



Public-Private Investment Partnerships in Health Systems Strengthening

Wilton Park
April 9-11, 2008

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For more information please contact: Heather Kinlaw, Global Health Group, UCSF at kinlawh@globalhealth.ucsf.edu or tel: +1-415-597-9247.

GLOBAL TRENDS IN HEALTH CARE PUBLIC-PRIVATE PARTNERSHIPS

INTRODUCTION

The rising demand and increased costs for health service delivery are straining health delivery systems worldwide. Addressing these challenges is overwhelmingly an issue for governments, as most health delivery systems today remain within governmental control. In general, governments' first step is to consider how public hospitals, in particular, are funded and operated – since, in most countries, public hospitals and the respective ancillary services account for the largest percentage of overall healthcare spending. In addressing this issue, governments are increasingly considering various models of private sector participation – often referred to as Public-Private Partnerships (PPPs). Such arrangements increasingly offer a viable approach to controlling costs, improving service, and even increasing access.

This paper will provide an overview of what we mean by PPPs, discuss challenges surrounding the designing and managing the transaction process, present a snapshot of interesting case study examples, and generate a view on ongoing global trends in the provisioning of healthcare services, with the goal of identifying common themes, highlighting notable case examples – and discerning what lessons policymakers can learn from healthcare development around the world.

CONTEXT - PROVISIONING OF HEALTHCARE SERVICES

Public hospitals represent the largest segment of health spending in countries worldwide. As a result, a prime focus in any health delivery system must be on controlling costs and creating efficiencies within hospital care. Countries worldwide have tried various strategies for achieving this goal including:

- shifting provisioning away from inpatient hospital care;
- decentralizing provisioning responsibilities from a federal to a state or municipal level;
- changing incentives through autonomizing, corporatizing, or even privatizing hospitals themselves;
- reducing the number of hospitals and hospital beds through consolidations and closings, as well as restricting the level of new entrants via regulation;
- accrediting and licensing to enforce quality standards and to ensure control over supply.

Within nearly all reform efforts private sector participation has been sought to complement the existing reform efforts. Often referred to in general terms as Public-Private Partnerships (PPPs), these models are seen as a solution to alleviate public health system pressures.

PUBLIC-PRIVATE PARTNERSHIPS - OVERVIEW

PPPs in health care typically involve the Ministry of Health (MoH) or national health insurer contracting with the private sector for a specific service and/or capital asset. Additionally, PPPs

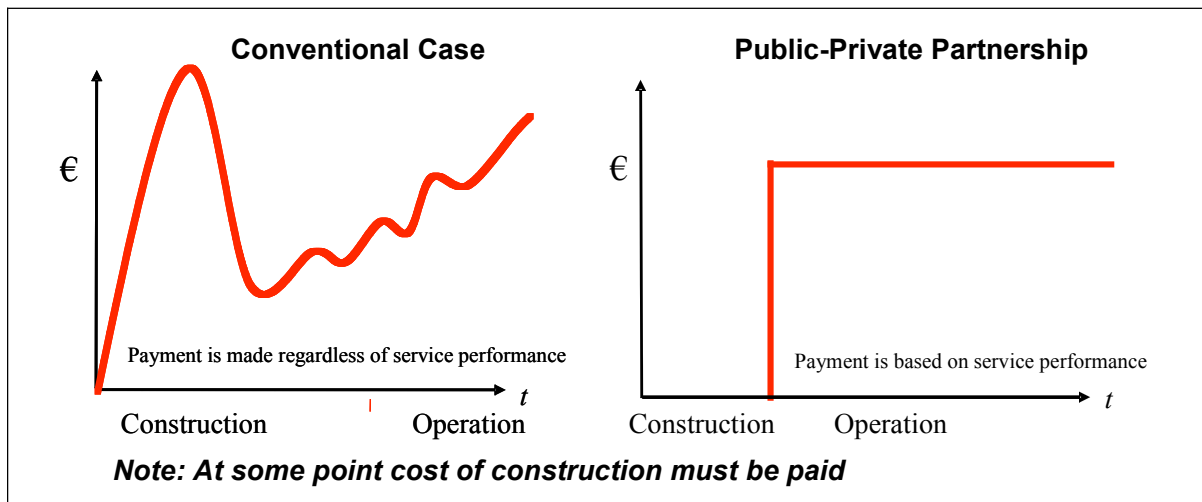
typically involve services for ‘public patients’ whose treatment is funded by an MoH or government health insurer.

Various Models

PPPs can be applied to a wide range of services, from facility construction alone, through support services such as lab analysis, up to management of a hospital or network of hospitals and clinics. The various models here will be restricted to hospitals or hospital-related ancillary services.

Risk Allocation

An essential component of a PPP is the allocation of responsibility and risk. When the private sector is included in public health service delivery, some component of responsibility and risk is shifted. The basic premise of the transfer of risk in a new hospital construction PPP is best illustrated in the graphic below. In the conventional case, payment is made regardless of service performance. In a



PPP, payment is based on service performance (i.e., is made only after a hospital is operational).

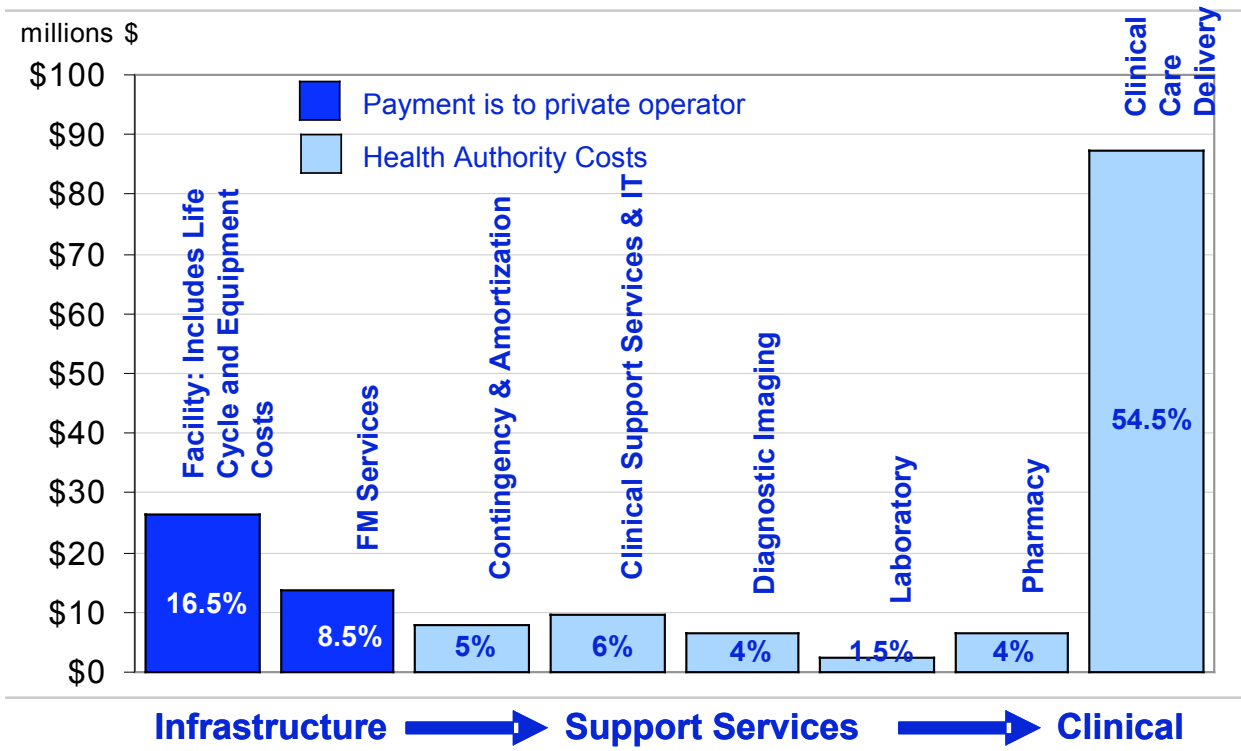
Which areas of risk and responsibility are shifted to the private sector will determine the opportunities for cost savings. Policy-makers often consider PPPs as a vehicle for building new hospital at no cost to the government.

PPPs in the health sector can take a variety of forms with differing degrees of public and private sector responsibility and risk. The private sector partner may be responsible for all or some project operations, and financing can come from either the public or private sector partner or both. Within these various areas of responsibility and risk the cost components vary significantly.

The chart below, taken from a Canada PFI project, illustrates where the private sector can be most cost effective. While new facility construction remains the focus of most PPPs (e.g. the PFI model); the largest cost-center is care delivery. As a result, the area of activity where application of private expertise is likely to have the greatest effect on cost-effectiveness will be in clinical care delivery.

Clearly, unless a PPP encompasses some aspect of the clinical service component, cost savings in the operations of a hospital are limited.

Projected Cost of First Full Year of Operation



Clearly, unless a PPP encompasses some aspect of the clinical service component, cost savings in the operations of a hospital are limited. In emerging markets, ongoing non-clinical facility expenses are lower than in high income countries, and the relative importance of clinical care efficiency gains are likely to be correspondingly more pronounced.

Strengths and Weaknesses

The three most common models for hospital PPP have varying strengths and weaknesses. The Private Finance Initiative (PFI) model reflects political incentives but is weak for implementing true healthcare reform. The 'Organisation Social' (OS) model allows for significant control but often is highly dependent on idiosyncratic leadership. Finally, the Concession model provides clear financial incentives for the private partner, but is often politically infeasible.

PFI Model

PFI's are typically based upon government contracts to private groups for the construction and maintenance of hospitals or other facilities, with payment spread evenly over a long (20 or 30 year) timeframe. The PFI model is ideal for real estate projects where government has continually underfunded the infrastructure and equipment. PFI's can be a vehicle for the public sector to work with the private sector in a politically acceptable manner. A major benefit is predictable cost distributions over a large time period. However the PFI model is very weak as a means to implement true

healthcare reform as the emphasis is on new facility development. In the PFI model, the clinical service component remains under public control, where the majority of costs are incurred as illustrated in the chart above.

OS Model

The OS model is a form of management contracting with facility and infrastructure provided (new) by government, and service delivery, including all employment of medical and maintenance staff, contracted to an independent non-profit organization. In Brazil where most experience for this is based, the arrangements with management groups are based on global budget contracting. The model is simple and transparent and has a number of inherent strengths including allocating to the responsible group full control over personnel and full control over purchasing. However, as applied in Brazil there remain a number of weaknesses, most notably that reimbursement does not cover depreciation of capital, and a lack of clarity on which party retains excess revenues after expenses.

Concession Model

Concession contracts are essentially an integration of the two models above, comprising both construction (or renovation), and operation of a medical facility. In some cases two separate but linked contracts are used to better allocate financial risk to facility or services. Payments are usually spread evenly across a long (20 – 30-year) period. The key strength of the concession model is that the private provider's purchase price typically fulfills the investment needs of the facility. Often, the bidders must also take over existing liabilities and debts. Like the OS Model, the concession model allows for full control over personnel and full control over purchasing.

However, the concession model is the most politically difficult model to implement. As a result, most of the types of transactions initiate in smaller cities and basic general hospitals. The concession model is dependent on experienced hospital operators – a particular challenge in emerging markets where budgets are too small to attract international investors.

Key Challenges

There are a number of key challenges in implementing PPPs which are true for all three models. These challenges are even more acute in emerging markets:

- **Lack of capacity to monitor and regulate.** Governments must increase their ability to monitor, regulate and enforce contracts with the private sector.
- **Lack of advisors.** Governments implementing PPP often do not have the funds for transaction advisors. This work can be divided into two phases. 1) the due diligence and transaction structuring phase, and 2) the transaction implementation phase.

The due diligence phase includes assessing the current and future needs of the project, assessing PPP options, providing the legal basis for the transaction and developing the business case.

The transaction implementation phase includes preparing the information memorandum and marketing to potential investors, drafting contracts and bidding documents, assistance in due

diligence and negotiations and ensuring that the bid submission and technical evaluation process is transparent and fair.

For both phases various advisors are needed, from lawyers to hospital planners. Localities often do not have these funds to invest so they are typically dependent on dedicated individuals, or champions, to promote and implement the project.

- **Very limited pool of strong bidders.** There are few international hospital management companies and often no existing market of local providers with operational experience.
- **Funding Risk.** Risk that public health insurance funding will decline and become unsustainable for the operator.
- **Payment Risk.** There is a risk that payments will be delayed and cause liquidity issues within the public facilities.
- **Political Risk.** Risk that a new local political environment may not value working with the private sector.

WESTERN EUROPE

An important driver for the implementation of PPPs and the PPP model of choice is the method of healthcare funding and how healthcare services are purchased. Western European countries generally rely on taxation and social insurance as predominant sources of healthcare funding. Some clearly favor taxation, as we see in Denmark, Italy, Portugal, Spain, Sweden, and the United Kingdom. Conversely, social health insurance contributions predominate in France, Germany, and the Netherlands. Belgium, Greece, and Switzerland offer dual systems (Evans 2002). In reality, most systems also include some component of private funding – which every year is increasing in total outlays, as well as a percentage of overall health funding.

No single approach to financing or provisioning in Western Europe has proven to be clearly superior. But Western Europe's diverse successes and failures nevertheless raise significant questions, issues, and opportunities – as we see in some salient case examples.

GERMANY

Overview

A new DRG reimbursement scheme, introduced in 2003, has forced hospitals to become more market-oriented, accelerating a process of privatization already underway (Busse and Riesberg 2004). In a typical DRG example, an operator takes over a facility on a lease-free basis for a certain period after a new hospital has been constructed. The DRG reform has shown initially promising results (e.g., increased hospital efficiency and shorter length of stay). Currently, it is estimated that 25% of public hospital beds are under private management (Morgan Stanley Equity Research 2006). New Design-Build-Operate (DBO) hospitals are typically privately financed in full, without the need of public funds (Loening and Kuestermann 2005).

Concession Contract Case

In the late 1990's The State of Berlin was not able to finance the replacement – estimated at over €350m – of the Berlin-Buch hospital, an old and dispersed 1,100 bed facility. At the time the hospital was faced with increasing double-digit losses and decreasing patient volumes. It was significantly overstaffed. Consequently, according to the dual financing law, it was mandatory for the government to step in (Loening and Kuestermann 2005).

In 2001, Helios-Kliniken, Germany's second largest private hospital operator, won a tender to operate the hospital. The resulting PPP included a number of important contracts. In the concession contract, Helios retained the hospital license and assumed the mobile assets and liabilities of existing facilities. The contract also allowed for the residual facilities to be operated on a lease-free basis through 2008. That created an incentive for Helios to have a replacement building completed by that time, in order to avoid making sizable lease payments for old facilities. The resulting €215m Build, Own and Operate (BOO) hospital model was privately financed in full, without the need of public funds, as mandated by the dual-financing law (Loening and Kuestermann 2005).

UNITED KINGDOM

Overview

There are a number of trends in increasing the market-orientation of health service provisioning in the UK. A Private Finance Initiative (PFI) has been the PPP model of choice for financing the construction of new facilities. In this model the NHS transfers responsibility and risk for assets and services to a private contractor. The contractor takes on obligations under a long-term contract (typically 20-30 years) and designs, builds, and manages non-clinical services of the facility. The NHS pays a fee for management of the non-clinical services during the concession period, which is to allow for the private operator, or consortium, to recoup the operational costs as well as the capital costs of the facility (Townsend 2005). Currently, there are over 600 PFI projects that have been signed across various sectors in the UK (McKechnie 2007).

PFI's have primarily been used to replace government construction of facilities, rather than to augment government construction. The NHS has also sought to add additional capacity to the overall delivery system via the Treatment Centre Program. Approximately sixty NHS-run treatment centers as well as sixty Independent (e.g., private) Sector Treatment Centers are being built to add capacity to reduce wait-lists.

Tony Blair's original goal was to give independent providers about £1.2bn worth of business a year – or £6bn worth over five years. In reality, however, the program may turn out to be less than half the amount originally promised (Timmins 2007).

The experiences of the UK are particularly important as many countries around the world, including Portugal, Canada, Egypt, and South Africa, have sought to emulate the UK system. For this reason, reforms in the UK offer a bellwether for reforms likely to emerge elsewhere in the world.

SPAIN

Overview

In Spain, healthcare governance is decentralized and organized within 17 regions, each of which is responsible for the management of its own facilities, benefits, and health service programs. As a result, each region forms its own policies – and its own strategies for incorporating private sector aid.

Concession Case

In the Alzira Health District the Valencia Health Department (VHD) allows for new hospitals to be privately financed, constructed, and managed by a consortium of private firms. The VHD pays the consortium an annual capitation fee for residents of the area; it also pays a DRG fee for patients who come from outside the catchment area. Since April 2003, new agreements have shifted focus to an integrated delivery system and an increased capitated payment to cover the cost of providing primary care services. This model has been successful, and tenders are planned for constructing eight new hospitals over the next few years in the region, all following the Alzira model (Loening and Taylor 2004).

In contrast, PFI is the model of choice in the Madrid Region. A first wave of eight PFI contracts was awarded in 2006. These contracts are typically for new hospital financing, construction, and providing maintenance services over a 30-year concession (Moriarty 2006).

PORTUGAL

Concession Contract Case

In 2002, Portugal announced a \$975 million DBO (Design-Build-Operate) program, involving the construction, replacement/refurbishment, and private management of a total of ten hospitals by the private sector. The plan was for two contracts under the Portuguese DBO model. First, a construction and maintenance contract following the PFI model in the UK. Second, a private operator contract for the provision of healthcare services (Vitorino 2003; Maikisch 2007).

FRANCE

Overview

Recent legislation has sought to include private sector investment in the public health system.

PFI Case

A “Long-term Lease” (bail emphyteotique hospitalier or BEH) is common form of PPP in France, whereby a private operator has rights to occupy public land subject to meeting obligations to build and maintain facilities. The BEH is accompanied by a contract that sets out the basis on which the private partner is to be remunerated for providing the serviced facilities so as to cover both amortization of capital and service costs. It is reported that there are four larger hospitals being built, requiring an investment of €700 million, and that there are thirty smaller projects in the pipeline (Linklaters 2004).

EASTERN EUROPE & FORMER SOVIET UNION

The transition economies of central and eastern Europe (CEE) and the former Soviet Union (FSU) have all experienced moderate to severe disruption in economic activity during recent years. Often, the tax base has severely deteriorated due to declines in the formal economic sector – all of which combines with expanded activity in the informal sectors, as well as a lack of administrative ability to enforce tax collection. As a result, governmental ability to finance health care has declined markedly in many countries in the region.

Health-sector reform echoes themes that characterize these countries' overall social and economic transition to establishing market-based economies: reduced direct state involvement, as well as increased decentralization, privatization, and organizational reform.

In general, new EU-Accession Countries – such as Czech Republic, Poland, and Hungary – are characterized by higher per-capita incomes, a history of less severe economic decline, and a history of progressive healthcare reform. In general, also, they commonly employ a social insurance model for health financing (Evans 2002; Mossialos and Dixon 2002; Normand and Busse 2002). Within nearly all of these countries, the private sector is increasingly contracting with National Health Funds for discrete clinical services (e.g., dialysis labs and imaging services). With that said, throughout all of these countries, funding has been insufficient, relative to existing over-capacity, and so informal out of pocket (OOP) payments have become widespread.

PPPs in the region take many forms, from private management contracts, lease agreements, concession contracts, or even equity stakes in the hospitals themselves. The following will illustrate specific examples of the private sector operating public hospitals in Hungary, the Czech Republic, Poland, and Slovakia that have similar business models.

POLAND

Overview

At the federal level there has been little reform. However, like its neighboring countries Czech Republic, Slovakia, and Hungary, the health system has embarked upon a process of decentralization of ownership, together with capital funding responsibility, to regions or municipalities.

Concession Case

There are already examples of PPPs in the Municipal areas of Poland. EMC Instytut Medyczny is a company that currently operates six regional hospitals and outpatient clinics in north-western and south-western Poland. EMC has been operating in the health sector since 2000. EMC's main source of revenue comes from contracts with NFZ (National Health Fund in Poland) and focuses on privatizations and restructuring of existing public hospitals. An example of a typical public hospital acquisition is Swiebodzice Hospital. In July 2006 EMC purchased a 90% stake in Swiebodzice Hospital from the Swiebodzice municipality for €127,400 in July 2006. The remaining 10% continues to be held by the local authorities. Under the contract, EMC committed to make a €508,000 capital contribution to the hospital over 4 years, to finance the center's modernization and the purchase of new medical equipment. The company is obliged to provide a €355,600 loan to the healthcare facility during the 4 year investment period, if any unexpected costs arise, and to keep its staff of 120 for at least twelve months. The newly-acquired hospital has a €1.8 million contract with

the NFZ.

SwissMed is another private provider in Poland. It has a small private hospital in Gdansk. Approximately 50% of its revenues are from the NFZ providing discrete inpatient and outpatient procedures. It also has a contract with the NFZ for being on call for emergency services one week a month.

HUNGARY

Overview

Hospitals account for 66% of the healthcare budget in Hungary, a very high proportion compared to the level of more developed countries (30-40%). The excess capacity within the health system is illustrated by hospital bed occupancy: well below the level of EU average (70% vs. 85%); the portion “one-day surgery” of total surgeries is only 4-5%, compared to 50% of total surgeries in developed countries; and 20% of inpatients in hospitals could have been treated on an outpatient basis.

In order to transform the system, the Ministry of Health is revamping the allocation of purchased healthcare services. The aim is to reinforce the DRG system that reimburses hospitals on the basis of treatments and the intensity of the treatment provided. In order to appropriately incentivize hospitals and force reorganization, the Ministry cut the budget of hospitals by 5% in 2006 and by an additional 10% in 1Q 2007. As a result of the reforms, the administrative regions will each have one large central hospital where specialist and emergency treatments will be available, while the smaller territorial hospitals will provide general care, chronic and long term care. These reform steps put pressure on primarily municipally owned hospitals and outpatient clinics that are inefficiently managed, likely resulting in tendering out to the private sector for management services. By the end of March 2007 all hospitals in Hungary signed a new contract with the NHIF. As a result of these new NHIF contracts, new system of reallocated capacities and reimbursement is complete. The only remaining issue is the planned reform of the insurance system.

Concession Case

There are currently four private management companies that operate public hospitals in Hungary. Hospinvest is the largest private hospital management group in the country, with a strategy to take over, restructure, and operate municipal hospitals. It currently manages four hospitals and six outpatient centers. The European Bank for Reconstruction and Development (EBRD) recently made a €4 million equity investment to fund its current expansion strategy.

CZECH REPUBLIC

Overview

As in Poland and Hungary there have been numerous examples of private management companies taking over regional and municipal hospitals. Agel (formerly Euromednet), the largest private provider of health care in the country, has invested over €25 million into its eight hospitals, mostly into facilities renovation and medical equipment upgrades. The eight hospitals acquired were ultimately all in poor state and operating for years in deficit. Currently, Agel is negotiating for three additional smaller size hospitals in Northern Moravia (Prerov, Sternberk, and Prostejov) owned by the Olomouc region. These would likely be under 20-year concession contract agreements.

German operator, Helios, has the majority (76.2%) of the shares in Meditera, also a Czech private management hospital group. Currently, Meditera owns and operates four hospitals (of which one is a rehabilitation facility) and operates 2 other hospitals under management contract.

SLOVAKIA

Overview

A main component of the recent reform efforts were hospital PPPs. There were two predominant models of choice: public hospitals under private management contracts or private firms taking an equity stake of up to 49% in the public hospitals. Some examples include, J&T, a major financial services company and insurer, which operates four public hospitals. Two of these, the Bratislava and Kosice hospitals, have been operating under ten year private management contracts for approximately two years and are both now operating at break-even, or better, after years of deficits. The Humenne and Svidnik Hospitals are 66% owned by J&T private management with the remaining 33% owned by the Municipalities. One of these hospitals was already operating at break-even in less than 12 months.

There are also a few other firms operating public hospitals under private management or similar PPP arrangements. UNIPHARMA has three public hospitals, one of which is 100% owned by the UNIPHARMA, while the other two are operating under similar private management contracts to J&T's in Bratislava and Kosice. Two other private operators of public hospitals in Slovakia are Apollo and Nemoncnica. Apollo has three hospitals under 20 year lease arrangements while Nemoncnica has four public hospitals under 20 year lease arrangements. Broadly, the UNIPHARMA, Apollo, and Nemoncnica hospitals were all operating in deficit for years, but are now operating at, or close to break-even, depending on how long the contracts have been in place.

ROMANIA

Overview

There have been two attempts in implementing the PFI model in Romania (Timisoara and Braila). Neither one of these has succeeded in getting off the ground. The reason for the PFI failure in the Romanian markets is because the government, or in these cases, the municipalities, do not have the funding possibility to support these facilities. As a result, the model of choice in the Region has been a concession where the bidder funds the initial capex and often pays the existing debts and liabilities. At the same time, Romania is well advanced in the National Health Insurance Fund (NHIF) contracting with the private sector. Some examples include contracting for dialysis services, inpatient radiology as well as outpatient labs.

Service Component Contracting Case

In 2004, the NHIF tendered for experienced private dialysis operators to take over and upgrade eight separate dialysis centers in eight different public hospitals across Romania and provide outpatient services for hemodialysis and peritoneal patients. The operators are paid flat fee per hemodialysis treatment and annual fee per peritoneal patient. The contract can be extended from four years to seven years if the operator relocates to a new facility within two years of the tender

award. The operator is to assume full responsibility for renovating/equipping facility, maintaining and operating the equipment, employing and paying the staff, and treating the patients. New standards for facility/equipment specifications and dialysis treatment have been implemented which are comparable to standards in EU countries. Following the success, the government has now embarked upon shifting the remaining outpatient dialysis services to the private sector.

There are a number of examples of private providers providing radiology services within public hospitals. Like in other markets, the private provider leases space from the public facilities, provides services to the hospital for public patients but also has the possibility to provide additional services to private patients. The private operator is typically responsible for renovating and upgrading building for radiology services, installing CT, MRI, and x-ray equipment per specifications set out in the tender documents, serving all patients referred by hospital according to specified standards of care, and employing and paying radiology/imaging staff. Meanwhile, the hospital is responsible for referring patients to the operator for designated tests, reimbursing the operator based on specified fee schedule (note: no Hospital contribution to capital cost of equipment or facility renovations).

The International Finance Corporation (IFC) assisted in one of the first tenders for a private radiology provider. All bidders bid on identical contract specifications and requirements with the winner selected on the basis of bidder who bid the largest discount to a specified fee schedule. The winning bidder proposed a 35% discount to fee schedule

GEORGIA

Overview

The Republic of Georgia is an anomaly in the region. Like the other countries, public funding has essentially collapsed, precipitating a massive loss of resources for social services such as health care. Out-of-pocket payments have become the predominant mode of health financing, amounting to 80% of total health revenue. In an attempt to decentralize financing responsibility, in the 1990s the government permitted most hospitals to become legal entities, i.e., Limited Liability Companies (LLC) or Joint Stock Companies (JSC). The government had hoped that an oversupply of hospitals could be reduced through free-market mechanisms (Gamkrelidze, Atun et al. 2002; Mossialos and Dixon 2002). However, hospitals and bed capacity did not rationalize as expected. As a result, the government has recently embarked on an alternative approach, including the privatization of 90% of public hospitals and clinics. By early 2008 it is expected that hospital beds will be rationalized to 7,800 from 17,000, with 100 new hospitals equipped to modern international standards.

Concession Case

Privatization in Georgia is accomplished by having bidders bid on blocks of hospitals which typically consist of a large hospital in Tbilisi with regional and rural hospitals. The winning bidder will build a new facility replacing the specified blocks and operate them for seven years. Following the opening of the new hospital, the investor is allowed to tear down the old structure and re-build as commercial or residential property. Investors are required to follow the master plan in terms of the various departments/services to be available in each hospital, with only minor changes allowed with the government permission. As a result, various consortia of bidders have formed from medical equipment suppliers, pharmaceutical companies, and real estate investors.

LATIN AMERICA

Latin America, predictably, faces many of the same funding and provisioning challenges previously discussed. The prime difference in Latin America is that most systems are based on social security systems – resulting in systems that are largely publicly funded, retaining only a relatively small private insurance component. As providers are typically publicly owned, there has been a slow trend toward autonomization and corporatization of public hospitals.

Of course, there are several notable pan-Latin-American trends and issues. Given the broad array of differing strategies we find throughout the region, though, this discussion will focus on the Brazil model.

BRAZIL

Overview

The majority of hospital facilities in Brazil are non-for-profit entities. Due to poor public reimbursement, many of these facilities have been forced to contract out to for-profit, private sector entities for lab tests, dialysis, imaging and other discrete clinical/non-clinical services. By contracting out of services, the private providers are able to gain efficiencies needed for profitability, while the hospitals themselves are able to obtain a new renovated facility and new equipment.

A number of the federal states (Sao Paulo, Bahia, and Rio de Janeiro) are contracting out management of public hospitals to non-for-profit entities. Providers are obliged to treat all local residents. In return, the provider receives a global fixed budget from the state, provided specified patient volume and quality parameters are achieved. Brazil has enacted some of the most far-reaching reforms in working with the private sector to enhance efficiency to the delivery system (Loening and Taylor 2004).

OS Case

In the State of Sao Paulo this is often referred to as the OS (Organization Social) Model. The Sao Paulo State Government financed, built and equipped 16 new hospitals under traditional public works contracts. State then contracted with ‘not-for-profit’ hospital operators to manage the hospitals (including all clinical and non-clinical services). Operator obliged to treat all local residents. Operator receives global fixed budget from State provided specified patient volume and quality parameters are achieved. Operator receives capital expenditure (La Forgia and Couttolenc 2008 (in press)).

The reimbursement works through a global budget. All parties know that the SUS covers approximately only one-third of the costs based on Fee For Service (set by Federal SUS) and thereby the State of SP incorporates a top-up of two-thirds up to the negotiated volume number. Normally, if figures are 10% above or below what is negotiated the global budget allocation is the same. However, in year 2005, there was a flu and one of the providers saw 31,000 emergency department visits in one month, rather than the contracted 22,000 per month. Therefore the reimbursement was renegotiated. All 16 OS hospitals run this way.

MIDDLE EAST / NORTH AFRICA

Generally, MENA Region (Middle East North Africa) health systems are structured around a centralized health sector, with a Ministry of Health responsible for ownership and financing of facilities. These structures seemingly stem from times of UK and French colonial control. General trends in the region include increasing universal health coverage (as in Egypt) while decentralizing service provisioning (as in Tunisia or Jordan) (Preker and Harding 2002; El-Saharty and Maeda 2006).

The countries in the Region, notably, wealthier Gulf Cooperation Council countries have undertaken significant reform efforts, including new national health insurance schemes (as in Saudi Arabia and the Emirate of Abu Dhabi). It is expected that other, wealthier countries will follow in developing new social health insurance schemes in due course.

There have also been examples of PPPs in the UAE, Qatar, Saudi Arabia, and Bahrain. The model of choice has been private management contracts. However, it is important to note that these countries are relatively wealthy and thus able to afford private management contracts with the hiring of a number of costly expatriate individuals.

SAUDI ARABIA

Overview

Currently, the Saudi Ministry of Health is considering a variety of options to reform its hospital services, all of them employing different market-based approaches. Indeed in Saudi Arabia, “market-based approaches” and “marketization” are terms broadly referring to policies that loosen government control, management, and even ownership of public hospitals. Commonly designed to subject hospitals to market-like pressures, these policies range from autonomization (granting hospitals greater management autonomy) to corporatization (moving hospitals under a new quasi-private umbrella) to privatization (selling hospital assets to the private sector). Additionally, there have been some examples of private management contracting with international hospital management companies.

TURKEY

Throughout Turkey, a number of private hospital projects have been initiated – indeed the Turkish healthcare industry seems to be on the verge of a major transformation, from being driven by the state to being driven largely by the private sector (Daruma 2006). The government is also considering launching the development of new public hospitals via the PFI model (Moriarty 2006).

AFRICA

While we witness examples of innovative healthcare strategies in Africa, these countries' significant lack of resources often prevents them from offering meaningful reform examples for Western countries like the United Kingdom. Still, once again, there are several case examples worthy of mention.

NIGERIA

In 2003, The National Hospital in Abuja experimented in private management, but this contract was terminated early. In general, public hospitals are in poor condition and poorly funded. Moreover there is a limited private hospital market in major cities run by the health maintenance organizations. In the future how national insurers contract with providers will be of significant interest to students of healthcare reform.

KENYA

Like the National Hospital in Abuja, the government of Kenya tendered for private management of the Kenyatta National Hospital in the 1990s. The contract was short-lived for the same reasons that transpired in Nigeria. First, the private management contract was designed so that the employees remained under the public sector and the private management group was unable to manage these employees. And second, there was a generally antipathy for the large salaries that were being paid to the expatriate workers of private management group which became a large political issue.

SOUTH AFRICA

South Africa has a similar structure to the UK's NHS. It has introduced PFIs as the model of choice for private sector participation. There is also a co-location in Bloemfontein with a major South African private provider.

LESOTHO

Lesotho offers a funding system based on budgetary allocations from the central government. The healthcare provisioning system, also, is primarily public. An IFC/World Bank hospital PPP project is under development to replace the existing national hospital. IFC is advising on the design, structuring, tender and implementation of the project, in which a private operator will build and fully operate the public hospital. Under the PPP contract, the Operator will receive a fixed global budget annually and has the obligation to treat all patients (within volume parameters established in the contract). The PPP contract includes well-defined performance indicators for clinical and non-clinical services. The Government is providing roughly 50% of the capital cost of the new hospital. As a result of the tender, a preferred bidder was selected in December 2007 and negotiations are underway to finalize the PPP Contract.

AUSTRALIA

AUSTRALIA

The federal and state governments have introduced private participation in more than 50 public hospitals, through a variety of different mechanisms. They have also completed 15 Build-Own-Operate transactions (in which a private firm builds, owns, and operates a public hospital), four conversions (in which a hospital is sold to a private operator as a going concern), four transactions involving private management of a public hospital that the government continues to own three build-own-leaseback arrangements (in which a private firm constructs a new public hospital, then leases it back to the government), and 30 co-locations (in which a private wing is located within or beside a public hospital). All of these initiatives were driven by a need for new capital, a perceived need to transfer operational risk, and a desire to increase efficiency (Brown and Barnett 2004; Schmiede and Bloom 2005; Moriarty 2006).

CONCLUSIONS AND FUTURE OUTLOOK

What can we learn from this global survey? There is an immense diversity of strategies for innovation and reform. However, one lesson is clear: the fate of healthcare systems, as we see in countless case examples, is in large part determined by the health system structure, that often determines what is, and is not, politically feasible in healthcare reform. For this reason diverse states must find customized solutions meeting their particular restrictions and needs. While the diverse examples of global successes and failures provide a menu of options for policymakers, no one-size-fits-all formula seems forthcoming anytime soon. Each government ultimately must plot its own course in making healthcare funding and provision more modern, more efficient, and more effective.

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