

[logos of the UNECE, WHO, and ADB]

DISCUSSION PAPER¹

**A PRELIMINARY REFLECTION ON
THE BEST PRACTICE IN PPP IN HEALTHCARE SECTOR:
A REVIEW OF DIFFERENT PPP CASE STUDIES AND EXPERIENCES**

DRAFT

¹ The Discussion Paper was prepared for the conference ‘PPPs in Health Manila 2012: Developing Models, Ensuring Sustainability: Perspectives from Asia and Europe

ACKNOWLEDGEMENTS

The Discussion paper on “*A Preliminary Reflection on the Best Practice in PPP in Healthcare Sector: A Review of Different PPP Case Studies and Experiences*” was prepared by Geoffrey Hamilton, Chief, Cooperation and Partnerships Section, and Meerim Kachkynbaeva, Consultant, Cooperation and Partnerships Section representing the the Public-Private Partnership Team of the United Nations Economic Commission for Europe (UNECE); Isabelle Wachsmuth, the World Health Organization (WHO) and adviser for the Cooperation and Partnerships and Sustainable Energy Divisions, the UNECE; and Emi Masaki, Social Sector Economist, Southeast Asia Department of the Asian Development Bank (ADB).

The UNECE, WHO and ADB would like to express its appreciation to Jill Jamieson, Deloitte Consulting LLP, Alberto Germani, former Member of the PPP Task Force in Italy, Leo McKenna, Chair of the Team of Specialists on PPPs of the UNECE and Kim Jungwook, Director of PPP Division, Public and Private Infrastructure Investment Management Centre (PIMAC) for contributing to some of the chapters and providing excellent advice and comments to the overall document.

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INTRODUCTION

The cost of delivering health care in developed and developing countries has been rising exponentially due to ageing populations, increases in chronic diseases, and rapidly changing and advancing medical technologies. With restricted budgets, governments are looking to PPP to contain costs and improve health outcomes and thereby achieve some of the critical goals in their health policies.

The purpose of this discussion paper is to define PPPs in the health sector, identify best practice/ excellence in PPP and then test from some case studies the extent to which PPPs are achieving this, concluding with some recommendations for their wider use.

PPPs are occurring all over the world and across many sectors like transport and energy with now a considerable history and track record of experiences – both good and bad. In the road sector for example, government policy makers can make use of case studies, toolkits and banks of knowledge on ‘best practice’ to design their programmes.

By contrast, in social sectors, such as in health, where experiences are rather more recent, there is no knowledge on ‘best practice in PPP for policy makers to draw on. PPPs in health have thus tended to grow ‘organically’ and as a result, anecdotes of what has worked or not worked have tended to dominate discussion as opposed to a systematic analysis based on actual case studies and aggregated data. In addition, and as a consequence of this lacuna, there is often a confusion that runs very deep, as to what PPPs precisely mean when applied to the health sector.

As stated in the title, this is a preliminary analysis of PPP in selected countries and in actual case studies. It constitutes a first attempt – which requires to be followed up - to define best practice/ excellence in the context of PPP in health. Of course some argue that trying to define excellence in PPP is something like an oxymoron. You cannot define ‘excellence’ in PPP because health services should only be delivered by the state². In the developed world and especially in Europe, national, comprehensive, state run and financed health services have been a force for good and one which has been a subject of great national pride (opening ceremony of the Olympics)³.

Accordingly, the use of PPP in the health sector today is a matter of some debate - and rightly so - in many countries in the world. Some key issues undoubtedly need to be resolved if their use in the sector is to be advanced and some of these issues will be raised in the cases studies. This being said, the premise of this discussion paper, is that PPPs are the only way to meet the enormous challenges facing the health sector in the 21st century (the only ‘show in town’ Alan Milburn Health Minister UK).

The Paper is organised as follows:

²There is a widespread confusion between PPP in the public health and private healthcare network, which inevitably lead to incorrect debates. In many (exp. developed) states both coexists, but never overlap. Public healthcare provision is a ground principle in many countries worldwide, often constitutionally guaranteed as fundamental right to citizens, whereas private healthcare is a business-like activity. PPP in the healthcare thus relates only to the public service area, and doesnot have anything to do with private care. Concluding, in many countries’ view PPP is a way to improve cost-effective public service provision in health, nothing to do with privatization of services that always, and rightly, scares both politicians and citizens. There is of course the case of countries (exp. in world developing areas) in which the public healthcare provision is yet lacking and process is ongoing. In such cases one should adopt tailored-based PPP schemes, without deviating from the general objective to create the grounds for fostering a public dispensed basic assistance. In achieving this - PPP can be very helpful. (Alberto Germani)

³The opening ceremony in London featured attribute to the National Health Service (NHS) which is held in great affection by all UK citizens.

1. Description of PPPs, their use in the health sector and search for excellence in PPPs;
2. Overview of the use of PPPs in the health sector in selected countries;
3. Experiences from case studies in hospital PPPs and healthcare related programmes;
4. Recommendations for advancing the PPP model.

DRAFT

CHAPTER 1

WHAT ARE PPPS AND HOW ARE THEY BEING DEVELOPED IN HEALTH SECTOR?

Categories of PPPs in health

For the purposes of this paper we have divided PPPs in health into two broad categories:

The first category refers to hospital-based PPPs which can be tailored to meet specific needs, with the private sector's role ranging from facility management and non-clinical services, to specialized clinical services, and to full hospital management including all clinical services. These are based on generally but not exclusively long term contracts and project finance where the private sector takes over the running of certain functions that had previously been reserved for the public sector like design, finance, and maintain some services and where the public sector can shift certain risks onto the private sector to manage. The four sub-categories identified are:

- (i) Infrastructural PPPs
- (ii) Integrated PPPs
- (iii) Facility-based hospital PPPs
- (iv) Lease contracts

The second category refers to the use of PPPs in delivering health programmes and we define these into five broad sub-categories:

- (i) Research and development
- (ii) Improvement of access to health products
- (iii) Public advocacy and increasing awareness
- (iv) Regulation and quality assurance
- (v) Training and education

Key drivers in the use of PPPs

There are multiple drivers for the use of PPPs in both developed and developing countries context; generally the main ones are the following:

- Using the expertise and skills of the private sector: In modern technology intensive health care systems PPPs allow governments to leverage the expertise and skills of the private sector and thereby improve the quality and accessibility of public health care systems. “PPPs shift the capability burden of the public sector and into the private sector, where – arguably – there is much greater capacity to deliver infrastructure. Simply put, the private sector has a wealth of experience in structuring, procuring and managing the delivery of massive projects and has access to a wide range of resources and skills.” (*James Stewart, KPMG*);
- Value for money: Governments want PPPs to provide more Value for Money (VFM) compared to traditional forms of procurement which do not transfer risks to the private sector. VFM is defined as the optimum combination of whole life cost and quality to meet the user's requirement. Value for money depends on

appropriate risk transfer between the public and private sectors⁴. Financially, private financing is a way to provide infrastructure without increasing the public sector borrowing and reduce pressure on public finance constraints⁵ and is driven by pressures for governments to reduce public spending to meet political, legislated and/or treaty-mandated fiscal targets (i.e. Maastricht criteria).⁶

- Increased funding being spent of GDP on health: According to PwC estimates, the BRIC nations (Brazil, Russia, India and China) are expected to experience even stronger growth in health spending, which as a percent of GDP is expected to grow from 5.4% in 2010 to 6.2% in 2020. This amounts to a 117% increase in actual spending over the decade, where China is leading the way⁷.

What is excellence in PPPs in health?

Excellence ‘in health care delivery’ in PPPs is difficult. There is also a huge literature on the topic although much less as it concerns PPP. For the purposes of this paper, we have defined the term according to four criteria: equity⁸, efficiency and replicability.

Equity means social justice or fairness. Health equity is the absence of systematic disparities in health between more or less disadvantaged social groups. Promoting equity in health can be defined as improving health outcomes amongst the socially and economically disadvantaged.

Access in health care is defined in terms of increasing access to services. One issue raised by critics of PPP is that PPP is so expensive relative to conventional procurement that there is less to spend on care, new wards, beds, etc. and thus decreases access to care.

Efficiency is the ratio of the output to the impacts of any system. Any efficient system is one which achieves higher levels of performance (output) relative to the inputs (resources, time, and money) consumed⁹.

Replicability is defined as property of a project that allows it to be duplicated at another location and can be easily adapted to another context. It is a major challenge to transfer PPP projects across borders: projects typically products of culture, institutions, legal framework and financial system unique to its own national environment.

⁴IFS Support to Health Public-Private Partnerships. International Finance Corporation, 2010.

⁵Somanathan, John C. Langenbrunner and Aparnaa. Financing Health Care in East Asia and the Pacific: Best Practices and Remaining Challenges. The World Bank, 2011.

⁶ A bad practice is that governments use private finance to disguise public expenditure and to push it ‘off-budget’, without any real risk transfer, innovation, or efficiency gain. The consequences of pushing commitments ‘off-budget’ are reduced incentives and ability to control costs and the risk that the government will accumulate more liabilities than it can manage. A good practice is to integrate PPPs into overall fiscal accounting and risk management framework, thus ‘on-balance’ (World Bank & PPIAF 2007).

⁷Build and Beyond: The (r)evolution of healthcare PPPs. PwC, Health Research Institute, December 2010.

⁸Access to care is a key measure of performance. Equitable access to hospital services is critical to the perception of performance in the country’s health care system.

⁹One metric used by the healthcare industry to measure efficiency is average length of stay (ALOS) in a hospital.

CHAPTER 2 SELECTED COUNTRIES EXPERIENCES

CANADA

Scope

The public – private partnership (PPP) model of hospital delivery – the procurement of hospital facilities through design build-finance-maintain (DBFM) or similar contracts - was introduced into Canada almost a decade ago, with the Brampton Civic Hospital project in Ontario and the Abbotsford Regional Hospital project in British Columbia.

Since 2003 more than 50 hospitals PPPs valued at over CAD 18 billion have proceeded, and are either in procurement, construction or already in operation. Most of these have been in Ontario with others in British Columbia, Quebec, and very recently, New Brunswick. Canada's healthcare infrastructure renewal goals are progressively being realised through the PPP model.¹⁰

Under the PPP hospital model, the private company constructs and owns the physical hospital building and lease to hospital board. Hospital board takes the responsibility of running the hospital. Based on performance, the provincial government adjusts the annual budget for the hospital for the next year. Other PPP models exist outside the hospital eg. for the care of the elderly. Another example comes from for-profit MRI (magnetic resonance imaging) clinic which speed up the access to MRI scan by payment to the private sector. In health sector PPPs in Canada, especially in hospitals, clinical services are provided exclusively by the public sector.

Rationale

Canada primarily uses PPPs in the health sector to generate savings to the public sector. Every PPP in Canada must be supported by a detailed economic case which demonstrates that the PPP approach represents better value for money to the Canadian taxpayer than a traditional procurement approach.

[Need to add a quote from Mark Romoff, NCCPPP, Canada]

Impact

Generally, the impact of using PPP has been positive:

- Value for money: PPPs are estimated to have saved hundreds of millions of dollars in costs to the taxpayer. Hospital PPPs in Canada were assessed for their ability to generate risk-adjusted costs savings against non PPP delivery options. Savings arise because PPPs better integrate construction and maintenance considerations into design, and transfer risks to the private sector that it can manage better and more cost effectively
- On time –on budget – delivery: the private sector has delivered in most cases hospitals on time and on budget, driven by contract structures strong project

¹⁰ Based on database of CCPPP, until Nov 2011, 59 out of 159 PPP projects all over the country are related to hospital & healthcare. Among 59 projects, 23 of them are using DBFM model, all of them are with cooperation of provincial/territorial governments, 25 are at operation stage, 26 are under construction, 40 located in Ontario, 10 in British Columbia, 6 in Quebec.

management. The reduction in cost and schedule for hospital PPPs is a key driver of value for money.

Innovation. Many PPP hospitals have output-based specifications – which articulate functional requirements, not specific design solutions. PPP competitive procurements trigger design and facility management ingenuity. Better more efficient solutions have tended to win, leading to more efficient use of space and better environment for patients, visitors and staff.

However, PPPs in Canada's health sector also have encountered problems with:

- Communications / misperceptions of the public
- Opposition by the trade unions /Canadian Union of Public Employees
- Long term nature of PPP contracts gives rise to uncertainty
- Complexity of transactions

TURKEY

Scope

Reform of Turkey's public healthcare system is a top priority of the Turkish government and has chosen to do this through PPP. Aware that very substantial capital investment in new hospital facilities is needed to achieve its goals, the government has launched an ambitious PPP scheme for the healthcare sector with the promulgation of a healthcare PPP regulation in 2006 and tenders for 15 integrated hospital projects throughout Turkey¹. These 15 projects represent more than 25,000 beds and total capital investment costs of more than \$5 billion; each will replace an existing hospital with a new healthcare complex. The PPP scheme is inspired by close study of European counterparts, in particular the UK PFI scheme²

Under the Turkish scheme, investors will finance, construct (or renovate, as the case may be), furnish, supply, operate and maintain the hospitals. The Ministry of Health will remain responsible for providing medical services but the project company will provide certain clinical support and other support services in these new hospitals. Clinical support services could include imaging, laboratory, sterilization and rehabilitation and other support services would include building maintenance, cleaning, utilities management, information management, grounds maintenance, reception, car park, waste management, laundry and catering. The project company is also entitled to offer commercial services if the proposed services are compatible with a hospital environment.

The model consolidates hospitals under one single medical campus in order to benefit from economy of scales and greater management efficiencies. It concerns mostly large hospital infrastructural projects and is expected to increase the quality of care in cities, i.e. Istanbul, Ankara, Bursa, Konya, Kaysari, Elazig, Manisa, Mersin and Yozgat.

[need to add quote from Ahmet Kesli, Turkey]

Rationale

The Government is using PPP because it has only limited public resources to achieve its ambitious plan and close its health infrastructure gap. For example, per 10,000 inhabitants, it has just 29.9 hospital beds, compared with over 80 per 10,000 in Germany. The Ministry of Health estimates that 93,500 new beds are needed up to 2023.

Impact

None of the proposed PPP hospital mega projects is operational. This being said the Kayseri Integrated Health Campus is the country's first real experience with PPP and is progressing well. The base case concession is for three years of construction and 25 years of operations. The second major hospital project has been awarded by the Ministry of Health for the Ankara Etlik Health Campus.

Amongst some of the critics of this PPP approach are those who warn that, with already apparent health inequality between the urban and rural areas in Turkey, this planned investment in the urban areas will merely accentuate such a division. Furthermore, with an increase in the number of PPP hospitals and a higher quality of care the impact could come to serve 'medical tourists' in public hospitals. Turkish citizens, it is further argued, eventually might not benefit from the innovations and quality brought by PPPs in health.

UNITED KINGDOM

Scope

The United Kingdom had vastly underinvested in its National Health Service (NHS) hospitals, many of which were built in the Victorian era (during the late 1800s). Beginning in the 1990s through the Private Finance Initiative (PFI), the UK built approximately 100 new NHS hospital buildings in 12 years.

The typical UK PFI hospital contracts are awarded and managed by local bodies, namely NHS Trusts and local authorities¹¹. These projects usually involve private funding to design, build and operate the hospital buildings, including ancillary (non-clinical services), such a cleaning, catering, pottering, etc¹². However, the core services such as the clinical, medical and nursing services, including doctors and nurses continue to be provided by the NHS. The Trust pays an annual fee or ‘unitary charge’ for the contracted period, which has two components: (i) *availability charge*, a payment for provision and management of the buildings and equipment; (ii) *service charge*, a payment for the provision of facilities management and ancillary services¹³.

Rationale

The rationale for using PFIs in the UK health sector has been the following:

- an extensive risk transfer to the private sector and accordingly greater cost certainty for the government ;
- achieving better value for money (VfM);
- PFI delivered on time and on budget relative to other options.

Impact

The PFI hospital scheme was a huge success, since without private financing it would have been impossible for the UK Government to build such an impressive number of new hospitals. It is not without its critics, however. According to the Treasury select committee report PFI was no more efficient than other forms of borrowing and it was illusory that it shielded the taxpayer from risk. In the same vein, The House of Commons Committee of Public Accounts in its report of 2011 concluded PFI was not a totally satisfactory option in financing hospitals. As it was stated ‘in many cases local authorities and Trusts chose the PFI route because the Departments offered no realistic funding alternative’.

¹¹39% are managed by Foundation Trusts, 49% by National Health Service Trusts, 12% by Primary Care Trusts (National Audit Office 2010)

¹²National Audit Office, 2010

¹³Hellowell and Pollock 2010, p.28

ITALY

Scope

Italy carries an old tradition of private partnerships for public services delivery.

PPP contractual arrangements for sectors such transport and energy are dated back in the years, the first concession law being enacted in 1923. As an example, the national highway network was funded and developed between 1950 and 1970 widely through concessions, thanks to favourable legislative framework available at that time.

Lately, the legislative reform enacted in 1998 and subsequent amendments occurred afterwards made generally possible the involvement of private initiative virtually in any field of public services, widening opportunities of private funding to practically every sector of public provision.

One of the sectors that most benefited of this new legislative opening was doubtless the public healthcare, soon becoming the most promising and fast-growing one, ranking second only after transport in volume of private capital invested.

Since its onset on 1999, numerous initiatives in the healthcare have been called for bidding in the market through PPPs, worth approximately **6 billion euros** of capital expenditure overall. This made Italy ranking third in worldwide PPP healthcare by capital investment in 2011, trailing Canada and UK only.

To date, nearly 50 major projects of hospitals or elderly care facilities have been successfully awarded or are currently at procurement stage. Of them, 30 projects relate general hospitals of 600 beds and more, totalling **3,5 billion euros** of overall capital expenditure. All of them are either in construction phase or operational, setting up best practises for the upcoming bids in the pipeline. Specific cases regard provision of highly specialised services, such as the Proton Therapy facility in Venice, recently awarded to privates.

According to the Italian procurement law, fully consistent with EU procedures, PPPs are awarded mainly in the three following ways:

- 1) ***Concessions under public initiative***, where project documentation, including preliminary or detailed design, outline business case and concession scheme is prepared by the Public Health Authority and then called for tender in the private market;
- 2) ***Concessions under private initiative***, when privates submit proposals to Public Healthcare Authority calling for interest, consisting of detailed technical, business and contractual project documentation. Upon acceptance of such proposal by public side, a formal bid will be called upon, open to other participants.
- 3) ***Concessions of service contracts***, where no major facility construction is foreseen and arrangements relate instead mainly to service provisions in the health.

According to EU rules, contract awarding is done in such cases on the basis of the most advantageous offer received, aimed at maximizing value for money for bidding Authority.

PPPs are mostly delivered through DBFO or DBFM (*Design, Build, Finance and Operate or Maintain*) arrangements, whereby private takes full accountability in designing, building, maintaining the facility and no-core services provision for a number of years (25-30 on average). In some cases concessionaires are ask to provide initial full medical equipment set, or to perform some clinical services such as imaging, radiology, diagnostic, laboratory analysis. During

concession period, although privately operated, public side retains ownership of the estate. At the end of concession period, both estate and management will be handed back in full to conceding Authority.

According to the national healthcare law, privates can operate no-core services only, being prevented from taking on accountability over hospital medical ruling, including hiring sanitary personnel. Public Health Authority alone will take care of medical ruling, as well as of any core medical service associated to it.

In PPP healthcare arrangements privates are customarily being paid twofold:

- Through a **availability-based fees** for estate provision, housekeeping and maintenance , including medical equipment whenever foreseen. Payments are measured against KPIs and subject to deductions in case of underperformance;
- Through **volume-based fees** for on-demand services like catering, hotelling, parking and, where foreseen, clinical (mainly diagnostic and laboratory analysis) ones.

Furthermore, privates are normally allowed to run inside the hospitals a wide range of user-charged, commercial services, bearing their own full risk, thus increasing project profitability.

Rationale

Public healthcare provision is a fundamental right, constitutionally guaranteed to all citizens living in the Country regardless of their social status or affordability. Public health assistance is covered in full through the National Health System, which is funded on its own by taxpayers.

Public and private healthcare in Italy are both run separately and completely apart, with virtually no overlapping. PPP in the healthcare relates only the public service area and shares same public interest principles, whereas private care, which coexists for those who still prefer to be cured in a more client-comfortable environment, is as business-like initiative.

Italy experience in PPPs is primarily aimed at improving cost effectiveness in public spending. The expense for public health in Italy accounts nearly to 50% of the expenditure at regional level, 110 billion euros nationwide, with large room for improvement. Through PPPs public entities could thus achieve better value for money, either by shortening delivery times, getting well balanced risk allocation and setting up a fully fledged performance-based payment system, ultimately reducing disbursements.

Impact

PPP in the healthcare provision has been so far beneficial in the following areas:

- ***Greater involvement of private risk capital***, whereby 60% of capital expenditure for facility construction and equipment provision was provided through private funding;
- ***On time, on budget project delivery***, with time for approval and construction completion dramatically shortened comparing to traditional procurement;
- ***Effective transfer to private of construction and O&M risks***, thus achieving a substantial rebalance of risks towards concessionaires. By virtue of this, Italian PPP hospitals have been placed, save for few exceptions, off public balance;
- ***Reduction of claims and disputes*** during construction, with few or no cost overrun associated to it;

- *Enhanced design and constructive solutions*, thanks to bidding procedure by private initiative that, albeit longer than a simple concession tender, granted workable, cost-effective, cutting edge innovative solutions to bidding Authorities.

Furthermore, in order to curb excessive profits matured by concessionaires, PPP contracts often foresee **profit-sharing clauses** in case of soaring IRR achieved by privates. Thus, remarkable cases of compensation paid back to Public Authorities have been so far recorded in some Italian PPP hospitals.

DRAFT

THE PHILIPPINES

Scope

The Philippine Government's recognition of the private sector as a partner in development particularly infrastructure development is embodied in the 1987 Constitution declaring the "indispensable role of the private sector in pursuing development objectives." With this recognition and the enactment of Republic Act 6957 or the Philippine Build-Operate-and Transfer (BOT) Law and its Implementing Rules and Regulations (IRR) further amended by Republic Act 7718, private sector participation is very evident in key infrastructure sectors. The amended law provided new BOT contractual arrangements and expanded infrastructure projects to be covered such as those in the social sector namely: information and communication technology, schools, hospitals and housing. As of September 2010, the BOT Program of the Philippines has an approximate capital investment of more than US\$ 21 Billion in different infrastructure sectors.

With the amended BOT Law, the former President Fidel V. Ramos directed the establishment of the BOT Center which institutionalized its role as the main coordinating and monitoring body for the Philippines BOT Program. The main responsibility of the BOT Center is to provide technical assistance support to implementing agencies and local government units in their BOT projects and also capacity building activities. With the new administration of HE President Benigno Aquino III, the BOT Center is now renamed the PPP Center of the Philippines.

At present, the expanded BOT/PPP policy framework covers the whole PPP agenda in response to the increasing need for infrastructure development in the Philippines.

Rationale

In healthcare, through the years, despite the increasing budget for the Department of Health (DOH), financial resources for health in the Philippines remain inadequate. The share of the gross national product (GNP) spent for health from 1993 to 2007 hovered between 2.75- 3.5%, which is below the 5% recommended by the "The Global Strategy for Health for All in the Year 2000" of the World Health Organization. The 2007 Philippine National Health Accounts reveals a total health expenditure of P 234.3 billion (US\$ 5.6 billion), which is 3.2% of the gross domestic product of the Philippines. With the Government's pursuit to achieve universal health care for all Filipinos, especially the poor, the DOH determined the 5-year financial requirements of the Health Agenda. From 2011-2016, the Philippine government will need a total of P 707.6 billion (US\$ 16.35 billion) for implementing the needed health reforms. Government will enroll to the national health insurance program the poorest 20% of the Philippine population using national government funds, and the next poorest 20% through the resources of the local governments. Defined entitlements for consultation and diagnostics, medicines, emergency and chronic care and inpatient services shall be available to all Filipinos. Government will be making investments for health facilities upgrading, human resources for health, information technology, and strengthening existing public health programs.

Through PPPs, the proposed upgrading of hospitals and other health facilities will require to the tune of at least P 37.5 billion (US\$ 866 million). To date, Government embarked on numerous healthcare projects to name a few: the Modernization of the Philippine Orthopedic Center, the Vaccine Self-Sufficiency Project II, Upgrading and Modernization of 24 DOH-retained hospitals including Cancer Center Projects, etc.

Impact¹⁴

“In the health sector, a number of PPP initiatives have been implemented in the country, for a variety of purposes and under different models and approaches. This provides a diverse and rich basis for future investment in PPPs, and a potentially important source for learning the lessons about what works and what doesn’t. However, current or past experiences are little documented or evaluated, which prevents a proper identification of the factors affecting success or failure.

The review of the country’s experience performed for this study suggests mixed results from this variety and richness of initiatives. While some are still striving, many initiatives that were successful at some time presently face substantial challenges, and others have lost steam or were all but suspended. As just mentioned before, these stories of success or failure have not been systematically documented or assessed, and thus it is often difficult to pinpoint the key factor in the demise of the initiative. But in general, the main issue faced by PPPs in the country is one of sustainability, which in turn can be traced to the following weaknesses:

- A number of PPPs have been, and are still, fostered by international donors, NGOs and development agencies, with funding that lasts while the project is ongoing; no provisions or planning are made to ensure long term financing, and when the donor supported project ends, so does financing.
- Many PPPs are characterized by informality and personal leadership; while inspired or charismatic leadership can be useful at start up; most initiatives remain centered on the leader figure and are not “institutionalized” through long-term mechanisms.
- PPP initiatives are usually based on “volunteerism” and willfulness, created and driven by donors or non-profit organizations, with insufficient concern for “professionalizing” management.
- Government has often a passive and weak role, and does not pick up the tab when international donors withdraw; changes in government seem to negatively affect the continuity of partnerships; further, government participation appears piecemeal, without any overall framework or long-term strategy to decide why and when it should go into PPPs with private partners.
- Financial arrangements are generally weak and loose, with no link to performance; even though most PPP managers state that monitoring and evaluation is a routine activity, it does not seem to strongly impact decision making.
- Lack of information on the private sector prevents government from systematically exploring and identifying opportunities and potential partners.

In the end, as shown by both international and national experience, the success of a PPP in achieving its objectives and producing good outcomes depends on the existence of favorable conditions (policy, regulation, market) a careful design of the contractual arrangement adapted to the particular conditions and type of services of interest in each case, and strong capacity in the government partner to monitor and evaluate the partnership.”

¹⁴ Heavily drawn from the main report entitled “PPP in Health in the Philippines: Assessment and Way Forward”, TA No. 4647-PHI/Contract No. S17231, Support for Health Sector Reform, Mr. Bernard F. Couttolenc, Consultant, March 23, 2009.

THE REPUBLIC OF KOREA

[to be added]

Scope
Rationale
Impact

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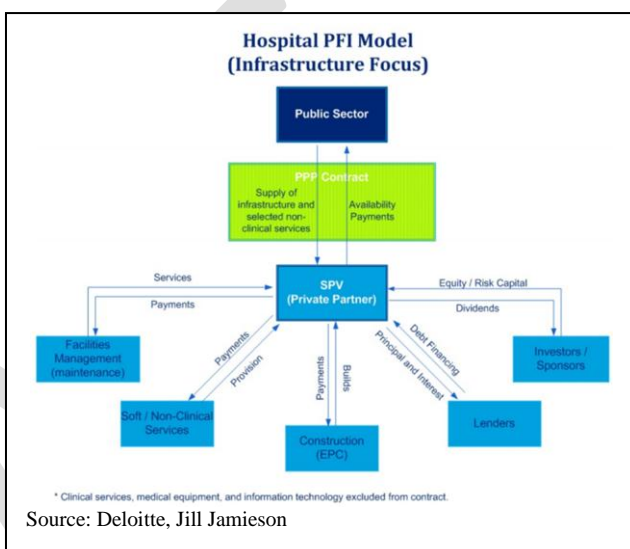
CHAPTER 3 TO WHAT EXTENT SPECIFIC PPP CASES ARE ACHIEVING EXCELLENCE

Measuring the performance of hospital PPP projects is tremendously complex as there are numerous indicators that are used to gauge the performance of hospital facilities and the provision of clinical and non-clinical services. The criteria used in this discussion paper are intended to be 'big dot' indicators of performance and shall not be considered as definitive measures to gauge the hospital PPPs and PPP health programmes.

HOSPITAL PPPS

INFRASTRUCTURAL PPPS

The basic characteristic of this model is the absence of clinical services in the range of services to be provided by the private partner. This model has been followed in a number of countries, namely, UK, Australia, Italy and Canada. Most of the contracts based under the 'infrastructural model' are design-build-finance-maintain (DBFM) contracts, including the additional provision of several non-clinical services, such as cleansing, catering, security, parking, etc.



Case study 1. University College London Hospital (UCLH), London, UK

Description. The UCLH National Health Service (NHS) Trust is one of the UK's largest providers of healthcare services, medical research and training. The Trust included eight hospitals spread across central London and were housed in antiquated, inflexible and cramped buildings. A private consortium, Health Management (UCLH) Plc., was selected as the private sector partner to replace the old building and construct new hospital under the DBFO (design, build, finance and operate) scheme (with Interserve providing the ongoing facilities services). It entered into a 40 year agreement under which the building will be leased back to the Trust in the exchange for an annual fee of £32m. In addition to building the new hospital, Health Management (UCLH) Plc was responsible for the provision of non-clinical support services (e.g. supplies, waste management, security,

UCLH & Interserve Sustainability Case Study

The NHS Trust and Interserve made significant sustainable improvements to change behaviours and introduce cutting-edge technologies. The result is a more energy efficient and improved environment for all.

http://www.youtube.com/watch?v=fOZBiJ_6NWk

car parking, laundry and linen, estate management and building services).

Access. Yes. The services that used to be provided at three of eight scattered sites became centralized into a new 669 bed acute hospital in central London. As a result of the new building it became possible to treat 54,000 patients, 10% more patients than used to be treated.

Equity. Not applicable. This criteria is not applicable due to the fact, that services at the new hospital are provided for free (subsidized by the government).

Efficiency. Yes. Under the PPP arrangement it was envisaged that over the life of the project, i.e. 40 years, over £30m would be saved in comparison to the construction and operation of the hospital under the traditional procurement. Thus, the PPP option is 6.7% less costly than the traditional procurement.

Replicability. No. The UCLH has been one of the largest hospital redevelopment schemes under PFI, at £422 million, which led to the opening of over a hundred new hospital schemes across the country. This project is always referred as bravest and the best decision "ever made in this part of the NHS". However, due to the amount of public investment by UK taxpayers required for the project, it is considered as hardly replicable in its whole scale not only in developing countries, but also in other developed countries.

Overall Challenges Facing PFI hospital in the UK

Delivering better value for money has been the underlying premise for choosing PFIs against the traditional public procurement. However, according to the Public Accounts Committee '*the use of PFI has been based on inadequate comparisons with conventional procurement which have not been sufficiently challenged*', whereas the UK House of Commons Select Committee concluded that PFIs are '*an extremely inefficient method of financing*'.

Case study 2. Royal North Shore Hospital (RNSH) and Community Health Facility, Sydney, Australia

Description. The Royal North Shore Hospital (RNSH) was opened as a cottage hospital in 1885, today it is a major public teaching hospital in Sydney, Australia and provides a comprehensive range of medical services. Its primary referral area accommodates 5.7% of the Australian population. In 2008 a PPP contract for \$950 million was awarded to the InfraShore Consortium. The contract involved the financing, design, construction, operation (with the exception of the provision of clinical services) and maintenance of the facility for a period of 28 years. The consortium redeveloped and consolidated 53 outdated buildings on the RNSH campus into two purpose-built, patient-centered facilities, constructed a new multi-storey car park facility and provided some facilities management and non-clinical support services (e.g. cleaning, security, waste management, etc.). The move into the Acute Services Building is already scheduled to begin on Monday, 15 October 2012 and the building will be fully operational by Friday, 7 December 2012.

Access. Yes. At the time of tendering, the hospital provided fewer than 600 beds; however, since then, the hospital has increased the number of beds by over 20%. In addition, on completion, the redeveloped RNSH will be able to offer additional chemotherapy and renal dialysis chairs; enhanced diagnostic services and ambulatory care services; and a total of 29 procedure and operating rooms. In addition a new Clinical Services Building is scheduled

for completion in 2014, which will contain a new burns unit, women's and children's health and mental health units.

Equity. Not applicable. This criterion is not applicable due to the fact that services at the new hospital are provided for free (subsidized by the government).

Efficiency. Yes. The cost benefit analysis of the private sector delivery of the RNSH PPP was conducted by applying the value for money assessment. The net benefit was reflected in the estimated cost savings of \$13.4 million. Besides, it has been delivered on time and on budget for Northern Sydney Local Health District (NSLHD).

Replicability. No. Although it is too early to judge whether new hospitals will be redeveloped following the RNSH model, it surely establishes an excellent precedent not only in Australia, but also in other parts of the world. However, due to the amount of investments required for the project, it is considered as hardly replicable in its whole scale not only in developing countries, but also in other developed countries.

Case study 3. Brampton Civic Hospital, Ontario, Canada

Description. In 2003 the William Osler Health Centre (WOHC), one of Ontario's largest hospital corporation, reached an agreement to build a new Brampton Civic Hospital under a PPP mechanism with a private consortium. According to the agreement the consortium designed, built, and financed a new 608-bed hospital, and provided certain non-clinical services and planned to operate the facility over a 25-year period. In return the WOHC agreed to a monthly payment over 25-year period, beginning on the completion date of the hospital.

Access. Not applicable. With the opening of a new Brampton Civic Hospital in 2007, another William Osler Health Centre (WOHC) facility, Peel Memorial Hospital, was closed. This led to moving 234 patients, staff, records and equipment from the Peel Memorial Hospital to the new Brampton Civic campus due to limited human and financial resources to operate two hospitals. Accordingly the PPP transaction resulted in fewer net new beds for the community than originally anticipated.

Equity. Not applicable. The decision to build a new hospital in Brampton was taken to fulfill the needs of the growing population in Brampton, primarily through immigration, which was already stressing the system's ability to provide necessary health services to the region. However, with the closure of other hospital in the region, the number of new 'available' beds was not sufficient not only to immigrants but also to the local people.

Efficiency. No. According to the Auditor General 'the value for money assessment conducted for the Brampton Civic Hospital project was not based on a full analysis of all relevant factors'. Accordingly the cost of the project could well have been lower had the Brampton Civic Hospital and the related non-clinical services been procured under the traditional approach¹⁵. Besides not long after the opening of the hospital two patients died. The families of these patients as well as the media argued that the long waiting time and lack of sufficient staff

¹⁵Legislative Assembly of Ontario. Standing Committee on Public Accounts. Brampton Civic Hospital Public-Private Partnership Projects

in the emergency room had led to medical errors, which led to the death of the patients.

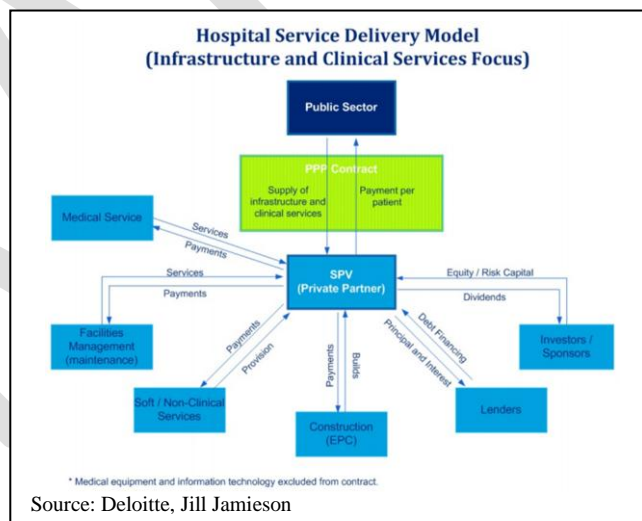
Replicability.No. The opening of the Brampton Civic Hospital led to several issues that created political tension. One of the main issues became the closure of the Peel Memorial Hospital. This created the perception that the area would be underserved and, thus undermining the whole idea of bringing the private sector investments into the healthcare. The Brampton case demonstrates failure in communication surrounding the PPP to the staff and the wider community.

***Point for Discussion ***

- *Bearing in mind the challenges of rapid technological change, which radically alter treatments available for patients, is it viable to consider shorter contracts, say between 10-15 years for hospitals?*
- *Would, for example, the private sector find such contracts worth bidding for?*

INTEGRATED PPPS

This PPP model integrates all hospital services in a PPP contract, which includes supply of infrastructure and clinical services. There are two types of 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). This scheme allows the governments to transfer risk to the private sector.



Case study 1. The Alzira Model: Hospital De La Ribera, Valencia, Spain

Description. Hospital de la Ribera is a Spanish pioneer of the PPP model. A private company *Union Temporal de Empresas-Ribera* (Temporary Union of Companies) (UTE-Ribera)¹⁶ entered a 10-year contract in 1997 with Valencian government to build a public hospital and manage clinical and non-clinical facilities in the town of Alzira. The hospital was opened in 1999, however, UTE-Ribera was not generating enough income to cover the costs, since the company underestimated cost inflation and the pace and nature of change

¹⁶ The UTE-Ribera was established by Adeslas, a Spanish private health insurance company (51%), the local building societies Bancaja and CAM (45%), and the construction company, Lubasa (4%).

in healthcare technologies and models of care. As a consequence, the private company was re-financed, and a second contract was awarded in 2003 for 15 years (extendable for 20 years). The unique feature is the fact that payment to the private entity is based on a perception basis not on the number of hospitalization. Also patients are free to go elsewhere for their treatment, which means that the private provider is incentivized to improve health outcomes of the population.

Access. **Yes.** The Hospital built new Health Centre, Haemodialysis Unit, Interventional Radiology Unit and a Medical Physics Gamma Camera as a part of the project, in addition invested into additional diagnostic tools in primary care and is providing of direct access to radiology, endoscopy, pathology tests, and so on, thus, providing access to high-quality health care services that previously were not provided or used to be provided in low quality.

Equity. **Not applicable.** This criterion is not applicable due to the fact that services at the new hospital are provided for free (subsidized by the government).

Efficiency. **No.** There are many controversial views regarding the effectiveness of the project. The Valencian government asserts that the Alzira model kept the local government from spending the initial investment of €68 million to build a new hospital, thus, avoided a significant increase in its local public debt. However, the same government paid the UTE-Ribera a sum of €69.3m on termination of the first contract, which consisted of €43.3m for the purchase of the infrastructure assets, and €26m compensation for lost profit despite the fact that the company was making losses during that period. Shortly after the termination the company known as UTE-Ribera II, which has the same parent companies as the first one, paid the government a premium of €72m for the new contract, which included taking over the infrastructure assets just bought back by the government.

Replicability. **Possible.** A study by the NHS European Office on whether the model could work in the UK concluded that while many aspects of the model look attractive from a UK perspective, there are some obstacles and issues that would need to be taken into account¹⁷. However, according to WHO's department of Health Systems Financing the developing countries would struggle with such complex projects. Besides there are some concerns that if Alzira model applied in a true commercial environment, it would fail to be affordable in the long term¹⁸.

Case study 2. The Queen Mamohato Memorial Hospital PPP, Maseru, Lesotho

Description. The Government of Lesotho facing an urgent need to replace the deteriorating 450-bed Queen Elizabeth II Hospital (the main public hospital in the country) contracted Tsepong (a consortium headed up by South African healthcare provider Netcare) in 2008 (i) to construct a new 425-bed Queen Mamohato Memorial Hospital (390 public + 35 private beds); (ii) renovate 3 strategic primary health care clinics in the greater Maseru area; (iii) manage facilities and equipment; and (iv) deliver all clinical care services for 18 years

¹⁷For example in the Alzira model the contract relates principally to outcome measures and only a small number of process measures. In the NHS in UK the practice is to use the contract to direct private providers on not just what to do, but also how to do it.

¹⁸ It is known that there was a political involvement in the Alzira model through local banks, where regional politicians sit on their governing bodies. These banks not only provided sufficient funding for the project despite the lack of viability of the investment, but also lent the project company loans at a favourable interest rate, at times below the average for an equivalent Spanish public debt bond.

(including 3-year construction period). In return, the Lesotho government agreed to pay Tsepong an annual fixed service payment (USD 32.6 million unitary charge) for delivery of all services, escalated only by inflation annually. In addition the private sector will be receiving profit from running a deluxe 35-bed private patient unit within the hospital. USD 120 million (85% debt + 15% equity) was raised to undertake the project. The construction of the hospital began on March, 2009 and was successfully completed and commenced operations in October 2011.

Access. **Yes.** According to the official data the national hospitalization rate was 3.2% of the population each year, which means that previously the hospital could treat only 64000 patients on annual basis. However, the new hospital is expected to treat all patients who present at the hospital and filter clinics, which is up to a maximum of 20,000 in-patient admissions and 310,000 outpatient attendances annually. In addition the private operator as a part of its community development programme set up the Women and Rape Crisis Management centre at the hospital at its own cost and coordinating it with the Lesotho Government.

Equity. **No.** On the one hand the management has targeted women as a specific beneficiary group in the allocation of attention/resources. On the debit side, the above-mentioned deluxe unit will be run separately by Netcare, who will, it is argued, 'keep all the profits'. Global health check has contrarily argued that the USD 32.6 million unitary charge to Netcare for the hospital and services represents a 100 per cent increase in costs given that the annual budget for the Queen Elizabeth Hospital and the filter clinics in 2007/2008 was less than USD 17 million.

Efficiency. **Yes.** According to IFC report, the Lesotho project was affordable for the government, on an operational cost comparison; the government does not pay much more for the PPP than it used to spend on the operation of the Queen Elizabeth II. Yet it is receiving vastly improved facilities, medical services and patient care. The project has also ensured maximum risk transfer to the private operator, protecting the government from most of the financial, operational, and legal risks inherent in a project of this nature.

Replicability. **Yes.** The Lesotho PPP structure is the first 'integrated' PPP hospital project in Africa, and one of only a handful of similar projects worldwide. Besides it is still in its early stages and may lead to certain challenges in the long term period. Yet, this project demonstrated that it is possible in a low-income country (with deteriorated health facilities, lack of equipment, shortage of staff and inefficient management) to embark on a very ambitious project that is attractive to private investors and affordable for the government and patients, who can benefit from high-quality health services.

Case study 3. Latrobe Regional Hospital, Victoria, Australia

Description. The Government of the State of Victoria with an objective to deliver improved health services to public patients in the Latrobe Valley signed a contract in 1997 with the private company, Australian Hospital Care Ltd. (AHCL), to design, finance, build and operate the new Latrobe Regional Hospital, as well as to provide (free of charge) core clinical services to public patients to specified quality standards and deliver other non-clinical services required to operate and maintain the hospital for a term of 20 years (with

***Point for Discussion ***

- *How to incentivize the private sector to deliver high performing hospitals that deliver better care?*
- *One of the challenges is to identify the right Key Performance Indicators. Performances have to be measured and public payments need to be subject to deductions (even heavily ones) if private operator is underperforming.*

the possibility to extend for additional 5 years)¹⁹. In return the government paid the private operator a service charge. The new hospital commenced operations in September 1998. In 1999 the hospital lost AUS\$ 6 million and was projecting ongoing losses. In 2000 the company was released from its contract in return for an agreement to drop legal action against the government. It sold the facility to the government for AUS\$ 6.6 million (about half of its estimated value) and made an additional payment of AUS\$ 1 million.

Access and Equity: Not applicable. It is hard to evaluate how this project was carried out in terms of these criteria, since the hospital was under the operation of the private company for only two years. Yet, if to refer to project documents, the private operator supposed to deliver high-quality health care services, which includes "*equitable access on the basis of clinical need regardless of financial or social circumstances; provision of effective linkages with other services providers for a smooth, integrated "seamless" transition between services for each episode of care; strategic targeting of services activity to maximise health outcomes in the context of demonstrated clinical needs of the region ...within the requirements of relevant funding frameworks*".

Efficiency: No. According to the post-evaluation project reports the Value for Money was miscalculated:(1) the government used an old benchmark to calculate the cost of a traditional procurement of the project (which wasnot giving sufficient attention to the qualitative aspects of the performance), and (2)the privatecompany did not fully understand the revenue implication of financing model used by the government.

Replicability: No. This project is certainly a good example of what parties need to avoid in any country. One of the contributing factors in the Latrobe's failure is that both parties mistakenly believed in the superiority of private sector management and innovation, where the government accepted an unsustainable bid price from the private sector. Therefore, it is important to note that (1) risks shall be borne by the party better able to manage them; and (2) accepting tenders at lowest cost is not necessarily in the best interests of governments.

FACILITY-BASED HOSPITAL PPPS

Description of the model [to be added]

Case study 1. B. Braun Dialysis Centers, Andhra Pradesh, India

Description.The Government of Andhra Pradesh provides basic medical treatment to patients living below poverty line (BPL) through the Arogyasri health insurance scheme (at no cost to the patients). However, while a significant number of BPL patients needed dialysis services and many state-run hospitals had limited or no capacity to perform dialysis. To address this issue, B. Braun Medical (India) Pvt. Ltd., a subsidiary of B. Braun Melsungen AG, one of the world's leading healthcare suppliers headquartered in Germany, was selected to establish and operate dialysis centers in eleven tertiary care state-run hospitals on a Build Operate and Transfer (BOT) basis for a period of seven years. The project launched in 2010. In return the Government of Andhra Pradesh pays the private operator an agreed price for each performed dialysis.

Access.Yes. 11 hemodialysis centers established and run by B. Braun together host 111 hemodialysis machines in medical colleges and hospitals across the state.Thus, providing services to more patients in comparison to the past.

¹⁹ Despite this fact, there was not a contractual requirement to transfer the hospital back to the government at the end of the term.

Equity. Not applicable. The dialysis is provided free of cost to the patients, who are covered under the Arogyasri insurance Scheme.

Effectiveness. Yes. B. Braun set up the centres with an investment of Rs.45 million (about 8,3 million USD). The Government of Andhra Pradesh pays Rs1200/- per each dialysis out of which Rs.1080/- (about USD 23) is paid to B. Braun and Rs.120 is paid to the respective hospital/medical college. Under the project the government also mobilizes patents, whereas the government hospitals provide space, uninterrupted power supply, water supply, clinical nephrologist, clinical responsibility for the patients, as 90% of staff are hired within the state-run hospitals. This project, therefore, considered as cost-effective.

Replicability. Yes. Although the projects was launched not long ago, it has already proved itself successful, thus, with high level of demand for dialysis treatment, this project can be implemented not only in other parts of India, but also in many other developing countries.

LEASE CONTRACTS

Description of the model [to be added]

Case study 1. National Kidney Transplant Institute (NKTI) Hemodialysis Center- Fresenius Medical Care Lease Agreement, Manila, the Philippines

Description. The National Kidney and Transplant Institute (NKTI) is a tertiary medical specialty center that focuses on the treatment of renal diseases. The rising demand for treatment of renal diseases necessitated the expansion of NKTI's hemodialysis centers. The NKTI Hemodialysis Center PPP emerged as a solution to NKTI's scarcity of funds to furnish the hospital with state-of-the-art machines for patients suffering from end-stage renal diseases. NKTI decided to undertake a long-term lease arrangement (BOT) with a private partner so that new machines can be acquired and housed under a new center.

Access. No impact evaluation study has been done to quantify how the NKTI PPP innovation has enhanced access to services and information, especially of poor households. However, interviews with hospital administrators indicate that NKTI was able to acquire the latest available technology in dialysis treatment and expand its services to more patients at the same cost of treatment and at less risk to the government. Moreover, access, especially among those with limited ability to pay for treatment in private hospitals has been enhanced. The hemodialysis rate at NKTI is still far more competitive than those in comparable private providers. Finally, since more machines with higher reliability are available, hemodialysis treatment was extended to more Filipinos.

Equity.

Efficiency. Yes. The machines were new and were less likely to break down. The provider was obliged to provide maintenance and service technicians at all times. Accordingly unlike before the PPP when machines often broke down and had to be withdrawn, under the PPP machines operated according to the maximum of their efficiency.

Replicability. Yes.

PPP HEALTH PROGRAMMES

The larger scope of Health PPPs to manage and finance care delivery and infrastructure means a much larger potential market for private organizations. \$3.6 trillion is projected to be spent on health infrastructure and \$68.1 trillion will be spent on non-infrastructure healthcumulatively over the next decade and estimated to be more than \$7.5 trillion annually, up from \$5 trillion in 2010. However not all PPPs in this category of health programmes are successful and some of them were failures.

I. RESEARCH AND DEVELOPMENT

There are international private partnerships usually referred as the Product Development Partnerships (PDPs). These partnerships focus on developing new products against diseases emerging in developing countries (e.g. vaccines and microbicides, as well as treatments for otherwise neglected diseases). These partnerships therefore are critical, as they improve access and availability of the products to those who have no or limited access to such products. The risk of this type of partnership is that *underserved poor populations in low income areas are not attractive for private sectors and the PPP approach specifically PPP-PP can be therefore critical to target these populations.*

Case study: Mobile Health technology programme in resource-poor settings

Description: In 2005 a coalition of several foundations and international UN organizations²⁰ was established to maximize efficiency of mobile communications and meet healthcare needs during humanitarian crises. The project was worth USD 30 million and continued till 2010. As a result of the partnership a free mobile phone- and web-based data collection system, called EpiSurveyor, was created. This system allowed to access high quality assessment and evaluation of interventions for clinic supervision, vaccination coverage, or outbreak response, and public health issues including malaria, TB, HIV, measles and others problems and it is a common platform for sharing those data collection instruments that represent best practices. This system support practitioners and community health workers to improve the quality of diagnosis and their knowledge on public health issues with an easy and standardize way. Mobile telephones can help deliver affordable urban health care by providing diagnostic tools for taking pictures and by their usefulness for writing prescriptions and monitoring the condition of patients in low-income areas.

Access: Yes. The deployment of rapid response telecoms provided improved access to life-saving mobile and satellite technology in natural disasters, conflicts, and famines. The frontline of communications was done without the need to create a database and the need to manually input the data. Build mobile health data systems that give local health workers rapid and reliable access to the data needed to stock medicines, track disease outbreaks. The rise of real-time data is creating new opportunities in development and humanitarian work for incentives and accountability.

Equity: Yes. Along with real-time data transfer, there has been a growing trend toward making that data transparent, sharing it more widely, and making it increasingly accessible to ordinary people.

Efficiency: Yes. The technologies most likely to succeed in any development or humanitarian project are those that are already in use.

Replicability: Yes. In 2010, the EpiSurveyor application was successfully tested for feasibility and scalability in a pilot project in Malawi to monitor the availability of malaria medicines with mobile phones. EpiSurveyor system mobile can be applied and adapted in a variety of ways when conducting surveys. It also looks at lessons learned, many of which can apply to other initiatives. The action-oriented culture of the private sector will be essential in this type of PPPAs of April 2012, EpiSurveyor, based in Kenya, has nearly 8,000 users in more than 170 countries worldwide including the US, Kenya, Guatemala, the UK, Tanzania, India, Pakistan, Mali, the Philippines, Zambia, Malawi, Nigeria, Peru, Brazil, Indonesia, and Liberia, making it the most widely-used mHealth software. The 15 sub-Saharan African countries where it has been implemented in conjunction with the World Health Organization's African Regional Office (WHO/AFRO) are also included.

²⁰The World Health Organization (WHO), DataDyne, the mHealth Alliance, the World Food Program (WFP), Telecoms Sans Frontieres, and the UN Office for the Coordination of Humanitarian Affairs (OCHA)

II. IMPROVEMENT OF ACCESS TO HEALTH PRODUCTS

The function of the access to health products is to improve access to commodity, such as medicine, vaccines and diagnostics in developing countries through technology transfer, local production and distribution. The access to essential affordable medicines has been recognized a right to health (Hogerzeil et al., 2006; Pehudoff, 2008) and it is also an integral part of the MDGs. Availability and price of the medicine in both public and private sectors are key indicators of measuring access to a medical treatment. Surveys on medicine prices and its availability have shown that poor medicine availability, particularly in the public sector, is a key barrier to access to medicines. For example, public-sector availability of a selection of generic medicines is less than 60% across WHO regions (WHO, 2011f). It is estimated that up to 10.5 million lives could be saved every year by improving access to essential medicines and vaccines; 4 million in Africa and SouthEast Asia alone.

Case study 1: Improving access to essential medicines in Sub-Saharan African region: Essential Health Products (EHPs) programme

Description: This partnership was established in 2006 for 5 years with a focus on sub-Saharan Africa, where 30-50% of the population lack access to essential medicines, specifically to antibiotics, essential paediatrics medicine. The aim of this contractual relationship between a mix of public and private players including manufacturers, distributors, governments, NGOs and bilateral and multilateral institutions was to improve the distribution and access of Essential Health Products (EHPs) in remote areas of sub-Saharan Africa through the establishment or improvement of logistic and inventory management system

Access: Yes. Standardize data required are now used for monitoring performance of EHP distribution systems, for sharing knowledge on distribution practices, for sharing infrastructure for distribution and also to encourage research and product innovation to lower the distribution barriers for EHPs. The partnership improved efficiency in transportation and inventory management. The regional distribution method through regional hubs aggregated volume, outsourced final-mile to local SMEs and provided high quality inventory management.

Equity: Yes. Many essential health products now are being used by a nurse or pharmacist to manage or administer them. In addition an integrated tracking system were introduced to make sure that the distribution is done equally on the regions, including rural areas.

Efficiency: Yes. Fuel Africa, a medical products distribution company, has shown how changes to the logistics and inventory management system can reduce pharmaceutical costs by 15-30% for consumers. Cost savings for health system can be done through the improvement of unnecessary waste from heat damage, freeze damage or disposal of unused portions of multidose vials.

Replicability: Yes. The existing partnerships on EHPs to prevent malaria through “Coartem” medicine distribution, for example, and can be easily replicated.

Case study 2: Improving access to Family Planning in Rwanda

Description: Currently in Rwanda, there is no private sector policy, strategy, or platform to guide PPP in the health sector. However, key representatives from government, non-profit, and commercial sectors (individual pharmacies and drug shops) had all expressed interest in creating a mechanism to foster joint dialogue/venture and develop, implement, and monitor a PPP strategy to support Family Planning efforts in Rwanda through contraceptives free of charge. An FP/RH strategy for PPPs helped guide the working relationship between the various sectors involved in FP service provision. This type of strategy presents the feasibility of different models and specifies the potential roles for various sectors and players—public, commercial, and NGO. The use of a joint strategy was effective to expand and scale up Rwanda's FP services and make them more sustainable in the long term. This PPP was established in 2009 and provided FP market segmentation analysis with information about clients, providers and products or services demanded and provided in the marketplace. Market segmentation data help to identify inequities in health coverage and thus determine where to target resources and expand service reach. In Rwanda, this type of analysis underscored the need for greater attention to the urban poor and the rural population.

Access: Yes. When market conditions are favourable, the private sector often has the incentives and resources for rapid scale-up and delivery of high-quality health services. Global experience shows that various types of partnerships with the private sector are effective in reaching poor and geographically hard-to-reach populations.

Equity: Yes. The provision of free contraceptives in both public and private sectors helped to reduce financial burden and to remove geographic barriers to FP access among clients so as to expand the reach and uptake of modern FP methods. This partnership helped to provide FP services for all.

Efficiency: Yes. Through these partnerships the government can make more efficient use of public resources by targeting and meeting the needs of specific populations and thus help ensure FP services and products will be available to all Rwandans in the long-term. It will be also the way for strengthening and expanding FP programs to reach the underserved. In turn, the private sector can seize opportunities for growth by developing niche FP markets.

Replicability: Yes. A voucher scheme is a demand-side financing mechanism that can reduce RH inequities by enabling access to services while empowering the poor to choose their own providers. Specifically, voucher schemes have proven to be an excellent means of (1) providing private sector services at deep discount rates; (2) expanding cost-effective services, despite understaffing at government facilities; (3) relieving pressure on government in certain areas; (4) enabling clients to save money; and (5) providing poor clients with services that would not be received otherwise. A voucher scheme designed already to reach the poor in two of India's poorest states helped reduce inequities in FP services.

Case study 3: Malaria prevention programme: Increasing the use of insecticide-treated materials.

Description: The NetMark Project started in 2003 was a 10-year cooperative agreement between the Academy for Educational Development and the US Agency for International Development but finished in 2005. NetMark was the catalyst with the ministries of health, international donors and NGOs. This PPP has launched an initiative to help African manufacturers increase the quantity, quality, and variety of nets they produce by providing technical assistance on net production and linking manufacturers with insecticide producers and net distributors to support new brands and markets and finally facilitating the transfer of LLIN technologies where feasible. The main goal was to increase equity in ITN ownership by subsidizing ITNs and treatment kits for the most vulnerable populations.

Access: No. Identification of needs of population not established. Heavy subsidized demotivate the commercial sector. NGOs failed to deliver value and quality of product.

Equity: No. Unfortunately, this PPP initiative failed because the market in targeted countries was not ready and well prepared. The distribution subsidized ITNs were done without ensuring they reach the poorest people or those at high risk for malaria. (1) wasted money and limited public health impact by providing subsidies to populations who do not need them, (2) drained scarce financial and human resources by having the public health sector purchased, distributed, stocked, and sold ITNs, (3) discouraged the commercial sector from investing in the development of a viable ITN market that can deliver products to a large proportion of the population without donor support.

Efficiency: No. This PPP failed because the market could not be sufficiently developed and it was not enough oriented for the benefit of population and specifically for poor (no nets affordable - free or inexpensive). The PPP drove local manufacturers out of business.

Replicability: Under certain conditions. It is difficult because there is no personal risk prevention perception and adoption of protective/well-being behaviour. If the PPP is catalysed by international NGOs or donors and have only market orientation, the risk of failure become very high because it is not possible to target the most vulnerable people and to develop local production and ownerships by the country. In addition to above PPP activities were addressed to the countries of low market maturity what contributed to the failure of the project.

III. PUBLIC ADVOCACY AND INCREASING AWARENESS

Public advocacy is a crucial and effective tool for influencing policy and increasing general understanding of different health issues. The function of advancing public health advocacy is from grassroots advocacy efforts to increase awareness about critical health issues and how mitigate their prevalence related to the local context including believes (taboo and traditions), habits, perceptions, constraint of the environment, economy and political situation. The advancing public health advocacy is translated under health preventive and promotion programmes.

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Case study 1: Hand washing for Diarrheal Disease Prevention programme in Central America

Description: Hand washing promotion initiative was contractual partnership to bring together soap companies, government ministries, non-governmental organizations, and the media in three Central American countries (Costa Rica, Guatemala and El Salvador) to prevent diarrheal disease. This PPP was established in 1996 to 1999 and focus on hand washing campaign based on radio and television advertisements, posters and flyers distributed by sales personnel and through mobile units to communities; school, municipal, and health center programs; distribution of soap samples; promotional events; and print advertisements. Hand washing promotion initiative improved hand washing behaviour associated with reductions in diarrheal disease, leveraging of significant additional resources for public health, and sustained involvement of private sector partners in public health promotion.

Access: Yes. Adhering to the communication strategy ensures that clear, consistent messages are conveyed to consumers. Based on information from the market survey about media usage, radio was identified as the primary medium for reaching the target audience. Two radio programmes were developed one for mothers and one for children. Television was the secondary medium. Again, two spots were created. Both were short and upbeat, using actors and contexts the target population could identify with to portray good health, and featuring the same popular tunes as the radio spots. Posters were created to support and reinforce the radio and television campaign. They were to be displayed in public places such as schools, health centres, stores, and pharmacies.

Equity: Yes. In Guatemala, about 25 percent of the total population recalled campaign messages on the radio—a key element of the strategy for reaching rural indigenous populations via Mayan-language radio stations.

Efficiency: Yes. Well-conducted market survey was done to develop a profile of the potential customers and to create a baseline for measuring the impact of the intervention on behaviours. Technical backstopping on the training of survey personnel was provided to ensure a uniform approach and high-quality results. The diversity of implementation methods underlines the importance of flexibility to be an efficient catalyst in the process. Internal issues of the soap producers and competitive stresses among them can have a significant impact on the implementation of a regional advertising campaign.

Replicability: Yes. These materials could be used as they were for promoting hand washing with no brand identification (a generic campaign). The Hand washing Initiative was to launch a two-pronged campaign in each country: a generic campaign on radio and television, followed or accompanied by the individual company's brand advertising through mass media, educational activities, and point-of sale promotion. This PPP is good illustration how to reach several countries in the same time and to foster the scale-up of health intervention. In Costa Rica set aside approximately \$114,900 to spend on media for the Hand washing Initiative (about \$82,400 on television and \$26,000 on radio). For the generic campaign, television spots were run on Channel 7, and printed materials and tapes of the radio spots or the poster were distributed to NGOs with direct reach to communities. In El Salvador, Unilever developed hand washing materials to be used in schools, health centres, prisons, and markets. The school program, which reached 3,500 schools, consisted of educational modules on hand washing for school children and distribution of "Gold Pro" soap samples, educational posters, banners, and leaflets.

Case study 2: Health promotion programme in Uganda²¹

Description: AFFORD is a public-private partnership aimed at growing the market for a wide variety of health-related products and services, including malaria treatment and long-lasting insecticide treated nets (LLINs) in Uganda. This PPP began as a five-year (2005-2010) health marketing initiative in contractual partnership with Futures Group International, the Malaria Consortium, Pulse Communication, Aclaim Africa and Communication for Development Foundation of Uganda and funded by USAID. With a three year extension (2011-2013), AFFORD will be led by Centre for Communication Programs (CCP) in partnership with Uganda Health Marketing Group (UHMG) to continue to integrate health communication and social marketing techniques to address a variety of health issues and behaviours in Uganda.

Access: Yes. Supports and improve the distribution of long-lasting insecticide treated nets (LLINs) through campaign style distribution, antenatal clinics, LLIN subsidies, and the NGO/LLIN facility. Malaria programming has expanded to include orientation of private health providers and IEC materials to complement net distribution.

Equity: Yes. AFFORD exceeded its targets for regular insecticide treated nets (ITNs) and LLINs distributed free to pregnant women and children under five.

Efficiency: Yes. Through targeted product promotion, demand creation, market research, and an innovative distribution system, AFFORD met or exceeded its targets for market share, couple years of protection, and percentage of married women of reproductive age using one of its family planning methods in 2006 and 2007. AFFORD created the Good Life platform which promotes simple things individuals and families can do to keep healthy, healthy products and practices through activities and the Good Life network clinics. AFFORD developed also the Model Village concept as an integrated approach to increase awareness of health issues, adoption of healthy behaviours and utilization of quality health services. UHMG provides training and support to community stakeholders and resource persons to conduct their own interventions within their community.

Replicability: Yes. The sustainable Ugandan organization dedicated to improving the lives of Ugandans, and nurtured its on-going development can be a relevant model for other LMICs. A key ingredient to AFFORD's success was the importance of evidence based programming. It appears critical to work in rural areas, upgrade the skills of private for-profit providers, and ensure that UHMG remains honest, transparent and sustainable. From 2011 to 2013, the primary goal of AFFORD will be to strengthen the capacity within UHMG to become a self-reliant organisation. As the sole implementing partner, UHMG will receive strategic guidance from CCP with the support of USAID funding.

²¹References: http://www.youtube.com/watch?v=b0_tL7PBULc

IV. REGULATION AND QUALITY ASSURANCE

The focus in Medicines Regulation and Quality Assurance Systems is on establishing and strengthening national medicine regulatory authorities to develop norms and standards to ensure the quality, safety and efficacy of all pharmaceutical products and to put in place necessary infrastructures and procedures for quality assurance mechanisms. Support is provided to medicine regulatory authorities to build their capacity, enforce national laws and regulations. The fight against circulation of substandard and counterfeit products is one of the priority areas.

Case study 1: Quality assurance for Emergency Obstetric Care (EmOC) in India

Description: This PPP was established in 2005 until 2010 by non-private sector, the state government of Gujarat in India, in collaboration with the Indian Institute of Management (academic institution), Sewa Rural (an NGO), and facilitated by the German bilateral aid agency GTZ, contracted with in-country private obstetricians to provide skilled birth attendant and comprehensive EmOC to the poor due to the shortage of skilled staff in the rural public health sector.

Access: **Yes.** Increase the quality of caesarean delivery. Contracts were offered to private obstetricians who had postgraduate qualification and their own equipped hospitals with access to blood for transfusions and anaesthesia among other infrastructure to provide free, skilled comprehensive EmOC when needed to poor women who carried a below-poverty-line card to qualify for the services. In return, the government paid the obstetricians about US\$40 per delivery. More than 800 obstetricians joined the PPP scheme and more than 269,000 poor women delivered in private facilities in 2 years.

Efficiency: **Yes.** In one year, the percentage of institutional deliveries among poor women increased from 27% to 48% and fewer maternal and newborn deaths were reported.

Equity: **Yes.** Reduce the high expenses of private facilities and the financial burden of household.

Replicability: **Probably.** This PPP can be replicate to other countries if institution like the Indian Institute of Management exist and can improve standard of care. Guarantee of quality of care through more safe conditions of blood transfusions and anaesthesia. This PPP demonstrates acceptance by the private obstetricians to work in public hospitals, increased utilization of services by the poor and reduced mortality. This was a way to motivate the obstetricians to adopt evidence-based clinical practice and to employ qualified staff. PPP appears also relevant to improve the access to blood banks and/or ambulances for emergency care.

Case study 2: Quality assurance for emergency medical services (EMS), Pakistan

Description: This project was established in 2000 until 2012 and focuses on injuries. These cause major national financial and productivity losses and are a leading cause of disability and health-related economic losses. The injuries are currently responsible for 12% of the disability-adjusted life years lost worldwide. It is predicted that over the next two decades, the injuries in many populations (especially low- and middle-income countries) will equal or exceed the burden from infectious diseases. Appropriate first aid and transport of the injured or pre-hospital systems saves many lives and reduces complications and disabilities. EMS programmes have three principal aims: to prevent premature death, to reduce pain and to prevent avoidable disability.

Access: Yes. Developing guidelines for medical treatment and rescue protocols. The project has not levied extra financial burdens on the government and has been sustained even with changes in leadership. A client survey also showed user satisfaction and confidence in the services. For an efficient evacuation network, a Geographic Information System (GIS) may be developed in Islamabad to enable ambulances and rescue squads to immediately transfer the patient to a nearby emergency centre under GIS guidance and save precious time.

Equity: Yes. The local community has also been involved with providing resources for the ambulances as well as supplying the medical doctors and paying their salaries. Furthermore, community members from both the public and private sectors are on the governing board of Rescue-15 initiative. The utilization of medical services increased with the increase in public awareness and confidence.

Efficiency: Yes. This PPP improve response time (the time that elapses between a call for help until an ambulance reaches an emergency site) and the quality of medical supervision and treatment. The mean response time of Rescue-15 vehicles was approximately 10 min, close to international standards.

Replicability: Yes. This initiative to involve the public and the private sector may provide a model for implementation of such services in other resource-poor developing countries, which may in turn facilitate realistic solutions for better pre-hospital care in developing countries. This EMS programme exemplifies the potential of public-private partnership involving the police and the private sector in project implementation and management in a developing country with scarce resources.

Case study 2: Health Insurance programme in Nigeria

Description: The government's answer to financing health care is the National Health Insurance Scheme (NHIS) was implemented in 2005 but focusing only on public sector employees and in this framework the Kwara State Community Insurance company in Nigeria entered in 2006 into contractual relationships with public/private providers of healthcare for 5 years to improve access for the poor and the informal sector and to decrease high cost of medical treatment one of the most commonly cited constraints in accessing health services. Under this partnership the State Community Health Insurance aimed to bring high-quality healthcare to rural and urban dwellers. The annual insurance premium in Kwara for Shonga farmers is approximately \$30 per person per year. Scheme members currently pay 8% of the annual premiums themselves. The remaining 92% of the premium is subsidized by the Health Insurance Fund and the Kwara State Government. Hygeia, the local executing partner, has contracted seven healthcare providers in Kwara of which four public and three private. All the providers are subject to quality improvement process.

Access: Yes. Today, nearly 35,000 low-income people have enrolled in Kwara North granting them access to quality healthcare in upgraded healthcare facilities.

Equity: Yes. The benefits of promoting universal access to quality care felt most keenly by the most vulnerable: pregnant women and children under 5, but not unsurprisingly, there was equally high uptake from the elderly.

Efficiency: Yes. The Kwara State Community Health Insurance Scheme guided the Federal Government to integrate a community health services package to be rolled out within the National Health Information System (NHIS).

Replicability: Yes. Kwara Community Health Insurance Scheme will be adopted and replicated in other communities. Uptake by patients of the scheme has been excellent. NHIS have technical assistance from the private sector (PharmaAccess and SafeCare) to expand health insurance to more than 100 communities in Nigeria based on the results achieved in Kwara State.

V. TRAINING AND EDUCATION

There is a critical need to increase and enhance mental and behavioural health workforce education and training because Health Education is opportunity for learning involving some form of communication designed to improve health literacy, including improving knowledge, and developing life skills which are conducive to individual and community health. Well-trained public health professionals are critical to address the changing context of global health challenges, including complex and persistent health problems, increasing health inequities, new and emerging diseases, necessity for greater collaboration within cross-sectoral approach and incorporation of social models and determinants of health.

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Case study 1: Residency programs and continuing medical education in Eritrea

Description: In 2004, there were only 215 physicians in Eritrea, or 4.5 physicians per 100 000 people. Eritrea had 5 formally trained general surgeons, 3 otolaryngologists, and 2 orthopaedists, all of whom had obtained their higher degrees from medical schools in Ethiopia or Europe. The PPP in 2008 until 2012, in Asmara, Eritrea was developed to train native Eritrean surgeons and postgraduate residencies in different fields of medicine, including surgery for Eritrea and address the lack of access to advanced medical education also contributed to brain drain. This partnership was based on humanitarian contributions. The George Washington University Medical Centre provided academic support and administration, Physicians for Peace (a private NGO) provided financial support, and the Eritrean Ministry of Health provided in-country coordination.

Access: Yes. Number of operations has increased by about 20% at the residency hospitals. Improvements in the consultation process, especially between surgery and paediatrics departments, because a concomitant paediatric residency program was initiated with in-house residents on call.

Equity: Yes. The Partnership continues to expand an obstetrics-gynecology residency program launched on July 1, 2009, with plans for residencies in anaesthesia and internal medicine. PPP can be successfully implemented in health programmes for education and training and specifically for surgical residency program and can improve health status of patients and physicians in the same time. This PPP demonstrates positive impact on improving precarious financial and political situation of Eritrea through the development of skills and competencies of local health human professionals.

Efficiency: Yes. Patient length of stay has decreased by 15% by emphasizing evidence-based care and resource usage such as antibiotic use has decreased by 42%. The establishment of regular ward rounds that included examination of supply orders led to decreased use. These practices led to decreased recovery times and faster discharges. The residency program improved practice standards, which improved postoperative care, decreased complications, and expedited discharges.

Replicability: Yes. The program has proved this model can be used in other parts of the world specifically in other developing countries with similar needs to establish tertiary medical education.

Points for Discussion

Faith-based organizations need to be considered for PPP Health programmes

Faith-based organizations can be an important gateway to services and care-giving for those living in poverty and in social exclusion. They have strong leadership roles in communities and provided job training, housing, economic development, educational support, meals and spiritual support to those in need. PPP in health with Faith-based organizations have also demonstrated sustainable and long term results (not 3-5 years but 20-30 years of existing)

How to design relevant PPP Health programme approach between private, Faith-based and NGOs organizations for LMICs ?

CHAPTER 5

EVALUATION: ADVANCING EXCELLENCE IN HEALTH THROUGH PPP

- Overview
- What sort of PPPs should be placed on the agenda of excellence in Health?
- What models are most appropriate for emerging markets and transition economies?
- What have been the key challenges in adopting PPPs?
- What have been the key challenges in adopting PPPs?
- What do governments need to do to build on success and achieve more excellence in PPPs in health?
- Conclusion and next steps

Overview

PPPs can help deliver health care. Governments everywhere, as previously stated, are facing rising costs due to a variety of factors, including economic growth (which increases demand for treatment), changing demographics and epidemiological trends (aging populations and more chronic diseases), and advances in medical technology (leading to more expensive equipment and tests). Governments worldwide are struggling to meet these demands within their limited fiscal space and simply lack the resources to provide healthcare to their citizens. They seriously must look to the private sector and explore PPP options. When done well, PPPs can:

- Help address the fiscal space;
- Improve efficiency within existing health assets, e.g. hospitals;
- Increase access and improve equity; and
- Contribute to meeting the health goals

In developing and transition economies these above mentioned health goals are multiple. In Asia there is a need for a more comprehensive universal service that replicates the scale and universal coverage of Europe. In addition, there is a lack of management and professional health care providers, doctors, nurses, technicians etc. In the latter European countries, particularly in transition economies there is a need for new investments, skills and technology and to make the existing assets more productive, through more efficient operations and maintenance.

The country review in [Chapter 2](#) demonstrates over two decades of PPP evolution. With successful roots in the UK, the use of PPP quickly spread, if not altogether successfully. There were failures in many countries and resistance to PPP, especially from trade unions, political parties and the medical profession – doctors and nurses. Initially, PPP in health care focused on infrastructure assets (hospitals) and since 2003, the trend has been towards more effective health care delivery (clinical services).

What sort of PPPs should be placed on the agenda of excellence in Health?

In this paper we have evaluated case studies both in the hospital sector and in what we have called health programmes. PPP in health programmes are aimed especially at low income developing countries, while PPPs in hospitals target mainly advanced developed

countries. Based on the case study overview, it can be seen that both types of PPPs share a few characteristics (both are not privatisation where the state relinquishes control, but each has a need for the state to oversee the project, if they are to be successful) but they are more distinguished by the differences which separate them.

Hospitals PPPs are more like PPP in what might be called the most commonly defined sense of the term, that is:

- Long term contracts (management contracts, lease agreements, concessions etc.);
- Project finance where rewards and risks are allocated between the parties;
- Involve large mobilisation of capital, for example, the McGill Health Centre PPP contract was worth CAD 1.3 billion, which is the largest hospital PPP in North America.

PPPs in health programmes by contrast:

- Focus on global health and disease specific partnerships;
- Have contracts but are very short term – two or three years;
- Mobilise far smaller amounts of funding;
- Concentrate on primary health care.

But making such an observation is not to state that the latter are less significant than hospital PPPs. Health care after all is more than hospitals and doctors. Hospitals and healthcare infrastructure represent only a small part of what keeps people healthy. Healthcare is just as much about prevention rather than just care; while care in the community is inherently cheaper than care in hospital. There is moreover a need to shift assets to service delivery and make them more efficient. PPPs in health programmes, although smaller than in the hospital sector, do just that for low income developing countries.

Thus, the paper takes a broader definition of PPPs than is normally accepted when applied to health care.

Definitions of PPPs in health

“models of cooperation, consisting of various types, with the common objective of improving health care, combining the best the state (regulation protection of the public interest) and the private sector (creativity, technology, management and finance) have to offer and avoiding the excesses of either an exclusively state run services or a fully private one”

What models are most appropriate for emerging markets and transition economies?

From the cases described above, we identify some proposed transactions. These can be divided in terms of (i) countries which are still starting out in this sector and (ii) countries with some experience of PPP

- (i) *Countries with only limited experience in PPP*

Dialysis Centres based on NKT model. Traditionally governments have purchased equipment/supplies from major manufacturers, but there has been a shift to governments buying complete services. This transfers the risks and responsibility to the private sector (which is best able to manage that risks). Moreover the major dialysis companies have also shifted to become complete service providers and, thus, it would be relatively easy to start with PPPs here given the growing interest of the private sector in building and operating such Centres.

Outsourcing clinical support services in hospitals, laboratory, and radiology/imaging. This would involve outsourcing the inpatient imaging services and lab analyses within hospitals. Often hospitals lack such equipment because it is too expensive. The private operator would assume responsibility for initial capital financing of equipment, maintenance/repairs. Since the private would not be paid if the equipment was not working properly, there would be sufficient incentive for keeping everything functioning properly.

(ii) *Countries with experience of PPPs*

Building, equipping and managing a public hospital by private management /consortium of. This could involve either the more limited UK model (where hospital management and clinical services remain in the public sector) or the full integrated PPP in hospitals in which the private operator is responsible for everything. Several developed countries, Canada, UK etc. have left the core health services within the public sector. In developing and emerging markets improving management and service quality is at least as important a need as improving the physical infrastructure hence; it is recommended that countries might consider using these ‘integrated’ models in hospitals.

Bringing clinical services under PPP

This approach is particularly important because in many emerging markets, the problem is not simply the lack of modern equipment or facilities; it is the lack of sufficient medical staff and hospital managers. Moreover globally health sector PPPs are deemed to have saved governments 20 to 30 per cent in the cost of providing healthcare services. Major savings are derived from clinical services, not infrastructure and facilities maintenance.

What have been the key challenges in adopting PPPs?

Based on the case studies and country reviews, while PPPs in health have appeared to be delivered on time and within budget, some challenges have been noticeable:

- Pace of change in the health sector;
- Labour resistance;
- Need for better monitoring and contract management;
- Rapid technological change and the need to introduce flexibility into the contract to accommodate change²².

²²A major issue in hospital PPPs is the need to constantly update medical equipment to reflect advances. This creates risk for PPP operators if they are required to periodically update equipment, as they will not know the capital or operating costs for new technology which may come into use.

In PPP health programmes the main challenges facing Global health partnerships have been

- The need to better involve the local partners in the programme;
- Undertake as much as possible ‘bottom up’ approaches for effective national implementation;
- Greater national preparedness /training of national partners;
- Critical to provide proper governance of Global Partnership Programmes.

What specific PPPs in health already advance excellence?

A number of cases mentioned above go beyond success and can be already described as achieving excellence in health care.

Lesotho

The case demonstrates that it is possible for a low –income country to embark on a very ambitious project that is affordable for the country and its patients, is attractive to top quality investors and has the potential to deliver high quality health services that address the MDGs and the critical shortage of health professionals. It has been remarkable in many aspects:

- (i) All too rarely have projects coming out of Africa obtained such recognition as being a source of inspiration to policy makers around the world.
- (ii) Sheer ambition of the authorities to go ahead in one of the region's poorest countries where the risks /reward ratio was decidedly unfavourable to the private sector investor.
- (iii) With exactly the same budget the authorities have vastly improved the coverage of the population .This new integrated health infrastructure will ultimately serve a total of 500,000 people in the district including vulnerable members of the population such as women and children.
- (iv) The hospital furthermore has and is continuing to make a lasting contribution to local economic development, through generating jobs, income and providing training to health professionals used by the whole country.
- (v) Furthermore the hospital made a special effort to promote women's groups both in the running of the hospital (40 per cent of the company's equity is owned by such groups) while women are employed in numerous services such as nursing, cleaning, laundry services etc.

Manila NKTI

The PPP used in the treatment of renal failure had the effect of motivating and increasing the job satisfaction of senior management. It demonstrates that ultimately the doctors are incentivised by their capability to deliver a better level of treatment to their patients. The experience produced PPP 'coverts' and it is the way if resistance from health professionals to PPP in envisaged.

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What do Governments need to do to build on success and achieve more excellence in PPPs in health?

From the case studies, there are, it would appear, several actions that Governments might consider as a priority.

(i) Mobilise political will

First of all for PPPs in health it is critical that there is political will from the highest level of government. Without strong backing from the Minister of Health (as there was in Lesotho) it will be enormously difficult to undertake PPPs. Political will is reflected in implementing strategic policy documents and plans, and in necessary legislation revisions and involvement of technical staff from Ministries and specifically the Ministry of Finance.²³

(ii) Institutional requirements (PPP Unit, standard contracts, management capacity to service contracts etc.)

Contracts are critical to the success of the PPP initiative: both for infrastructure and for service contracts. There is a critical need for adequate contract management knowledge and for institutional development so that this action can be properly delivered. (e.g. PPP unit created in the Health Ministry). The key challenges based on experience in numerous countries in Europe are the following:

- Shifting the specifications in contracts from inputs to outputs. This puts a considerable challenge on the public administration to define the KPIs and to link 'rewards' to the same.
- Establishment of long-term (20-30 years) performance based contracts and how to manage the monitoring
- The setting of and enforcing of penalties where the contract has not been complied with.
- Incompleteness of contracts: The incompleteness of contracts is unavoidable, because long-term contracts will necessarily face technological, demographic, managerial, and political changes.
- Technological change. PPP contracts accommodate the risk to the private operator by sharing it among the parties. The same principle applies to new (more costly) medical treatments. For example if the PPP operators are receiving global fixed budget, then they will wish to avoid costly treatments such as transplants. The PPP contractors should include provisions for how to address whether the operators will be required to undertake such treatments and, if so, how they will be reimbursed.

(iii) Legal frameworks

This refers to the following:

- New legislation, which provides for the removal of barriers to the use of PPP (e.g. monopoly provisions for health care delivery);

²³In the UK PFI was so successful because of total unity from the Government. In the Minister of health Alan Milburn who described it as the only show in town to Alan Johnston, who said that PFI in health is Plan A.

- Need for greater attention in regulating and enforcing safety and quality of care, a body that can regulate health PPP contracts and reassure the public. Most countries use a combination of independent monitoring, Ministry of health regulations/norms, and contract administration by the national health insurer.
- Procurement: there are important differences between procurement methods. In Europe much is made of the ‘competitive dialogue’. A major difference between countries is whether there are detailed negotiations after the winning bid is selected (e.g., as in the UK.)

Conclusion and next steps

The evidence presented in this paper suggests that PPPs are a valuable tool in delivering health care. One of the positive effects has been how PPPs have bridged the former divide between association of the private sector with the rich and the linkage of the public sector with the poor. One can under PPP obtain excellence in health care despite being poor.

The increasing number of PPPs in health is helping to build a considerable base of international experiences to draw upon for future projects. Philippines have kindly volunteered to become a Specialist s Centre on PPPs in Health. Such a task is greatly needed. First, as the above mentioned cases demonstrate the devil is often in the details and effort will be required to uncover the detail.

Secondly, data are often hard to come by as contracts are typically confidential and time is required before a project can be fairly evaluated. PWC’s study on PPPs in Health described how performance metrics and financial details are frequently viewed as confidential. It argued that where there was talk of transparency there was a risk of misinformation or distortion of the limited information available. Indeed many countries do not regularly monitor the performance of their PPPs, which gives ammunition to detractors.

Finally a Centre of Health that pursues excellence will encourage all the partners to PPP to make sure that PPP increases equity, improve access and efficiency in healthcare for patients. It will set a global standard – that up to now does not exist – for benchmarking excellence.