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A Deductive Analysis of Public Private Partnerships for Health Technology
Les partenariats public-privé et les technologies de la santé - Une analyse déductive

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Article abstract

In several countries, consulting firms, think thanks and even government agencies spend a considerable amount of energy trying to expand the scope of public private partnerships (PPPs). Initially confined to the construction and maintenance of public infrastructures, PPPs are currently discussed and experimented with in sectors as diverse as health care provision, crime reduction, immigrants' integration and even the organization of elections. This paper discusses the way PPPs are likely to transform the adoption of novel medical technology in countries where health care is publicly funded. I believe, however, that several ideas presented here can be useful to consider in applying PPPs to all sectors of state intervention relying on expensive technologies. In the first section, I begin by presenting the economic understanding upon which PPPs rest. I then present the simple and uncontroversial assumption that, in democratic countries, PPPs are negotiated by politicians. Withholding the rationality assumption upon which economic theory rests, I argue that rational politicians are unlikely to prefer a PPP contract appealing to a private partner, unless politicians accept occasional renegotiation of given clauses of PPP contracts. Where this occurs, however, the alleged economic efficiency of PPPs is seriously undermined. In the second section, I present a series of reasons to contest economic theory's treatment of health technology choices as economic choices. These reasons, I suggest, made significant contributions to health technology assessment and purchase reforms. The economic reasoning behind PPPs, I conclude, poses a serious threat to these reforms.

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In several countries, consulting firms, think thanks and even government agencies spend a considerable amount of energy trying to expand the scope of public-private partnerships (PPPs). Initially confined to the construction and maintenance of public infrastructures, PPPs are currently discussed and experimented with in sectors as diverse as health care provision, crime reduction, immigrants' integration and even the organization of elections. In fact, I began thinking about this paper after receiving an invitation to participate in a roundtable on PPPs at a conference for research institutions and firms providing medical technology. People in this sector believe PPPs will shortly transform the way they have been doing business. In line with the idea behind this conference, this paper discusses the way PPPs are likely to transform the adoption of novel medical technology in countries where health care is publicly funded. I believe, however, that several of the ideas presented here can provide direction for thinking about PPPs in all sectors of state intervention which rely on expensive technology.

Medical technology comprises all the equipment involved in the diagnosis of patients by physicians and in the treatment of the diagnosed diseases and injuries. This equipment can be developed by researchers working in public institutions, normally universities and publicly funded laboratories. In most developed countries, however, this equipment is supplied by private firms. In fact, technologies patented by universities will normally be provided by private firms, in which universities have invested, and which, it is hoped, will become a source of revenue for the university. In countries with publicly funded health care systems, such as Canada, France or the United Kingdom, the purchase of medical technology has either been directly handled by the state or is regulated so as to avoid large territorial disparities regarding the availability of diagnosis tools and treatments, or redundancy when it comes to high cost technologies to treat rare diseases. In other words, centralizing the purchase of medical technologies has been the traditional solution to strike a balance between equal treatment, a key principle behind publicly funded health care systems, and economies of scales to be achieved by equipping given hospitals with specialized and high cost technologies.

However, this traditional solution does not work very well. In most industrialized countries, the cost of health care increases at a faster pace than economic growth. New technologies, which would enable more precise diagnosis can contribute to these cost increases. An aging population, who grew up in the age of technological advancement, put an increasing pressure on governments to purchase technologies to hold back death. The pressure of this aging population would not be favourable to the purchase of cost saving technologies. In this context, the management of medical technology purchases represents an enormous challenge and PPPs can be seen as a solution to this challenge. Indeed, it has been argued that the risks involved in the management of medical technology could easily be passed to a private purchaser, tied to the principles of a publicly funded health care system through a PPP contract. I will argue in this paper that PPPs are an easy political way out of the management challenge health technology represents, but that PPPs do not at all represent a solution to the problem of cost control. In discouraging the adoption of advancements in technology assessment, PPPs may, in fact, be a source of other problems.

The paper is divided into two sections. In the first section, I begin by presenting the economic understanding upon which PPPs rest. I then present the simple and uncontroversial assumption that, in democratic countries, PPPs are negotiated by politicians. Withholding the rationality assumption upon which economic theory rests, I argue that rational politicians are unlikely to prefer a PPP contract appealing to a private partner, unless politicians accept occasional renegotiation of given clauses of PPP contracts. Where this occurs, however, the alleged economic efficiency of PPPs is seriously undermined. In the second section, I present a series of reasons to contest economic theory's treatment of health technology choices as economic choices. These reasons, I suggest, made significant contributions to health technology assessment and purchase reforms. The economic reasoning behind PPPs, I conclude, poses a serious threat to these reforms.

Rationality and PPPs in health technology

A PPP in the area of medical technology would involve a firm, or more likely a consortium of investors (Cohn, 2004), responsible for the provision of medical technology in one or several areas of health care. Unlike regular contracting out with private firms for given services, the consortium would own the technology and would thereby be responsible

for its maintenance. More importantly, the consortium would be responsible for the risks involved in the purchase of medical technology, including costs hikes. Risk sharing, allegedly absent from regular contracting out, is claimed to be a key feature of PPPs and its precise form is normally specified in contracts spanning between 15 and 30 years (Pollitt, 2003: 57-63; Flinders, 2005).

Economic thinkers are key proponents of such PPPs. Neo-classical economists insist on the competition facing the consortium when bidding for a PPP contract. These economists would argue that, unlike a monopolistic purchaser, the consortium has powerful incentives to come up with innovative business plans for the purchase technologies. Competition, or the fear to loose the contract, would be the source of these powerful incentives. Once in a contract, these economists would further argue, responsibility for risks should incite the consortium to avoid technologies with low marginal benefits and high marginal costs. Neo-classical economists would argue, such technologies are likely appealing to a single state purchaser vulnerable to the political pressure of an aging population. This reasoning is based on the assumption that life expansion by one increment for old people is at least as costly in technology as health improvement by one increment for younger people. The appeal of inefficient technology may even be greater in political systems where risk responsibilities are dispersed and where blame avoidance strategies are common. In such systems, several actors may be able to claim credit for the care given to the aging population, but more importantly these actors can also pass blame on others for the bad investment. Lastly, neo-classical economists could suggest, because the consortium owns the technology, it is likely to insist more on appropriate maintenance, to the extent maintenance has an impact on profits.

Neo-institutional economists are more likely to recognize the imperfect competition arising from information asymmetries or incomplete information inherent to the bidding processes. They should further insist on the high cost and time required to reduce these information problems and other transaction costs, at least to an extent where it becomes possible to identify the most efficient private consortium. However, they would argue that subsidizing the bidding process to deal with information problems would be a good public investment. The subsidy should be set at a level where consortia become willing to accept the risks of bidding, knowing that the benefit to the successful bidder is high, because of the contract's duration. Indeed, the successful bidder will receive contractual guarantees for a period sufficiently long to amortize the costs incurred during the bidding process. Neo-institutional economists would lastly insist on the importance of the quality of the PPP contract, negotiated between the successful bidder and the state, to specify clearly the responsibilities of each party over the entire period. Because the transaction costs of PPPs are higher than those of contracting out, any premature termination of the contract, that is termination within the amortization period, forcing a return to a competitive bidding process, would be economically inefficient.

Common to neo-classical and neo-institutional economists is the assumption that the economic actors involved in PPPs behave rationally, in accordance with their individual interests. In turn, their rational behaviour becomes a source of economic efficiency for society. Now, what happens if we assume that political actors, just like economic actors, calculate the cost and benefits of health technology PPPs to them? After all, politicians are key actors in the process leading to the completion of a PPP in democratic countries. Should we expect them to prefer PPPs over a single state purchaser of health technology? Would rationally motivated political actors also be a source of efficiency? If one assumes rationality on the part of political actors, I argue, PPPs should be preferred over conventional modes of health technology purchase. However, when rational political actors negotiate PPP contracts with rational economic actors, there is no need to relax the rationality assumption to conclude about the economic inefficiency of PPPs.

Rational-choice political scientists argue that politicians are risk averse, that is they accept foregoing credit claiming if it can shield them from blame (Weaver, 1986; Hood, 2002). Elections, the argument goes, are not won on achievements for which contenders can claim credit, but can be lost on blame for past mistakes. To the extent this assumption is true, PPPs in the area of health technology are appealing to politicians. Again, in a publicly funded health care system, where technology is purchased by a single state actor, the pressure an aging population is likely to put on politicians to opt for inefficient technology should be high. Longer life for old people is a lower marginal benefit for society than a healthier life for younger people, but the marginal cost of longer life technology to society is equal or higher than the marginal cost of technology for a healthier life. In other words, opting for the health technology preferred by an aging population is a socially inefficient economic choice. In this context, any choice would bring blame to politicians. If politicians opt for inefficient technology, they will naturally be blamed for wasting taxpayers' money. Conversely, if they purchase efficient technology, the aging population should blame them for not supplying the technology they need. A PPP provides a way out of this loose-loose choice situation to the extent it transfers the responsibility for the purchase of technology to a private consortium. In contrast to a single state purchaser accountable only to politicians, the consortium should clearly prefer efficient technology, economists would predict, because it is primarily accountable to investors. And in relation to politicians, the choice between efficient and inefficient technology matters little since in either case politicians will pass any blame on the consortium, a blame that will matter little for the consortium. In short, PPPs provide rational politicians an easy way out of the difficult political choices facing health technology in the publicly financed health care systems of countries with an aging population (for a similar reasoning see Scheingate, 2004).

If rational politicians are likely to be inclined to prefer PPPs over a single state purchaser, can we expect them to negotiate the high quality contracts neo-institutional economists insist upon? Not only do I argue that rational

politicians have no interest sealing the benefits and costs expected of health technology in contracts valid over long periods, I also believe it is not in the interest of any private consortia. And if contracts cannot be sealed for such long periods, risk sharing, the acknowledged key economic advantage of PPPs, cannot be ascertained.

Unlike contracting out for a given health technology, which normally involves a contract dealing with technology specifications, quantity and price, a PPP contract should minimally detail the benefits expected from health technology, in terms of diagnosis and treatment improvements, determine a rent to be paid by the state to the consortium and the validity period of the contract. As indicated above, given the transaction costs involved in the bidding and contract negotiation processes, contract duration for PPPs are normally somewhere between 15 and 30 years. In line with the principles of result management, the contract clauses on benefits should provide for outcome measurements. The focus of outcome measurement is the health of populations. For example, a PPP contract could specify a success rate for the treatment of a given cancer under desired technological conditions. Naturally, outcome measurement creates negotiation difficulties as health technology is just one factor impacting on the health of populations. Under these conditions, output measurement becomes attractive. The focus of output measurement is on the advantages technology provides to health specialists. A PPP contract relying on output measurement could, for example, set targets of precision for treatment equipment or define the level of optical definition for diagnosis technology in a given area. Naturally, health professionals could view sealing such technological outputs in a long-term contract as making little sense as they tend to believe health technology should always aim at better precision and definition.

Unless benefit targets are equal or below those achieved by existing single state purchaser and the price is particularly generous, it is not in the interest of the private consortium to sign a long term PPP contract. And quite obviously, it is not in the interest of politicians to be generous with the private consortium, especially when it comes to benefit targets. Any politician signing a PPP contract with targets and prices to the taxpayer equal to the status quo will easily be blamed for signing a lousy contract. Assuming that politicians understand that PPPs are to enable the adoption of technologies with high marginal benefits and low marginal costs for society, as economists suggest, it is not in their interest to sign a contract that does not promise any improvement. Even if technologies themselves were not capable of generating health and treatment improvements, economists expect the PPP to be a source of improvement. Clearly then, output or outcome targets should be set at levels higher than those achieved by the single state purchaser. In other words, PPPs should achieve outcome and output improvements, even if the available technology remains constant, hence the likely blame to any politician accepting targets that are no more ambitious than the status quo. Unfortunately, the risk for the private consortium of accepting ambitious targets and prices appealing to the taxpayers over long periods is too high for any PPP to be in its interest. In contrast to the assumption of technology's constancy, the private consortium knows that new technologies, promising for the health of populations, will become available, at least in the medium term. What the consortium ignores, however, is the precise marginal benefits and costs of the technologies to be developed; technological development is indeed unpredictable. Therefore, a private consortium has no means to assess precisely the risks for which it becomes responsible when it commits to a benefit target that is more ambitious than the status quo. Under these circumstances, setting a price for a long-term period is akin to guessing and rationality should dictate that economic actors refuse to sign a PPP contract setting prices in such a way for the purchase of health technology. In other words, a PPP contract attractive to politicians will not be attractive to a private consortium and vice versa.

This last prediction is premised on the idea, widely diffused by neo-institutional economists, that PPP contracts are tightly sealed for periods spanning between 15 and 30 years. Will private consortia still be reluctant to sign a PPP contract appealing to politicians if they believed these contracts were not tightly sealed, but could be partly renegotiated occasionally, notably as technological changes occur? Such a belief, indeed, would make PPP contracts far more appealing to private consortia. When a PPP contract is not tightly sealed, the private consortium can demand adjustments to benefit targets and prices whenever their guesses about the marginal benefits and costs of new technologies are proven wrong. And I further argue that private consortia are right to believe that politicians, to the extent they act rationally, should accept partial PPP contract renegotiations before their end. If a private consortium were to ask a renegotiation of benefit targets, for example, politicians would have to face a relatively simple decision situation. On the one hand, they could refuse opening the contract to new negotiations. This would be a good decision only if the consortium were bluffing. Otherwise, the consequence of the decision would likely be a breach in the terms of the contract by the consortium, followed by a costly judicial battle potentially followed by the bankruptcy of the consortium. Meanwhile, politicians would have to provide the technology, either by returning to a single state purchaser, not any easy option as the PPP transferred the expertise in the private sector, or by negotiating a new PPP contract. This last option is not an easy one either because it would involve high transaction costs, as with any PPP, accrued during the amortization period of the PPP terminated prematurely. In other words, refusing the renegotiation demanded by the private consortium would generate severe blame for politicians (Flinders, 2005: 229). On the other hand, politicians can accept renegotiating given clauses. They would certainly be blamed for accepting this, as the agreement was for the private partner to be responsible for its share of risks. However, the blame would be moderate in comparison with that stemming from a refusal to renegotiate. The transaction costs of renegotiating a limited number of clauses with a known private consortium should be much lower than negotiating an entirely new contract with a new consortium or even setting up anew a single state purchaser. The duration of the

renegotiation should be shorter than that of a new negotiation reducing as much media attention on the issue and therefore the extent of the blame. In short, rational politicians should prefer making concessions during the duration of a PPP to save existing contracts over risking their termination, a situation more favourable to blame passing toward politicians.

Thus far, I have made the following argument: assuming actors act rationally, private consortia should not sign PPP contracts acceptable to politicians, unless they know politicians will renegotiate clauses occasionally. And risk averse politicians should prefer such renegotiations over contract termination, because contract termination should generate more blame. Under these circumstances, PPP contracts are good deals for both, politicians and private consortia. But are PPP contracts, which cannot be tightly sealed to make them acceptable to politicians and private consortia, still a good deal for economic efficiency from the perspective of society? If we return to the neo-institutional economic theory presented at the beginning of this section, the answer has to be no: sealed contracts serve an essential economic function.

Competition during the bidding process is the incentive for bidders to come up with an innovative plan to purchase high marginal benefit and low marginal cost health technologies. After the state's selection of a successful bidder, a private consortium, competitive incentives vanish. The 15 to 30 years contract guarantees the private consortium a monopoly over the supply of given health technology in publicly financed health care centres. In absence of competitive incentives for the private consortium to remain innovative, the contract becomes the incentive. If the consortium fails to remain innovative, as indicated by benefit targets, the contract should provide for penalties, which are the risks to the consortium. Conversely, the contract should reward innovation with profit generating prices. Thus, a sealed contract serves the function of maintaining incentives for innovation in the absence of competition. Naturally, any renegotiation of the contract's clauses modifies the incentive structure. A change in the benefit target, for example, may open the possibility for the consortium of purchasing technologies with lower marginal benefits for patients, without changing the costs and benefits for the consortium. Opening a valid contract enables the consortium to transfer a share of the risks, for which it had accepted responsibility, to the state. It is worth mentioning that a key alleged advantage of PPPs is risk sharing between the state and a private partner. In addition, given the absence of competition during a partial renegotiation of a PPP contract, the private consortium has no incentive to worry about economic efficiency for society and can focus on profit maximization. Once a PPP contract is partially renegotiated, which by definition can only occur outside bidding processes, all incentives for the consortium to favour economically efficient health technology for society disappear, hence the importance of sealed contracts.

In sum, PPPs can alleviate difficulties encountered by politicians in the politics of health technology provision. Private consortia, however, will sign PPP contracts only if they know they can be partly renegotiated during their long-term validity period, something politicians should prefer over negotiating a new PPP or setting up anew a single state purchaser. However, this possibility of contract renegotiation becomes a real problem from the perspective of economists who justified the adoption of PPPs in terms of efficiency for society in the first place. Indeed, tightly sealed contracts are an essential condition for PPPs to deliver economic efficiency.

PPPs and the irrational aspects of health technology decisions

Treating the purchase of health technology as an economic choice, as I did in the preceding section, is an interesting exercise as PPPs are themselves justified as choices relevant to economics only. I have shown that the rationality assumption, upon which economic theory is premised, can lead analysts to conclude that PPPs are not efficient economic solutions in the area of health technology, to the extent the essential role of politicians in PPP decisions is acknowledged. Critics often reject PPPs by rejecting the rationality assumption first; the above demonstration was to show that one does not have to reject the rationality assumption to reject PPPs. This been said, there are good reasons to contest the treatment of health technology decisions as economic decisions in rationality-based analyses. In fact, health technology decisions may warrant a broader outlook; one that also accounts for the ethical, the social, the cultural and the political aspects of these decisions. In this section, I present arguments pressing for the adoption of this broader outlook and consequential reforms in health technology decision arrangements. I argue that in comparison to a single state purchaser, a PPP is unlikely to encourage the adoption of a broader outlook on health technology decisions.

The assumption that the marginal benefit of health improvement for younger people is higher than the marginal benefit of life expansion for older people is based on an ethical judgment. It indeed suggests that a just society should care more for a young but ill person than for someone who has already enjoyed a relatively long and healthy life. Life has already given a lot to the latter person and not as much to the former. Therefore, it is only fair to spend more on health technology benefiting younger rather than older people. It should be underlined that this ethical judgment does not stem from any universal philosophy. From a philosophy of society, it could easily be depicted as discouraging social cohesion, by pitting younger generations against older ones. Equity, some philosophers argue, should be built as to avoid threatening social cohesion. Most social scientists would find highly simplistic any view of society around a single cleavage, societies been divided around gender, wealth and culture. If purchasers have to choose between health technology for young and old people, they certainly also have to choose between health

technology for women and health technology for men, between health technology for the wealthy and health technology for the poor and so on. Health problems indeed differ for each of these groups and therefore each needs different health technologies. Economists, who tend to rely on simple ethics, have little to say about the marginal benefits of health technology along these other social lines, hence their focus on young versus old people.

Ethical judgments are tainted by cultural norms. For example, caring for the elderly counts among essential values for some cultural groups. In these groups, the legacy left by the elderly is treated as incommensurable and consequently their life deserves much better than been treated as a marginal benefit. To these cultures, any suggestion that health technology should prioritize younger people is shocking, at best. In countries where citizens are proud to belong to pluralistic societies, these cultural norms cannot be ignored. In addition, I believe important to stress, as a political scientist, that any health technology choice is a political choice, reflecting power relations among social groups. Some political scientists would warn against any reasoning presented in a technical language, which appears politically neutral (Jasanoff, 1990). The treatment of life expanding technology for older people in terms of marginal benefit provides a good example. Older people are unlikely to view their life as any less valuable than that of younger people and consequently could understand this discourse of marginal benefit as one to disguise an intergenerational conflict over health care resources. Far from the neutrality-claim of economists, the discourse would provide younger generations an advantage in a political game in which older people are vulnerable participants.

In any case, the ethical judgment behind the reasoning of economists says nothing about how much more should be spent on health technology for younger people, assuming resources are always shared, even if unequally. Economists can only suggest that between two technologies, with equal marginal cost, decision makers should opt for improving the health of younger people over expanding life for older people. Naturally, real life decision situations are never this simple. Health technology purchasers, in fact, never choose between two technologies. They normally decide upon technologies, one at the time. To the extent the ethics of economists do not ban all technology benefiting older people, it fails to provide any guidance in a process that does not allow comparisons. Again, economic reasoning provides no indication on how much should be spent on young versus old people.

In short, excellent reasons exist not to view health technology choices only as economic choices. And these reasons are behind new ideas to reform the assessment and purchase arrangements for health technologies. Where these arrangements have placed technical expertise above all other principles, reformists demand transparency, openness to actors from various backgrounds and political responsibility (Jasanoff, 2003; Einsiedel, Jelsoe and Breck, 2001). Reformists hope to transform health technology assessment and purchase arrangements into sites where legitimate ethical perspectives can be expressed and debated in a politically responsible manner. Interestingly enough, these reform ideas, increasingly accepted in the technology assessment literature, also begin to influence policy makers, notably in Europe. The introduction of PPPs as an alternative to a single state purchaser of health technology, however, threatens this progress.

Social scientists recognize increasingly that the institutional environments in which actors are involved shape their preferences (e.g., Hall, 1986). While rational choice theory holds that actors develop preferences from calculations of benefits and costs of every possible alternative, several social scientists believe that the cognitive capacities of humans are too limited to proceed with such a calculation. Under these circumstances, the worldviews and norms embedded in institutions can help actors form their preferences. Institutions provide actors with given understandings of given situations and suggest appropriate courses of action. While all actors involved in institutions will not automatically integrate the institutional perspective, it nevertheless provides a more realistic basis for preference formation than rational calculation. And to the extent PPPs represent an institutional change in the area of health technology purchase, it can be argued that it will contribute to changing the preferences of the actors of this area.

Institutionally speaking, PPPs encourage actors to view health technology choices strictly as economic choices. Again, a PPP in the area of health technology involves the replacement of a single state purchaser by a private consortium. The single state purchaser, is solely accountable to elected politicians. In contrast, the private consortium in a PPP has a contractual relationship with elected politicians, but is accountable to investors. Under this latter accountability structure, the consortium, more than the single state purchaser, is likely to view health technology choices as economic choices. Unlike politicians, whose concerns arise from a broad constituency, investors only worry about the profitability of their investments. As such, they have little time to devote to understanding and discussing the views of such and such cultural groups on the elderly, for example. From the perspective of a private consortium, transparency and openness represent unpredictable costs, which can inspire fear among investors. Moreover, the consortium should not accept the intrusion of external actors in its decisions, to the extent the PPP contract attributes an important share of the risks to the consortium.

PPPs might even contribute to truncating the perspective of politicians on health technology. Without private consortia that view potential profits in PPP contracts, PPPs are impossible. Even politicians, who could be convinced that the ethical judgment upon which the economic perspective rests is too narrow, might be pressed to accept this latter perspective in an institutional environment favourable to PPPs. Social, cultural and political perspectives on health technology purchase, unlike the economic perspective, just cannot be reconciled with the idea of profits.

Therefore, adopting the economic perspective is a prerequisite for PPP contractual negotiations. Where PPPs are perceived as easy solutions to the difficulties of health technology purchase (because blames can be passed to a private consortium) politicians should view health technology choices as economic choices for the sake of contractual negotiations.

To be sure, single state purchasing arrangements of health technology are also likely to serve as anchors for narrow perspectives. As suggested above, these arrangements have valued technical expertise above any other principle and therefore their internal logic might offer resistance to change. Unlike PPPs, however, nothing in the accountability structure of conventional single state purchasing arrangements should prevent broadening the ethical judgment upon which health technologies are chosen. Public administrations are normally accountable to politicians who themselves must be responsive to broad constituencies. Therefore, once freed from prerequisites arising from PPP contractual negotiations, and assuming they are not entirely risk averse, politicians should be favourable to broad and even plural ethics rather than narrow ones. And in an institutional context where health technology decisions should be explained to politicians rather than investors, assessors and purchasers would be well advised to remain in touch with various social groups representing various perspectives. In a few words, more than in a private consortium in the context of a PPP, public administrators accountable to politicians obey the prerequisites of democracy (Du Gay, 2005).

Conclusion

In this paper, I have argued that rational and calculating actors can influence the success of a PPP in the area of health technology. Economists, essentially analyzing the behaviour of economic actors, argue that PPPs create an incentive structure favourable to the making of efficient health technology choices for society. In democratic countries, however, PPPs cannot be negotiated without politicians. Because they are risk averse, rational and calculating, politicians are likely to view PPPs as a way out of the difficult decision situation created by health technology. However, the specific PPP contracts acceptable to politicians are unlikely to be accepted by rational economic actors, unless they can be partly renegotiated occasionally. Unfortunately, economists predict that the efficiency of PPPs is lost when PPP contracts are not tightly sealed for long periods.

Relaxing the rationality assumption upon which the first section of this paper is based, I argued in the second section that institutional contexts can shape the preferences of actors in significant ways. And PPPs create an institutional context favourable to an understanding of health technology choices as economic choices only. Private consortia involved in PPPs are accountable to investors who demand profitable economic decisions and politicians, if they desire avoiding blame through PPPs, must treat health technology choices as economic choices to attract private consortia. Unfortunately, the institutional context created by PPPs undermines other perspectives on health technology choices, which have legitimate claims at least as strong as the economic perspective.

Just like health care, public services in several sectors have come to rely on sophisticated and costly technologies. The analysis presented above should therefore have some resonance in other sectors. The above analysis would certainly benefit from adjustment in sectors whose nature is significantly different from health care, but it nevertheless provides me with great confidence that PPPs constitute an unattractive alternative to conventional modes of public administration in a large number of sectors.

I have written this paper, however, I do not believe that calculating actors and institutions alone determine political choices: ideas also shape institutions and the preferences of actors. I have argued that PPPs, in the area of health technology, will unlikely be economically efficient and that a single state purchaser presents considerable advantages from a democratic perspective. I hope this idea will contribute to institution building and to shaping the preferences of influential actors.

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