financing, operation, or maintenance. In return, it receives compensation through a predetermined revenue mechanism, funded by user charges, government payments, or a mix of both. Even though PPPs are justified by claims of shifting risk and managerial expertise to the private actor, the state retains ultimate accountability for healthcare provision (Stafford et al., 2022). This reflects the hybrid architecture of PPPs, where private actors operate within a framework of public oversight to meet social and policy-oriented goals.

PPPs in the health sector are often categorised according to how responsibilities and risks are divided between the public and private partners (Montagu & Harding, 2012; PwC, 2018). These arrangements vary in the extent of private-sector engagement, from design–build–finance models to comprehensive contracts covering operation and maintenance, each supported by specific mechanisms of remuneration and risk allocation. Yet, as underscored by Romero and Van Waeyenberge (2020), an overly typological emphasis can mask the deeper structural reconfiguration that PPPs entail. Beyond their contractual configuration, PPPs contribute to the redefinition of public health infrastructure as privately monetised assets. National and international institutions play a pivotal role in enabling this shift through regulatory frameworks, financial support instruments, and policy measures that incentivise private capital participation. Payment modalities are defined contractually and may take the form of availability payments, performance-linked fees based on service quality metrics, or user charges collected from patients. The configuration adopted reflects the

negotiated balance between public control and private initiative that shapes PPP governance in the healthcare sector (World Bank, 2017; Yescombe, 2018).

Theoretically, PPPs have been analysed through multiple complementary frameworks that illuminate their rationale, governance dynamics, and performance outcomes. Agency theory interprets PPPs as institutional mechanisms that reduce incentive misalignment between public principals and private agents through structured risk allocation. Transaction cost economics posits that PPPs are chosen when contracting and supervision costs are comparatively lower than those associated with direct state provision. Incomplete contract theory (Hart, 2003) underscores the impossibility of specifying every contingency in advance, implying that long-term PPPs depend on flexibility, renegotiation, and trust-based relationships. The New Public Management (NPM) framework views PPPs as vehicles for importing private-sector efficiency, performance metrics, and accountability mechanisms into public service delivery. Meanwhile, financialisation scholarship interprets PPPs as part of a global shift that recasts public infrastructure as financial assets, embedding public goods within market-based valuation and risk frameworks (Romero & Van Waeyenberge, 2020; Cordilha, 2022). Collectively, these theoretical lenses highlight the hybrid, evolving character of PPPs as both governance mechanisms and financial instruments within contemporary health systems.

Methodology

Literature reviews represent comprehensive academic efforts designed to map, describe, and critically analyse the state of knowledge within a given field from both theoretical and contextual angles. Ensuring rigour in such work requires a transparent and well-articulated methodological framework, ideally rooted in methodological pluralism or mixed-method approaches to guarantee reliability and replicability. This need for synthesis is particularly acute in the field of healthcare PPPs, where research on hospital management and infrastructure has expanded rapidly and diversified considerably. In addition, reviews conducted within organisational and management disciplines must contend with unique difficulties arising from the field's inherent fragmentation and multidisciplinarity (Rodrigues, N.J.P., 2023).

To ensure transparency and academic rigor, this study adopts an integrative literature review methodology, which enables the synthesis of both theoretical and empirical contributions across diverse disciplinary perspectives. The literature was identified through a structured search of major academic databases, including Scopus, Web of Science, PubMed, and Google Scholar, covering publications from 2000 to 2024.

The search strategy relied on combinations of keywords such as "Public–private partnerships", "Healthcare PPPs", "Hospital PPPs", "Health system governance", and "Private sector participation in healthcare". Peer-reviewed journal articles, academic books, and institutional reports published by international organizations (World Bank, OECD, WHO, European Investment Bank) were included.

Studies were selected based on their relevance to healthcare systems, governance structures, financing mechanisms, and performance outcomes of PPPs. Non-scientific publications, studies unrelated to the health sector, and duplicated sources were excluded. The selected literature was then analyzed through a thematic and comparative approach, allowing the identification of converging results, contradictions, and contextual determinants shaping PPP outcomes in healthcare.

For the purposes of this study, an integrative literature review methodology was employed, grounded in the analysis of reliable, varied, and authoritative sources. This approach enables a comprehensive exploration—both theoretical and empirical—of the role that public–private partnerships play in shaping the development and performance of healthcare systems. The literature consulted includes a broad corpus of academic works and institutional publications, such as specialised textbooks, peer-reviewed scientific articles, and reports from international bodies including the World Bank, the OECD, and the European Investment Bank.

The chosen approach focuses on analysing the relationships among health infrastructure, investment strategies, and service provision; to outline the theoretical foundations underpinning PPPs; and to synthesise practical experiences derived from national and international case studies. Its overall objective is to offer a critical and comparative understanding of the deployment of PPPs within contexts marked by limited fiscal resources and increasing pressures on health systems. As no fieldwork or quantitative techniques were employed, the study provides a conceptual and synthetic analysis that integrates theoretical insights with empirical observations drawn from institutional and policy practices.

Empirical Literature Review

The empirical literature on public–private partnerships in the health sector has grown substantially over the past thirty years, mirroring both the rising policy importance of PPPs and the increasing diversification of their use across different health system settings. Initial studies tended to focus on issues of efficiency and cost-effectiveness, particularly in relation to hospital infrastructure and management (Montagu & Harding, 2012; Hodge & Greve, 2017). More recent scholarship has broadened this scope to investigate governance effectiveness, service quality, healthcare access, and fiscal

sustainability (Hellowell, 2019; Romero & Van Waeyenberge, 2020; Casady & Mikic, 2022). Overall, the findings remain mixed and highly sensitive to context, reflecting differences in institutional strength, regulatory design, and the developmental stage of national health systems.

Research on health PPPs encompasses both high-income and developing countries, with a substantial body of empirical work stemming from early adopters like the United Kingdom, Australia, and Canada under the Private Finance Initiative (PFI). In developing regions—including Asia, Latin America, and Sub-Saharan Africa—empirical research has emerged more recently, frequently examining PPPs as vehicles for expanding health infrastructure and improving service delivery in settings marked by resource constraints (Kumar & Gupta, 2022; Moyo et al., 2020). In contrast, the MENA region remains relatively underexamined, with only a handful of studies addressing PPPs in healthcare, including Zine El Abidine, Hajji, and Bouhmala's (2021) analysis of PPP implementation in Moroccan dialysis services.

These studies reveal significant methodological variety, with quantitative analyses of costs and health outcomes complemented by qualitative examinations of governance dynamics, stakeholder engagement, and policy effectiveness. This heterogeneity reflects both the richness and the fragmentation of empirical research on PPPs, echoing Romero and Van Waeyenberge's (2020) observation regarding the inherently multidisciplinary character of PPP scholarship.

The positive effect of PPPs in health

Across an increasingly diverse set of empirical studies, Public–Private Partnerships have been identified as an important levers for expanding access to health services, improving quality of care, and strengthening organisational performance. Despite varying contexts, much of the literature converges on the idea that PPPs—when embedded within strong governance structures and supported by effective coordination can serve as complementary instruments to improve the efficiency and equity of healthcare delivery.

Joudyan et al. (2021) indicate that, despite the significant challenges inherent in their implementation, PPPs constitute a promising means of improving access to healthcare services, particularly in remote or underserved areas. The authors underline that the success and sustainability of these partnerships depend on several essential conditions: ase transparency, trust, and cooperative relationships between public authorities and private partners, as well as flexible contractual arrangements capable of evolving with changing needs and circumstances. They also highlight the importance of securing stable and sustainable financing, fostering genuine

mutual commitment, and reinforcing the public sector's capacity to oversee and ensure the quality of services provided by private actors. Governments are encouraged to establish long-term strategic plans and coherent policy frameworks that facilitate the development and ongoing viability of health PPPs. Drawing on international experiences and adjusting them to local realities can strengthen institutional learning and improve the design and performance of future partnerships.

Expanding on these insights, Ghasemi et al. (2022) provide further evidence showing that cooperative arrangements between public authorities and private actors in healthcare systems have generated favourable results across multiple dimensions. heir analysis indicates that such partnerships strengthen service provision, broaden coverage, and enhance overall system performance, as well as enhanced provider responsiveness—particularly through stronger referral mechanisms and more efficient patient flows. Moreover, the authors show that the extent and effectiveness of participatory service delivery vary with countries' economic and institutional development. In contexts where collaboration between government and private stakeholders is more developed, the evidence points to broader service coverage and a reduction in access inequalities. Collectively, these findings underscore the significant contribution that sustained public–private cooperation can make to advancing efficiency and equity in national health systems.

Reinforcing this multidimensional understanding, Basabih et al. (2022) argue that PPPs offer an appropriate and effective strategy for filling persistent gaps in health infrastructure, access to care, and service quality, particularly in settings characterised by fiscal limitations. Their review analysed the performance of PPPs through hospital financing and service delivery indicators, identifying both notable achievements and the challenges that arise during implementation. This reinforces the conclusion advanced by Ghasemi et al., namely that the performance of PPPs is highly sensitive to contextual factors, particularly institutional maturity and the coherence of policy frameworks.

Placed within this wider international landscape, the study of Zine El Abidine, Hajji, and Bouhmala (2023) offers Moroccan empirical evidence the beneficial impact of PPPs on healthcare quality and performance, with a particular focus on renal dialysis services. Their findings reveals significant improvements in patient outcomes, continuity of care, and operational efficiency after the implementation of PPP arrangements. These results illustrate the capacity of PPPs to fill structural gaps in the public health sector, especially in specialised areas that require advanced technologies and professional xpertise. Nonetheless, the authors emphasise that achieving sustainable outcomes requires sufficient stakeholder training and

preparedness, highlighting the importance of developing managerial and technical capacities. The Moroccan case adds to the broader evidence base by illustrating how national adaptation and institutional learning can enhance the benefits e of PPP schemes.

Likewise, Gharaee et al. (2021), examining the case of East Azerbaijan Province in Iran, confirm the positive contribution of PPPs on healthcare system development. Their study demonstrates that PPP initiatives improved service delivery, strengthened hospital management, and expanded patient access, while also mobilising resources and enhancing the overall responsiveness of the health system. Nevertheless, consistent with the findings of Zine El Abidine et al., the authors note that weaknesses in infrastructure and coordination can limit the extent of achievable improvements. This convergence across national contexts underscores that institutional preparedness and governance capacity are critical determinants of PPP success across different socioeconomic environments.

Extending the perspective to a broader international scale, Sadeghi et al. (2022) conducted a cross-country comparison involving the United Kingdom, Canada, Turkey, Australia, and Iran, demonstrating that PPPs can deliver tangible improvements in hospital performance across both clinical and non-clinical areas. Their analysis underscore that long-term contracts, ranging between 12 and 40 years, promote continuity, stronger accountability, and greater operational efficiency when built upon robust performance indicators and balanced risk-sharing arrangements. This focus on contractual design and performance monitoring aligns with earlier findings by Gharaee et al. and Basabih et al., reinforcing the idea that PPP effectiveness depends critically on the coherence between institutional frameworks, regulatory capacity, and the competencies of participating partners.

Evidence from lower-income environments, such as the study by McIntosh et al. (2015) on the Lesotho hospital network, reinforces these broader findings. By comparing a PPP-operated referral hospital with a publicly managed system, the authors observed superior clinical quality, higher levels of patient satisfaction, and improved efficiency under the PPP arrangement. These improvements were linked to modern infrastructure, efficient resource allocation, and more responsive managerial systems. Echoing the conclusions of Sadeghi et al. and Ghasemi et al., McIntosh and colleagues emphasise that robust contractual structures and strong regulatory oversight are essential for unlocking the full benefits of PPPs in resource-limited settings.

Lastly, the study by Krivenko et al. (2021) expand the debate by assessing PPP initiatives at local and regional levels in Russia and abroad. Their findings indicate that PPPs have improved not only healthcare access

and service quality but also contributed to wider socio-economic development through infrastructure improvements, job generation, and technological innovation. The authors argue that localized, bottom-up PPP configurations—in which municipalities engage directly with private investors—enable more context-specific, adaptive, and accountable healthcare solutions. This perspective is consistent with the conclusions of McIntosh et al. (2015) and Gharaee et al. (2021), confirming that PPPs are most effective when embedded within governance structures that promote coordination, responsiveness, and shared accountability.

Taken together, these empirical contributions provide a coherent picture of the positive impacts of PPPs across diverse geographical and institutional contexts. They indicate that PPPs can enhance access to healthcare, improve service quality, and strengthen resource mobilisation within health systems. However, a critical insight emerges: the scale and durability of these benefits depend less on the PPP model itself than on the institutional, regulatory, and managerial capacities that underpin its implementation.

Table 1: Empirical Studies Reporting Positive Impacts of PPPs in the Health Sector

Authors and Year	Country	Focus of Study	Main Positive Findings	Key Success Factors Identified
Joudyan et al. (2021)	Multi-country / Conceptual	Access to healthcare, especially in remote areas	PPPs improve access and service provision in underserved regions	Transparency, flexibility, sustainable financing, strong monitoring by public sector
Ghasemi et al. (2022)	Multi-country (comparative)	Public–private cooperation and coverage of health services	Improved service provision, responsiveness, and reduced inequalities	Strong government–private interaction, institutional development
Basabih et al. (2022)	Global (hospital-focused review)	Hospital financing and service delivery	PPPs bridge infrastructure and service gaps under budget constraints	Institutional maturity, financial sustainability, effective policy frameworks
Zine El Abidine, Hajji & Bouhmala (2023)	Morocco	PPPs in renal dialysis services	Enhanced quality, continuity of care, and efficiency	Capacity building, training, institutional governance
Gharaee et al. (2021)	Iran (East Azerbaijan Province)	Hospital PPP implementation	Improved hospital operations, patient access, and	Institutional readiness, coordination

			resource mobilization	mechanisms, infrastructure capacity
Sadeghi et al. (2022)	UK, Canada, Turkey, Australia, Iran	Comparative hospital PPP performance	Improved clinical and non-clinical performance, facility management, and maintenance	Long-term contracts, performance indicators, balanced risk-sharing
McIntosh et al. (2015)	Lesotho (Africa)	PPP-managed vs. public hospital network	Higher clinical quality, patient satisfaction, and management efficiency	Robust regulation, clear contracts, leadership and accountability
Krivenko et al. (2021)	Russia / International	Local and regional PPP initiatives	Improved infrastructure, service quality, and local socio-economic development	Local coordination, managerial flexibility, stakeholder accountability

Source : Author's own elaboration

The negative and mixed effect of PPPs in health

While the majority of empirical evidence underscores the potential benefits of Public–Private Partnerships (PPPs) in healthcare, a significant number of studies also report mixed or negative outcomes, especially concerning fiscal sustainability, governance practices, and equity in access to care. These studies stress a fundamental point: PPP outcomes are not inherently beneficial. Their success depends critically on contextual factors such as institutional strength, contract design, and the alignment of incentives and responsibilities between public authorities and private partners.

A key study by Hellowell (2019) on the Lesotho hospital PPP illustrates the inherently contradictory nature of PPP outcomes in low-income settings. Although the project achieved measurable improvements in clinical quality and facility management, it also created severe fiscal pressures, diverting a disproportionate portion of the national health budget. Hellowell warns that weak procurement capacity, limited competition, and poor budgeting practices can turn PPPs into enduring financial burdens rather than efficiency-enhancing mechanisms. These results show that without strong institutional safeguards, improvements in service quality may come at the expense of affordability and public accountability.

Extending this line of critique, Romero and Van Waeyenberge (2020) adopt a political-economy approach to show that PPPs often contribute to the financialisation of public health infrastructure, converting hospitals and

services into revenue-generating assets for private investors. From this standpoint, PPPs represent more than contractual arrangements; they function as mechanisms of structural change that redirect public value creation toward private accumulation. The authors caution that such tendencies can weaken the redistributive mission of health systems and amplify social inequalities, especially where regulatory capacity is insufficient to safeguard equity and public accountability.

A complementary line of critique is provided by Hunter and Murray (2019), who situate the growth of health PPPs within the broader "private turn" in development finance. They contend that growing dependence on private capital to finance public goods—most notably healthcare—may lead to the dominance of market imperatives over social objectives. Their analysis shows that donor agencies and international financial institutions often encourage PPPs as a substitute for public investment, thereby embedding commercial logics within essential health services. Similarly, Dentico (2021) highlights the expanding role of private-equity firms and investment funds in health PPPs, framing this trend as part of a financialised development paradigm in which investor returns are prioritised over equitable health outcomes.

These financial and governance concerns are echoed by Hodge and Greve (2017), who argue that PPPs frequently face transparency and accountability challenges arising from complex long-term contracts. Their review reveals that governments routinely face difficulties in supervising performance, handling renegotiations, and maintaining control, which can lead to escalating costs and rigidity in service delivery. Similarly, Casady and Mikic (2022) argue that PPP failures are commonly linked to poorly designed risk-sharing mechanisms and insufficient regulatory oversight, conditions that can leave the public sector exposed to unexpected fiscal liabilities and undermine long-term value for money.

Collectively, these contributions offer a critical counterweight to prevailing enthusiasm about PPPs. While demonstrating that PPPs can indeed improve service delivery when supported by strong institutional arrangements, these studies also show that PPPs carry significant risks of inefficiency and inequity when introduced in environments marked by weak administrative capacity or limited transparency. The evidence thus supports a balanced interpretation: PPPs are not inherently good or bad, but their outcomes depend on the balance between performance incentives and public accountability, as well as on the strength of the institutional environment in which they operate.

Table 2: Empirical Studies Reporting Negative or Mixed Impacts of PPPs in the Health Sector

Authors and Year	Country	Focus of Study	Main Negative or Mixed Findings	Key Success Factors Identified
Hellowell (2019)	Lesotho	Fiscal sustainability and hospital PPPs	Improved service quality but excessive fiscal burden on the health budget	Weak procurement capacity, poor contract design, limited competition
Romero & Van Waeyenberge (2020)	Global / Theoretical	Political economy of PPPs in health	PPPs contribute to the financialisation of health infrastructure	Inequality, private asset conversion, weak regulation
Hunter & Murray (2019)	Global (development finance)	Private capital in health PPPs	PPPs embed commercial logics into public services	Overreliance on private finance, loss of public control
Dentico (2021)	Global (development critique)	Financialisation and private equity in health PPPs	PPPs prioritize investor returns over equity in access	Dominance of private capital, weak social orientation
Hodge & Greve (2017)	OECD countries	Comparative PPP performance	Contract complexity leads to cost overruns, inflexibility, and low transparency	Poor monitoring, accountability deficits, rigid long-term contracts
Casady & Mikic (2022)	OECD / Global	Risk allocation and fiscal sustainability	PPP failures often stem from unbalanced risk-sharing and poor regulation	Inadequate oversight, weak risk transfer, public fiscal exposure

Source : Author's own elaboration

Determinants of success and failure of PPPs in healthcare sector

The contrasting outcomes reported across empirical studies highlight that the performance of Public–Private Partnerships (PPPs) in the health sector is fundamentally determined by the institutional, contractual, and relational conditions under which they are implemented. Rather than intrinsic features of the PPP model, it is these enabling or constraining factors that explain why some projects achieve efficiency and quality gains while others generate fiscal risks or governance failures.

A first determinant concerns the institutional and legal framework within which PPPs are developed. Empirical evidence consistently shows

that clear regulations, transparent procurement procedures, and standardized contract templates enhance predictability and reduce transaction costs (Yescombe, 2018; OECD, 2012). Countries with dedicated PPP units or specialized agencies tend to perform better in project preparation, evaluation, and monitoring, ensuring that partnerships deliver value for money and remain fiscally sustainable. By contrast, weak institutional oversight often results in poorly drafted contracts, limited competition, and unbalanced risk allocation—issues that have been recurrent in several developing contexts examined by Hellowell (2019) and Gharaee et al. (2021).

Second, the capacity of public authorities to manage complex long-term contracts is central to PPP success. Studies such as those by Roehrich, Lewis & George (2014) and Zine El Abidine et al. (2023) demonstrate that governments must possess strong technical, managerial, and financial expertise to negotiate, implement, and supervise PPP agreements effectively. Without this capacity, asymmetries of information and dependence on private operators can emerge, undermining accountability and performance monitoring.

A third determinant relates to the design and quality of contractual arrangements. As emphasized by Hodge & Greve (2017) and Sadeghi et al. (2022), well-calibrated risk-sharing mechanisms, performance-based payment systems, and clear dispute-resolution procedures are essential to align incentives between public and private actors. Inadequate risk allocation—where the public sector retains most financial exposure or where private partners face unrealistic performance targets—has often been at the root of PPP underperformance or failure.

Equally important is the relational dimension of governance. Successful PPPs are characterized by cooperative relationships built on mutual trust, transparent communication, and joint problem-solving. Montagu & Harding (2012) and Roehrich et al. (2014) show that relational governance mechanisms—such as steering committees, shared monitoring platforms, and adaptive management—facilitate flexibility and learning over time, particularly in dynamic sectors like healthcare where demand and technology evolve rapidly.

Financial structure also plays a decisive role. As noted by Casady & Mikic (2022) and Basabih et al. (2022), blended-finance models that combine public and private capital can expand fiscal space for health investment, but only when supported by transparent accounting standards and sustainable revenue flows. Projects reliant on volatile or uncertain funding streams risk generating hidden liabilities and long-term fiscal stress.

Finally, political commitment and policy continuity are indispensable for maintaining investor confidence and ensuring project longevity. Frequent policy reversals, administrative turnover, or shifts in political priorities can

disrupt project implementation and weaken stakeholder trust. Conversely, stable political support, as seen in successful cases documented by McIntosh et al. (2015) and Krivenko et al. (2021), helps consolidate institutional learning and attract further private participation.

In sum, the empirical literature demonstrates that PPP outcomes depend on a multidimensional ecosystem of institutional quality, contractual rigor, financial stability, and relational governance. When these conditions coexist, PPPs can enhance efficiency, innovation, and accessibility in healthcare delivery. When they are absent, however, the same arrangements may generate inefficiencies, inequities, or fiscal burdens. These determinants thus provide the analytical bridge between the optimistic and critical strands of the literature, underscoring that PPPs' effectiveness lies not in their form but in the governance context that sustains them.

Discussion

The empirical evidence reviewed reveals that Public–Private Partnerships in the health sector constitute neither a universally successful policy instrument nor an inherently problematic one. Their performance depends fundamentally on the governance architecture, institutional capacity, and contractual arrangements underpinning their implementation. This conclusion aligns with the theoretical frameworks discussed earlier, which explain PPP dynamics through the interaction of agency relationships, contract incompleteness, and the broader paradigms of New Public Management (NPM) and financialisation.

At a broader analytical level, the divergence of PPP outcomes between developed and developing countries reflects structural differences in institutional capacity, regulatory enforcement, and fiscal resilience. While high-income countries may absorb contractual rigidity and long-term financial commitments, developing economies face higher vulnerability to fiscal stress, renegotiation risks, and governance asymmetries. This structural gap explains why similar PPP models can generate efficiency gains in some contexts and fiscal fragility in others.

From the perspective of agency theory, PPPs are conceived as mechanisms designed to align the incentives of public principals and private agents through performance-based contracts. The positive outcomes identified in the reviewed studies—such as efficiency gains, enhanced quality of care, and improved infrastructure in contexts like Morocco (Zine El Abidine et al., 2023), Iran (Gharaee et al., 2021), and Lesotho (McIntosh et al., 2015)—illustrate situations in which risk-sharing arrangements and performance monitoring effectively mitigated opportunistic behaviour. When the principal (the government) possesses sufficient contractual and technical capacity to specify measurable outputs and monitor performance, agency

problems diminish, resulting in superior outcomes. Conversely, the failures documented by Hellowell (2019) or Romero and Van Waeyenberge (2020) highlight how information asymmetry and weak oversight allow private actors to capture rents, leading to fiscal burdens and loss of public accountability. Thus, PPP performance depends on the balance between incentive alignment and the state's ability to control and evaluate the agent's behaviour.

The theory of incomplete contracts further clarifies why PPP results diverge across contexts. Health-sector partnerships are intrinsically complex and long-term, encompassing multiple tasks and uncertain contingencies that cannot be fully anticipated ex ante. Incomplete contractual clauses therefore create "grey zones" of interpretation that require renegotiation or discretionary adjustments. When these arrangements are supported by institutional trust and adaptive governance—as noted by Joudyan et al. (2021) and Sadeghi et al. (2022)—they promote flexibility and innovation. However, in institutional environments where administrative capacity and transparency are weak, contractual incompleteness becomes a source of risk exploitation, opportunism, and escalating costs. This theoretical lens explains why PPPs in developing contexts may initially deliver visible results but later encounter sustainability problems once unforeseen events arise or financial commitments accumulate.

From the standpoint of New Public Management (NPM), PPPs embody the managerial reform agenda that seeks to introduce private-sector efficiency, accountability, and customer orientation into public services. The reviewed evidence confirms that NPM-inspired principles have indeed fostered improvements in hospital performance, patient satisfaction, and service responsiveness (Ghasemi et al., 2022; Sadeghi et al., 2022). Nonetheless, the translation of private-sector logics into the public domain also produces tensions between efficiency and equity. Studies such as those of Hunter and Murray (2019) and Hodge and Greve (2017) demonstrate that managerialism and performance contracting can shift attention away from universality and affordability, especially when cost recovery through user fees or long-term payment commitments undermines fiscal equity. Consequently, while NPM provides a useful efficiency framework, its application in health PPPs requires strong public stewardship to preserve the social objectives of healthcare provision.

The concept of financialisation provides a complementary macro-level interpretation of these dynamics. As Romero and Van Waeyenberge (2020) and Dentico (2021) argue, the expansion of PPPs in health systems reflects a structural transformation in development finance: public infrastructure and services are increasingly treated as financial assets generating predictable cash flows for investors. This evolution explains the

growing involvement of investment funds and private equity actors, as noted in the empirical cases of Sadeghi et al. (2022) and Krivenko et al. (2021). Financialisation thus redefines the nature of PPPs—from collaborative service arrangements to investment vehicles—raising normative questions about accountability and the public value of private profit. The challenge for policymakers is therefore to design PPP frameworks that attract private capital without surrendering public control or compromising equity outcomes.

Integrating these theoretical perspectives, the empirical literature suggests that successful PPPs are those that reconcile contractual efficiency with public accountability. They rely on robust institutional capacity to manage risk, on transparent governance to ensure fiscal discipline, and on continuous stakeholder coordination to sustain trust over the project lifecycle. The Moroccan and Iranian experiences exemplify how capacity-building and adaptive learning can transform PPPs into catalysts for system-wide improvement. Conversely, the Lesotho and international cases remind that when political oversight, technical expertise, or regulatory safeguards are weak, PPPs can generate fiscal fragility and social exclusion rather than efficiency.

Ultimately, PPPs in healthcare should not be understood merely as funding instruments but as complex governance mechanisms that redistribute roles, risks, and rewards between the state and the market. Their success depends less on contractual formality than on the institutional and ethical capacity of governments to steward partnerships in the public interest. Ensuring that private participation serves collective welfare rather than private accumulation requires transparent frameworks, measurable performance standards, and the political will to enforce them. In this regard, the synthesis of theoretical and empirical evidence underscores a critical insight: PPPs are neither a panacea nor a peril—they are tools whose outcomes are shaped by the quality of governance, not by the partnership itself.

Conclusions

This article has examined the role of Public–Private Partnerships (PPPs) in the health sector through an integrative review combining theoretical analysis and empirical evidence drawn from diverse national contexts. The findings demonstrate that PPPs have become a central instrument in contemporary health governance, providing governments with alternative mechanisms to mobilize capital, expand infrastructure, and enhance service delivery. Yet, their outcomes remain highly contingent upon the institutional, contractual, and political environments in which they are implemented.

The synthesis of empirical studies reveals a dual narrative. On one hand, PPPs have produced tangible improvements in healthcare quality, infrastructure, and efficiency, particularly in countries where institutional capacity, clear regulation, and mutual accountability mechanisms exist. Cases from Morocco, Iran, Lesotho, and Russia illustrate how PPPs can generate innovation, attract investment, and strengthen public health systems when embedded within transparent governance structures and supported by adequate technical expertise. On the other hand, several experiences highlight the risks and limitations of PPP implementation—ranging from fiscal dependency and inflexible contracts to weakened public oversight and growing financialisation of health services. These mixed results confirm that PPPs are not a universal solution but context-sensitive arrangements requiring strong state capacity and coherent long-term planning.

The theoretical integration of agency theory, incomplete contracts, New Public Management (NPM), and financialisation perspectives provides a coherent explanation for this diversity of outcomes. PPPs succeed when incentives are aligned, risks are properly distributed, and the public sector retains the ability to monitor performance and enforce accountability. They fail when contractual asymmetries, information imbalances, or profit-driven logics dominate, eroding the public value that health systems are meant to protect. The intersection of these theories underscores a broader insight: PPPs are not merely financial instruments but hybrid governance mechanisms that redefine the boundaries between state and market in the provision of essential services.

From a policy standpoint, the review suggests that the effective use of PPPs in healthcare requires robust legal frameworks, institutionalised capacity building, and transparent evaluation systems to ensure fiscal sustainability and social equity. Governments should adopt context-adapted models that emphasize accountability, community engagement, and flexibility rather than replicating generic PPP templates promoted internationally. Furthermore, developing countries, such as Morocco, can leverage PPPs as complementary tools for achieving universal health coverage, provided that they are accompanied by solid regulatory supervision, long-term policy coherence, and mechanisms for skill transfer between sectors.

In conclusion, PPPs in the health sector embody both opportunity and risk. They hold the potential to accelerate health system development, foster innovation, and improve service delivery, but only under conditions of good governance, institutional maturity, and sustained public stewardship. The debate surrounding PPPs should thus move beyond ideological polarization toward a balanced understanding of partnership governance—one that recognises private participation as a means to achieve public health

objectives, not as an end in itself. Future research could expand on this analysis by exploring country-specific models, quantitative assessments of fiscal impact, and the long-term effects of financialisation on health equity, thereby contributing to the design of more inclusive and resilient partnership frameworks.

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