Report on Wilton Park Conference WP1045

PUBLIC-PRIVATE INVESTMENT PARTNERSHIPS: INNOVATIONS FOR QUALITY AND EFFICIENCY IN HEALTH SYSTEMS

Monday 20 – Wednesday 22 September 2010

Summary

This report summarises discussions at Wilton Park aimed at providing a deeper understanding of the Public Private Investment Partnership (PPIP) model. It draws on a wide range of technical expertise represented at the conference, from operational management to professional advisory services and financial institutions. The key lessons and discussion focused on recent healthcare PPIPs in the Turks & Cacaos Islands (TCI), Lesotho and several from Spain in Valencia and in Madrid. It also draws on the experience of other related projects in healthcare such as a PPIP for supply chain management for medicines across Africa and several health insurance PPIPs. This report of the discussion is structured to address the following questions:

- When is a PPIP an appropriate solution in healthcare?
- How can a PPIP be effectively financed?
- How to get the PPIP deal right?; and
- How to evaluate success or failure?

The report highlights key actions for further collaboration to improve, refine and develop the PPIP model as suggested by the participants at the conference.

Background and context

1. In 2008, a conference was held at Wilton Park which gathered a wide range of stakeholders from private, public and financial sectors. They explored strategic opportunities for the private sector to support governments in strengthening publicly run health systems through long term investments and commitments which

developed the model of PPIP. A PPIP is a type of public private partnership which has the following features;

- Significant infrastructure and service delivery capacity provided by the private partner specifically to support public policy objectives;
- Long term commitment by both the public and private partners;
- Ownership of assets retained by the public sector.

2. The 2008 conference introduced the PPIP concept and its advantages and outlined top-line critical success factors and potential weaknesses of this novel approach. Since the first conference there has been significant progress in PPIP initiatives; most notably two PPIP projects in TCI and Lesotho, have recently become operational.

3. Interest has grown in the potential of PPIPs to improve quality, efficiency, access, and ultimately patient outcomes in healthcare. There has been a marked shift in the willingness of many governments towards exploring PPIPs as a means of achieving their public policy objectives. This has stimulated an appetite for a greater understanding of best-practices and processes which guided the objectives and design of the 2010 conference. Participants brought a wealth of PPIP experience both from within and outside the healthcare sector. The aim of the conference was to integrate their diverse experience and perspectives to inform, improve and refine the PPIP model.

The global context

4. The healthcare industry currently accounts for 11% of global GDP[1] ranking it above spending on military and defence procurement. The USA has the world's largest military budget spending 7-8% of GDP on military and defence procurement, but this is only half what is spent on healthcare (16% of GDP). Globally healthcare spending per capita is growing at a rate of 7% per year[2]. The sustainability of this spending trend is questionable, and there is no consensus on whether any of the

[1] World Health Organisation (WHO)
[2] WHO: per capita growth rate based on per capita spending 2000 compared with 2007 compound annual growth rate (CAGR) on Purchasing Power Parity $ (PPP) basis

existing healthcare systems across North America, Europe and Japan, are well placed to respond to the current and future challenges.

5. The growing burden of healthcare spending is not limited to developed countries alone. In low income countries (LIC), healthcare accounts for 5% of GDP with growth in spending per capita at 10% CAGR[3]. The challenges for the LICs are two-fold:

- weak and often dysfunctional public healthcare facilities, lacking basic sanitation, trained staff and essential medicines;
- limited public finances to upgrade these facilities or improve the skills of personnel. Many of the LICs which are former British colonies have attempted to emulate the UK's National Health Service (NHS) model. This blueprint of a state owned and controlled system funded through central government tax revenues remains and is supported by international donor agencies. In parallel to these state facilities is a growing private sector provision. This private sector is often unregulated, of variable quality and focuses on selling services for urban elites.

6. There is heated global debate on the appropriate role for the state in healthcare. This debate often lacks clarity and insight, for example, in the USA many of the people protesting against state involvement in healthcare are beneficiaries of the publicly funded Medicare system which has existed since 1965. In many LICs there is evidence that the state has been unable to deliver high quality, accessible healthcare but most donors still insist on funding purely state-based healthcare activity. Many state actors are increasingly looking to alternative models to meet their public service objectives. This is driven by dual pressures from public spending cuts and other austerity measures with ever-growing public needs, expectations and demands for health services.

7. Globally, from HICs (High Income Countries) to LICs there are now a plethora of innovative and experimental approaches to improve quality, efficiency and access to healthcare by leveraging private sector expertise for public benefit. Valencia in

[3] WHO: per capita growth rate based on per capita spending 2000 vs. 2007 CAGR on PPP$ basis

Spain (HIC) has several successful PPIP initiatives which improve facilities, the provision of care, and human resources; Germany has embarked on a PPIP to facilitate provision of hi-tech healthcare facilities. India (a Middle Income Country) demonstrates that PPIPs can improve access to healthcare through the evolution of microfinance programmes. In a similar fashion, Nigeria has used public private partnerships to fund health insurance for the poor and specifically for high cost diseases such as AIDS. Innovative approaches have not been isolated to single country pilots and solutions; there have also been large scale PPIPs addressing supply chain management efficiency across Africa improving access to medicines on a continental scale.

PPIP Innovations: key insights

When is a PPIP an appropriate solution in the healthcare environment?

8. Where there is public failure or risk of failure on defined objectives and priorities. There was overwhelming consensus in all the cases reviewed, where there are explicit political priorities and objectives which the public sector is either currently failing or potentially expected to fail to meet, that a PPIP can offer an effective and timely solution. More often than not, long term sustainability has been the key trigger in PPIP innovation. In Valencia, the rising burden of disease, pressure of a growing population and mounting public sector debt restrained the ability of the regional authority (public sector) to improve quality and efficiency of healthcare provision to the local population in a cost-effective manner. This was the catalyst for seeking an alternative model, resulting in a PPIP which has been operational for 10 years, delivering the same range of services but with a 25% cost-saving compared to the purely public sector facilities in the region. Similarly, in both Lesotho and the TCI the existing healthcare facilities were so inadequate that patients were sent to neighbouring countries for treatment at great public expense. Not only was this an unsustainable model for public finances, it was also failing to provide equitable access to basic healthcare for the broader population. The limited capacity of the public sector to finance and execute a radical change in healthcare facilities and provision alone led to the need and adoption of a PPIP.

9. In a similar vein, the public sector supply chain management of medicines in LICs, especially across the continent of Africa, fails to meet its primary objective of ensuring access to good quality medicines. It is assessed that in parts of Africa essential medicines are available to patients only 30% of the time. The supply of medicines across Africa is predominantly through a publicly owned and controlled Central Medical Store (CMS). A public CMS generally preferred over a free market or private sector CMS because it is believed it ensures equality of access and quality of medicines. However, growing evidence demonstrates that public CMSs have only achieved patchy success. In contrast the supply chain of medicines in most HICs is managed and delivered by the private sector and has guaranteed access to medicines. A radical overhaul of the management of the medicine supply chains is required. The expertise and the infrastructure already exist in the private sector, and attempts to duplicate these in the public sector would not only be wasteful but also likely to fail. A PPIP can provide a timely and effective solution. For instance, the need to treat HIV/AIDS patients across Africa gave impetus to the improvement of supply chain management for antiretroviral (ARV) drugs. This need was identified by a private company, RTT (a pan-African wholesaler and distributor) who now have a contract to support the US PEPFAR (USA President's Emergency Plan for Aids Relief) initiative. This PPIP was initiated by a private contractor willing to bear the full market risk of setting up the necessary capacity and infrastructure. This PPIP has proved to be a highly effective solution and has been replicated across the continent through regional hubs. It is expanding into the supply of other essential medicines and medical technologies

10. Where political will is strong and policies are focused on outcomes. Political will and a coherent communications strategy are crucial in developing and implementing a PPIP. Strong political leadership will ensure that all key stakeholders understand that a PPIP does not mean privatisation of public sector services. Nor does it mean piecemeal outsourcing and tendering of public services. It is important to recognise that a PPIP is a comprehensive solution to improve quality and efficiency leading to better public health outcomes. The PPIP pilot in Alzira (Valencia, Spain), was met initially with significant resistance from professional medical unions. However, strong leadership ensured that the PPIP pilot would be evaluated on its

ability to achieve substantial quality and cost benefits, which were more than the public providers could deliver. It is strongly noted that the debate and the final decision either for or against a PPIP needs to be based on a rational assessment of the evidence available and the desired outcomes and actively seeks to avoid arguments based on ideology. Such rational policy debate requires consensus on the desired outcomes as well as the methods and indicators to measure and monitor those outcomes; it requires a policy process that incorporates them into decision-making.

11. Where private sector involvement can provide an integrated solution and avoid additional policy distortions. A PPIP in healthcare should ideally provide primary, secondary and tertiary care; an integrated solution to avoid replicating the distortions which fragment care delivery. A PPIP that does not include primary care may not be able to effectively manage patient needs which might then over-burden the secondary and tertiary care facilities. This is reflected in the different Spanish PPIP experiences of Valencia and Madrid. In Valencia, the PPIP is an integrated care delivery network; in Madrid the PPIP is focused only on hospital provision. The emergency room specifications for the PPIP hospital in Madrid are six times larger than those in Valencia reflecting, in part, the lack of control the Madrid PPIP has of primary care which would reduce unnecessary emergency visits. In Lesotho the PPIP includes several primary care "filter" clinics to treat and refer patients. This approach is especially important in developing countries where traditionally even basic healthcare is provided and dispensed by hospitals. These "filter clinics" are designed to ensure the hospital will not be oversubscribed by patients and that secondary care facilities and resources can be utilised more appropriately.

12. In addition, a PPIP may need to provide solutions for wider public sector challenges to achieve its desired outcomes. An example is that in many developing countries there has been a continual drain of trained medical professionals abroard, leaving a severe skills gap for the delivery of health care in the home country. An effective PPIP would need to address this by providing attractive working conditions and job opportunities to the skilled diaspora. In Lesotho and TCI, training of existing and new medical staff has been included in the PPIP agreement. In Alzira (Valencia,

Spain) there were chronic staff shortages due to its rural location, so the PPIP deal included a medical teaching hospital which significantly improved the supply of trained staff.

13. In developing countries an integrated approach to addressing chronic problems in the health care system may also demand providing solutions for improving access to quality medicines. The supply of medicines and medical equipment is at best sporadic in many developing countries. A PPIP that only offers new or improved healthcare facilities with fully trained staff would fail to improve patient outcomes if it did not also provide consistent access to medicines. In these circumstances a PPIP would need to address the logistics of effective supply chain management in order to have a real impact on the access and quality of healthcare.

What is required to effectively finance PPIP deals in healthcare?

14. Sustainable incremental revenue flows. In order to ensure the long-term sustainability and scalability of a PPIP in healthcare, it is crucial to establish a dependable revenue stream. It is needed to fund the transaction costs once the contracts are signed as well as capital investments. The PPIP revenue flows should ideally be cost-neutral or offer cost-savings to the public budget (as was the case in the majority of the PPIPs discussed from Lesotho to Valencia, Spain). Ultimately, the PPIP needs to offer better value for money and the acceptable cost-impact will be dictated by the public finances available over the period. There may be instances where the provision of services increases costs to the individual or public-sector subject to affordability and political mandate of the public payer but offers benefits that supersede these costs.

15. In HICs (High Income Countries) long-established tax revenue streams or public health insurance contributions can provide the sustainable revenue flows required. In the Spanish PPIPs existing revenue streams from the regional authorities were utilised in the same way that they are in public run facilities which ensured cost-neutrality. In fact, in the Alzira (Valencia, Spain) PPIP they were able to achieve a 25% cost-reduction alongside service improvements. However, in LICs tapping into tax revenue streams to finance, a PPIP might only serve to divert funds from other

needs. There is a potential role here for donors in providing revenue support in order to cover initial transaction costs. This would encourage commercial lenders to fund PPIPs at affordable rates[4].

16. New social health insurance mechanisms (SHI) may offer a sustainable solution in some countries. This approach has been used in TCI where the PPIP was underpinned by the launch of a national health insurance (NHI) scheme. The NHI scheme is funded through small salary contributions (5%) split between employee and employers. While there was initial scepticism whether a population of 35,000 could generate sufficient revenue to support an NHI plan, actuarial studies demonstrated that it would be sustainable.

17. In many LICs there are multiple challenges to implementing an SHI scheme; the size of the informal economy makes collecting contributions very expensive; and lower income groups do not necessarily see the value of buying-in to such a scheme. There have been several initiatives to address these challenges and offer solutions for the poor and vulnerable segments. One example of this is led by PharmAccess Foundation[5]. They have set up a Health Insurance Fund in Hygeria, Nigeria supported by the Dutch government. The Fund introduces a collective health insurance for low income groups, based on risk pooling, donor support, co-payments and utilization of local private infrastructure. This insurance scheme will cover basic health care services, including treatment of HIV/AIDS, tuberculosis and malaria. This initiative demonstrates how it is possible to mobilise existing resources to set up a SHI scheme in a LIC. It also emphasises the importance of addressing the needs of poorer households with a suitable benefits package; one that offers regular primary care related services and benefits alongside security for acute and chronic care. Ultimately, they need to demonstrate value for money to poorer households to justify the short-term loss in household income.

18. An SHI scheme alone may not be able to deliver sustainable improvements to the quality and access of healthcare, but it can form an important component to a

[4] In LICs interest rates are often as high as 30%
[5] Not-for-profit foundation based in Amsterdam, www.pharmaccess.org

PPIP solution. Neither will it solely be able to ensure access to adequate and appropriate services and benefits for patients in the long-term. If the SHI scheme is unable to influence and manage the costs of service provision whilst ensuring levels and consistency in the quality of care it is likely to be unsustainable. An example is the USA healthcare system where premiums continue to increase (or benefits are rationed) in order to finance continual price increases from providers and suppliers of services.

19. Clarity on both the risks and expected returns. A key barrier to financing PPIPs especially in developing countries has been raising capital both in debt and equity. A lack of understanding within banking and financial sector of healthcare delivery and its risks has meant there is reluctance to take on "white coat risks"[6]. Firstly, financial institutions are often only willing to lend money for the infrastructure component of PPIP's, as that enables them to secure their risks on a physical asset. This has led to PPIP contracts being split into two, one for infrastructure financing, construction and maintenance; and another for the financing and delivery of the service provision. This situation requires pro-active and sophisticated management to align the activity of construction companies or infrastructure developers with the needs of clinical service provision. Secondly, equity investors are reluctant to invest when they perceive high risks and low returns in unstable political and economic environments. In Lesotho, the government permitted the private operator to build an additional wing to the hospital to serve private patients. The purpose of this private facility is to supplement profits for the private consortia and potentially mitigate risks through subsidising activities/losses. There are clearly risks to this approach; in particular that service delivery may become distorted as increasing priority is given to the private facility guided by profit maximising behaviour. In order to address these risks, in many PPIPs the private operator is subjected to a cap on profits.

What does it take to get the deal right: from contract development to implementation?

20. Ensuring the deal structure suits the intent of the PPIP. Securing the right deal requires specific and particular skills and capabilities. First, it is crucial to ensure the

[6] This refers to the risks associated with the provision of medical services as opposed to physical infrastructure such as hospitals

'right' players are brought into the discussions early to ensure transparency and acceptabilities. The 'right' players will be determined by the project objectives. For example, health insurance providers are essential where population risks need to be managed effectively, whilst experienced hospital managers will be needed to improve operational productivity. Secondly, the deal needs to align the incentives for all parties around core objectives. There needs to be recognition that private companies are driven by profit and must be structured into the contract. An example of this is in Valencia, where financial incentives encourage rational prescribing practices and the use of generic medicines. Public sector objectives need to be clear and explicit in order to structure a deal effectively and to align the incentives for all parties.

21. Alignment of the agreement with existing legal and regulatory framework. The novelty of a PPIP means it will often exist outside a formal regulatory framework. In most developed countries the legal framework is sufficiently mature to support a proper binding contract for all parties involved. In situations where the legal and regulatory framework is less developed, it is important to understand the limitations of the local civil and common law environment and appropriately adapt and customise the structure of the deal.

22. Building in flexibility. Flexibility in the contract is important to reflects its the long-term nature. This flexibility must address several key issues. Firstly, recognition of the evolving environment and situation; the costs incurred by the private provider are likely to change for contracts which span several years not least because of advances in medical technology. The PPIP agreement will need to recognise this and permit episodic review and discussion on prices and costs. If the private provider only breaks even, or starts to make a loss, it is very likely to withdraw from the PPIP. Secondly, the deal needs to respond to broader external changes in circumstances and environment. This can be achieved through informal dispute mechanisms, which lock the parties into regular dialogue with episodic reviews. These can resolve a wide range of potential problems from the failure to achieve set objectives to dealing with the bankruptcy of the private provider. Effective informal dispute mechanisms can avoid lengthy and expensive formal dispute resolutions.

23. Importance of contract management after the deal is signed. A central theme for many PPIPs has been the need for intensive focus on contract management after contract signature. This pressure is most acutely felt in developing markets where capabilities and capacity to be "hands-on" after the deal has been signed is limited. In the TCI, the professional external advisors who helped the public sector to structure the deal left once the contract was signed. Significant gaps in expertise and skills of the public sector in the PPIP risks its long term sustainability.

The Evaluation of PPIP's: What does success look like?

24. PPIPs need to be comparable with or better than previous public sector performance. In order to demonstrate benefits measurement and comparison over time is needed. In Alzira (Valencia, Spain), the PPIP has led to significant improvement in the levels of quality and access as well as cost-savings of 25%. The ability to provide evidence of PPIPs impact helped rational political debate over the use of PPIP. This led to an expansion of PPIPs in Valencia. In addition, the evidence sparked interest from other regions in Spain such as Madrid who are embarking on their own PPIP in healthcare. In TCI and Lesotho will need to compare the value for money of their previous model (re-sending patients abroad for treatment) with their new PPIP model as well as accessing its impact on healthcare outcomes amongst the broader population.

25. Comparisons with the past are not always possible in countries where there has been little or no monitoring of outcomes. That increases the acceptance of collating information now to support future evaluations, ensuring standards are at the very least maintained and demonstrating when significant improvements are made.

26. Outcomes should be central to evaluation. PPIPs ultimately seek to improve access, quality and efficiency, leading to better health outcomes for patient. It is important that evaluation criteria and indicators help link these outcomes to the incentive structures for the private consortia. In the Alzira (Valencia, Spain) PPIP model, 86 indicators are used to compare all health facilities including PPIPs. These indicators form part of Valencia's Annual Quality Plan to which all healthcare facilities are subjected (both private or public sector). The monitoring is carried out by a team

of public sector administrators and clinicians throughout the region. The team utilises data from patient claims, records and surveys and from financial management information.

27. In many PPIPs there can be additional benefits for wider society. For example, in Lesotho the PPIP was designed to increase participation of local businesses such as local commerce in contracts in catering and grounds maintenance. Similarly, RTT's PPIP to supply ARVs led to growth in business for local haulage companies, job creation in the regional hubs and improvements in IT infrastructure. Whilst these are welcome benefits, it is important that the success of the PPIP be evaluated on its core objectives. Additional benefits should be viewed as a bonus.

28. Monitoring should not be burdensome. Whilst monitoring is crucial to evaluation it needs to be simple. Extensive monitoring can create distortions in delivery of services. For instance, in donor sponsored HIV/AIDS centres the reporting needed for donors places a huge additional burden on staff when information is consolidated by hand by nurses and doctors who should be focused on providing treatment. It is essential that simple and effective metrics are identified which can be collected and summarised without consuming significant medical resources. Information technology and systems might offer the most efficient solution to monitoring, but, in many countries the upfront investment in the IT equipment and training required is prohibitively high. A monitoring and evaluation system in LICs using existing technologies such as mobile phones would be a more effective solution.

29. Independent outcomes and impact evaluation. Evaluations should be conducted by an independent party. This body would be responsible for integrating evaluation into the project from the beginning, including providing the IT infrastructure and information systems for evaluation and monitoring. This body may also advise on creative solutions and initiatives to monitor performance with minimal investment. An independent body helps ensure objectivity and the building of a reliable evidence base and it must maintain its independence and transparency.

The Road Ahead: Key actions for further collaboration

30. Addressing the need to improve access to capital for the right PPIP projects in developing countries. There are two major barriers to raising capital for PPIP in developing countries. Firstly, raising debt from lenders is inhibited by their reluctance to shoulder any 'white coat' risk. Risk transfer or risk sharing therefore is key to improving access to capital. There has been some progress where donor agencies and development banks can provide credit guarantees to lenders. Interest for these credit guarantee schemes are growing with increased recognition of its multiplier effect; for example, $1 of donor funds can leverage up to $30 of benefits. Secondly, equity investors in healthcare are often deterred through perceptions of high risks and modest returns. A solution is for donor agencies to offer equity investments rather than the donation of large sums of money to public institutions. This approach has several advantages; more efficient use of donor resources and improved incentive structures. Donor funds would no longer be poured into dysfunctional public institutions; instead they could be invested into specific projects with defined objectives. Incentive structures would be less geared to securing donor funds with minimal scrutiny and more geared to developing a proposal for effective use of these funds and the creation of value. Successful equity investments can be re-invested into other similar projects.

31. Address the lack of contract management and supervision capabilities in the public sector (especially in developing countries). A central concern to all PPIP projects in developing countries is the inexperience in the public sector in taking an effective role in the implementation or supervision of PPIP deals. There is a lack of relevant skilled resources and processes. Donors have the opportunity to provide technical assistance to both the public and private sector. The sustainability of existing PPIPs such as in TCI and Lesotho will be determined by the ability of the public sector to manage effectively their current PPIPs contracts. These state actors are likely to rely initially on assistance and guidance from external experts.

32. Refine the contracting capabilities in the public sector (especially in developing countries). A limited body of knowledge exists to guide the structuring of new PPIP deals. A centralised repository that can build on lessons learned from PPIPs and act

as a stepping stone towards best-practices guidelines for structuring deals would hugely benefit those setting up future PPIPs. Internationally, there is a need to make existing expertise and technical assistance available to both the public and private sector. This expertise should be used to set international standards and develop best-practise guidelines. They might also offer tools for new PPIP projects such as skeleton proposals, legal advice and links to organisations that provide technical and professional advisory services and assistance.

33. Facilitate the sharing of lessons learned internationally. The need for a central database of existing PPIP initiatives globally has grown significantly. Its purpose would be to share information and experience. This would enable those embarking on a new PPIP project to draw lessons from previous and current projects. This could potentially evolve into a directory of expertise supporting the identification of organisations, governments and individuals that have been involved in PPIP projects. This would facilitate cross-fertilisation of ideas and encourage dialogue for future developments nationally and internationally.

34. Bespoke support to Small and Medium Enterprises (SMEs). It is estimated that seventy-five percent of all PPIP projects in developing countries are under $3 million and are carried out by SMEs. SMEs often struggle to gain access to capital, and often lack the personnel and skills to develop business proposals that can be fairly assessed by financial institutions. This restricts PPIP activity to a fewer larger players and potentially reduces the efficiency gains that come from a highly competitive environment. Development of be-spoke packages that SMEs can access to support their inclusion into the PPIP process could redress the current imbalance.

35. Local and regional workshops and meetings. Local and regional dialogue is required to understand the needs in detail and clarify where private sector involvement might have the greatest impact. This will broaden experience and facilitate sharing of information and evidence of PPIPs. This process can support a significant ‘mind shift’ in the public sector through evidence-based rational debate on the locally appropriate solutions.

36. Develop a network of independent bodies to monitor outcomes. Developing a network of monitoring bodies would support their independence and transparency without undermining their relevance locally. This network would share information and lessons on efficient and effective methods of data collation and analysis, as well as on novel and innovative approaches to various challenges.

37. Role of participant activism to scale up and drive ahead. Conference participants are the driving force in taking forward the key actions. "Never doubt that a small group of committed individuals can change the world, in fact indeed it is often the only thing that has"[7]. In order to meet the global challenges in healthcare, governments, private providers and international agencies will need to share information and facilitate the rapid adoption of PPIP initiatives.

Rema Sabri
September 2010

[7] Margaret Mead

GLOSSARY

ARV – Antiretroviral

CAGR – Compound Annual Growth Rate

CMS – Central Medical Store

HIC – High Income Countries

LIC – Low Income Countries

NHI – National Health Insurance

NHS – UK's National Health Service

PEPFAR – USA President's Emergency Plan for Aids Relief

PPIP – Public-Private Investment Partnerships

SHI – Social Health Mechanisms

SME – Small and Medium Enterprises

TCI – Turks & Cacaos Island