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PPP hospitals and the Portuguese experience

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In Portugal, experience has demonstrated PPP effectiveness for the rapid development of infrastructure and for the improvement of service to end-users, but sustainability and efficiency matters are still being addressed, and currently being challenged by the financial crisis and by affordability concerns. The goal of this short paper is to present the Portuguese PPP models for acute hospital infrastructure, in the context of a significant diversity of PPP models and experiences around the world.

Hospital PPP models. Currently there are many experiments on PPP contracts for hospitals, in several countries, using a few different contractual models. For now, we can say that a few of them failed and the vast majority demonstrated effectiveness and fast delivery of infrastructure — but their efficiency is not proved, and that efficiency will depend critically on the quality of contract management and on the environment.

The vast majority of contracts for PPP hospitals were signed in the UK, under a model called PFI (from Private Finance Initiative), a model that changed over time but maintained some basic characteristics, such as the absence of clinical services in the range of services to be provided by the private partner. This model —we may call it **'infrastructural model'**— was followed in other countries, such as Italy, Germany, and Canada. Most of those contracts are design-build-finance-maintain (DBFM) contracts, including the additional provision of several non-clinical services (cleansing, catering, and security). The last contracts that were signed in the UK tended to a streamlined model, only including DBFM, and with less and less additional services.

Another PPP model for hospitals integrates all hospital services in a PPP contract — we may call it the **'integrated model'**. The first few experiments were done in Australia (Latrobe hospital, in the State of Victoria) and Spain (Alzira hospital, in the Region of Valencia) and, for different reasons, failed.¹ Despite these setbacks, Portugal decided to procure integrated contracts (with success until now) and Spain (Region of Madrid) also procured some contracts (and is procuring a few more). There are two different subtypes of these DBFM integrated PPP contracts: one based on the payment of availability and services, another based on per capita payments (and typically integrating also some non acute-hospital services, such as primary care).

A third type of model for hospital PPPs is a facility-specific DBFM contract, used in France, that includes parts of a hospital: one building with beds for in-patients, or radiotherapy facilities, or a medical/technical block, or a rehabilitation unit, or nurse training facilities, or dry-cleaning facilities.

Integrated models. These models transfer significant risks to the private partners, but at the same time give those partners the ability to manage the risks efficiently.

¹ The Latrobe hospital reverted to public management. The Alzira hospital was renegotiated and is now operating under private management, but with payments from the public to the private partner much higher than initially contracted.

-Higher potential for innovation and efficiency gains: Due to the integration and to the allocation of property rights, many externalities are internalized, and so the private partners are entitled to benefit from the innovations they introduce and from the better management practices they apply.

-Lower interface risks: The interface between private partners and public sector is located in an area related to the quality of final services provided to the end-users of the hospital, and not in the very complex area of infrastructural services, or other services to be provided to a public sector hospital management.²

-Higher political sensitivity: The ‘price’ of having lower interface risks is precisely the increased sensitivity of contractual problems, due to having private operators providing clinical services to the end-users. As a matter of fact, this is a difficulty that benefits the end-users, because public authorities will be forced to care more for the quality of service than they would if the hospital management was in public hands.

-Contract management: Because it is output-based, focussed on clinical outcomes, there will be scarce need for daily co-operation, reducing conflict. However, it will imply a significant need for benchmarking (better information on performance of public hospital, an additional benefit for the public) and a game-theoretical reasoning in preventing perverse strategic moves by private partners.

Infrastructural models. These models (e.g. the PFI model) reduce political risk but create significant interface risks that may jeopardize the efficiency of the contract.

-Lower potential for innovation and efficiency gains: Private sector decisions will affect the operation of clinical services; but the operational benefits and costs will not impact on the private partner, so their decisions will tend to be biased, avoiding costly but highly beneficial innovations, and trying to deliver cost-cutting innovations regardless of their impact on the operation of the hospital.

-Very high interface risks: Because the private partner will be providing infrastructure and services to a public sector management, there is a wide range of matters that provide opportunity for conflict and require prevention.

-Lower political sensitivity: Most interface problems relate to internal management problems, and so will have very low visibility or political sensitiveness.

-Contract management: The large volume of interface risks suggest a high need for co-operation between partners and many other stakeholders, emphasising daily routines vs. long-term management/strategy. This creates a high potential for cost-overruns.

Other models. The PPP models that contract a DBFM for a part of a hospital (a block, a building, or specialized facilities) present the advantages of having low political sensitivity and, at the same time, low potential for conflict as long as the private partner is able to manage a specific ‘business’ inside the hospital (and so being able to benefit from efficiency savings). However, their potential for efficiency savings is low.

Why hospital PPPs in Portugal? The experience of procuring public hospitals was not a good one in the last two decades of the XXth century: several design-build contracts had been signed and the results were disappointing: sub-standard performance and high cost-overruns. The evidence pointed to the fact that competitive tenders for design-build contract were pushing bids down and inducing contractors to cut corners to an unacceptable extent. So, the options were (a) the improvement of traditional

² E.g. the allocation of responsibility for the contamination of an operating room, either by failure of the surgeons or by failure of the infrastructure, will not be a matter of disagreement between public and private partners, but a problem to be addressed by the private managers.

procurement, re-developing a procurement capacity that the Ministry of Health had been loosing for many years, and (b) the use of long-term performance-based contracts (i.e. PPP contracts). The political decision was to go for PPP contracts.

Implementing hospital PPPs in Portugal. The PPP hospital program was launched in 2003, following more than two years of research on PPP hospital procurement. In order to attract private partners, the government announced that it would procure a number of hospitals, presenting an indicative timetable and listing the hospitals involved. The launch of this program was simultaneous to the approval of a new framework for PPP procurement, so the hospital PPPs were the first projects in Portugal that were launched on the basis of a carefully scrutinized business-case, including a public sector comparator (PSC). The Health Minister created an ad-hoc organization in charge of the logistical support for PPP procurement, but each project was managed by a Steering Committee and a Tender Board, both jointly appointed by the Finance Minister and the Minister of Health.

The need for a pipeline of projects. When preparing the program, a critical point was the need for competition among several business groups with the know-how and management ability for such a complex task as managing public hospitals. The size of the health market in Portugal did not allow for that competition. So one of the first decisions was the public announcement and commitment on delivering PPP projects for hospitals, and on delivering a significant number of hospitals, not only a few. The government announced plans for two new hospitals and for eight replacement hospitals.

This announcement encouraged several business groups to initiate a strategic move for reaching critical mass, through buying small clinics and hospitals, hiring managers and experts, establishing alliances with foreign health-sector firms. In just two years, five or six private sector health firms had created the ability for bidding for PPP hospitals, creating conditions for competitive tenders and for the delivery of innovative proposals.

Why was an integrated model selected? The integrated model presented higher political sensitiveness but a higher potential for obtaining efficiency gains. And, because PPPs were introduced at the same time that a complete reorganization of the hospital sector was being delivered (transferring all public hospitals to business units, managed by private or by public partners, and contracting their services with the public authorities), the higher efficiency gains obtained with an integrated model would benefit not only the PPP hospitals, but the whole network. So, PPPs were introduced in a context of institutional reform, and led to additional institutional reform (because they required better care for quality and performance, and because they created new benchmarks). The decision to select an integrated model was, of course, a political decision — transferring the provision of clinical care to private partners requires political willingness to face the inherent political risks and to manage them.

The Portuguese government that entered office in 2005, two years after the first call for tender, had a different political complexion, and so decided to call for a new type of PPP contracts (similar to PFI contracts), but kept the procurement of integrated contracts that were being tendered (a total of four, of which three are now signed, and one is reaching contract close). The decision to have a new PPP model for hospitals was never clearly stated, but we may say that it was a mix of concerns regarding political risks, pressure from trade unions, and ideological positioning.

Rationale for integration. The rationale for integration, stated when the program was launched in 2003, pointed to:
-Innovation in management;

- Innovation in the design of infrastructure;
- Synergies between infrastructure and services (whole-life costing);
- Potential for risk-transfer (avoiding cost overruns and project completion delays);
- Incentive to control investment and operational costs, allowing for increases in quality;
- Ability to benchmark performance.

Range of services. Integrated contracts include the provision of every kind of service needed in a hospital. As a matter of fact, those contracts even allow for the provision of private clinical care, not provided by the National Health System (e.g. non-essential aesthetic surgery), but subject to some constraints.

The infrastructural contracts (currently being tendered) include only the DBFM of infrastructure (including non-medical equipment) and a few services: catering, cleansing, laundry, security, management of parking and shops, waste management, pest control, sterilisation of equipment, and utilities management. The provision of medical equipment is not included, as well as IT services and clinical services.

Risk allocation and reward mechanism. The main goal is allocating to the private partner the risks it can manage efficiently. In integrated contracts, demand risk is allocated to the private partners, but mitigated by a split scheme: the winning bidder will create two special purpose vehicles (SPV), one responsible for the management of infrastructure, the other for the management of clinical services. There is a single contract, signed by the public authority and by these two SPVs. The infrastructure SPV (the one that delivers most of the investment) signs the contract for 30 years and is paid according to availability (a unitary fee, plus penalties for lack of availability and for sub-performance). The clinical SPV (the one that receives the largest payment every year) signs the contract for 10 years (with the possibility of extension until 30 years, conditional on contractual performance and on the public interest) and is paid according to effective demand (but with a mechanism that mitigates demand risk), plus an availability payment in the case of emergency services (just to pay for having a fully operating emergency service even if demand is low, always ready to be used in case of need). Demand risk is mitigated by a process of annual 'expected demand' negotiation, allowing for the hospital capacity to be adjusted to demand and to the needs of the health network taken as a system.

Payments for effective demand refer to final outputs (e.g. out-patient visits, emergency visits, ambulatory surgery and in-patient discharges) and not to inputs or intermediary outputs. Except in extreme cases, in-patient discharges are paid according to the complexity of event (classified according to the table of homogeneous Diagnostic Related Groups, or DRG) and not to length-of-stay. Of course, this creates incentives for efficiency (e.g. no need to delay discharge in order to fatten the bill) but could also induce some perverse incentives (e.g. incentive for early discharge), so the contract includes a set of penalties for sub-performance, including, for instance, heavy penalties for higher-than-standard mortality and for in-patient re-admission for the same motive.

Allocating risk to the private partners implies paying a risk premium. And sometimes allocating a risk to a private partner implies also creating a risk to the public authorities. For instance, locking the partners into a long-term contract allows for an efficient pricing of public services, but locks also the public partner into a long-term relationship that may be affected by technological, demographical or political change. So PPPs create political and fiscal/budgetary risks that need to be addressed. That is why the integrated contracts are split between two SPVs with different contractual terms (30 years for amortizing the investment in the long-life infrastructure, but only 10 years for the shorter-lived assets of the SPV potentially more affected by change).

The allocation of risks is related, not only to the capacity to manage the risks, but also to the public sector capacity to manage the contract (to enforce it, to manage fiscal risks). Contract management capacity needs to be created when a PPP program is launched, but there are limits to that capacity. So, potential perverse incentives need to be considered in designing the contracts. In the case of integrated contracts, they include incentive mechanism for dealing with cream-skimming³ and demand-fostering⁴.

Financial constraints. The current financial crisis, exacerbated by the fiscal sustainability concerns, creates a context not favorable to PPP development. The higher cost of private finance impacts on tenders with bids already delivered. But the reduced tenor is affecting all projects, creating a more important role for multilaterals (e.g. EIB) as providers of long-term finance. Government guarantees are being sought, creating additional concerns regarding moral hazard and adverse selection of bidders. The current higher risk-aversion is influencing contracts. The need for bankability is forcing changes in risk-allocation. Efficient contractual risk-allocation could be damaged. In the end, political willingness to promote PPP may be affected.

New institutions. An interesting aspect of PPP development is that it is inducing institutional reforms. And the new institutions being created are more focused on quality and performance. PPP hospitals may (and should) be used as benchmarks. PPP procurement requires shifting public administration resources from input and process definition to output prescription and outcome measurement, so the focus will be quality and effectiveness. The end-user benefits from this, and the taxpayer should also benefit.

Current situation in Portugal. After a somehow slow procurement process, Portugal has now three PPP contracts signed, interesting experiments on private management of public services. One PPP hospital (Hospital de Cascais) is already built and operating under management of the private partner. Two PPP hospitals are being built by private partners (Hospital de Braga and Hospital de Loures). The private partner is already managing the Hospital de Braga and preparing the transfer to the new building. A fourth (all-inclusive) PPP hospital contract (for Hospital de Vila Franca de Xira) is nearing its closure. Two other hospitals (Hospital de Lisboa Oriental and Hospital Central do Algarve), both based on infrastructural PPP contracts, are being tendered now. Other PPP-hospital projects (only infrastructural) are prepared and waiting for the market conditions to improve.

As international experience demonstrates, managing PPP contracts is usually a challenge to the public authorities. In the Portuguese case, three main contract management activities are now being developed: contract enforcement, co-operation between partners for solving common problems and management of fiscal/budgetary risks and prevention of perverse strategic moves by the private partner. These are inducing natural changes in the management of the public sector.

The future. Several models are now implemented, in the UK, Portugal, France, Spain, and other countries, many hospitals were built under PPP schemes, and many more are being built. Contract management is also evolving, responding to the perceived needs. Some PPP models will survive, others will evolve. And it will be important for decision-makers and procurement managers, to have the necessary information and better analysis of the available PPP models.

³ e.g. undue transfers of costly users to other healthcare units

⁴ e.g. creating excess supply that attracts demand in a way that jeopardises the Health System by paying excessive demand in some units and excessive capacity in others