



WILTON PARK

# PUBLIC-PRIVATE INVESTMENT PARTNERSHIPS IN HEALTH SYSTEMS STRENGTHENING

Conference Report

909<sup>th</sup> WILTON PARK CONFERENCE

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THE GLOBAL HEALTH GROUP

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## **Report on Wilton Park Conference 909**

# **PUBLIC-PRIVATE INVESTMENT PARTNERSHIPS IN HEALTH SYSTEMS STRENGTHENING**

**Wednesday 9 – Friday 11 April 2008**

**In co-operation with  
The Global Health Group  
at the University of California, San Francisco, Global Health Sciences  
and The Healthcare Redesign Group**

### **Summary**

Health systems in developing countries are in a state of crisis. As countries seek new ways to rebuild aging infrastructure and improve access and services, several are beginning to engage the private sector through a variety of public-private partnerships. This conference explored a subset of these partnerships, which engage the private sector in not only the financing and rebuilding of health systems infrastructure, but also the long-term provision of services, and most importantly, management oversight. This subset, termed “Public-Private Investment Partnerships,” or PPIPs, was explored to better understand its current and potential application as a model for further country adoption. Several country examples were presented, critical success factors and potential strengths and weaknesses were identified, and a range of potential next steps were set out. The need was highlighted for further evaluation and documentation of PPIPs to assist countries in examining this model for possible adoption.

### **Background**

1. Weak, poor quality, and ineffective health systems are at the heart of chronic problems preventing major health gains and economic development in many regions of the world. While unprecedented amounts of money are flowing into countries for

particular interventions for diseases such as AIDS, TB, malaria, health systems bottlenecks can severely affect how quickly these interventions reach patients and communities and, ultimately, how many lives are saved for each dollar invested.

2. The components of health systems' deficits which are often mentioned include a lack of health professionals, inadequate finance, poor quality of service, and inefficient supply chains. Less discussed, but equally serious problems exist with decaying and derelict infrastructure lacking reliable water, sanitation and electricity. Without adequate infrastructure, doctors and nurses, even when they are available, cannot provide quality care. Underlying all of these is a serious shortage of skilled and trained managers. The management deficit is greatest in sub-Saharan Africa where only 17% of the total health workforce is employed as managers, compared to 33% globally.

3. While increasing attention is now focused on strengthening public sector management of health systems, less attention is being given to how the private sector's financial and management resources can be harnessed to aid governments in meeting their responsibilities for the health of its population. An often unrecognized reality is that private delivery of health care in developing countries is large, often unregulated and, frequently the place where the poorest of the poor receive their care. The private share of healthcare spending, particularly out of pocket spending by the poor, in developing countries is large and growing.

4. The focus of this conference was to assess strategic opportunities for the private sector to support governments in strengthening health systems in low and middle income countries through long-term investment and commitment. The importance of private sector investment goes well beyond mobilizing funds to upgrade facilities, while keeping capital expenditures off-balance sheet. It can be a powerful instrument to introduce world-class expertise in service delivery, quality, and management into the health systems of developing countries.

5. Public-private partnerships in health fall along a continuum from limited private sector involvement through "contracting out" defined support services such as laundry or housekeeping, to bringing in expertise to build facilities and manage a full range of

ancillary and clinical services in hospitals and primary care. Choices on how to involve the private sector depend on the public policy goals to be achieved and the level of risk and potential reward expected. As one moves along the continuum, the challenges and risks for both sectors are greater; but the potential performance rewards are also greater as a result of larger investments, longer investment periods, and better alignment of incentives between the public and private partners.

6. If the policy goal is to improve particular services at the margin in a relatively well functioning system, then defined contracting out of services may be the best option. If, however, the goal is to fundamentally improve quality, access, and efficiency in health services delivery and mobilize long term private investment, then a bolder approach is required. This approach is characterized by what the conference organizers are calling Public-Private Investment Partnerships (PPIPs) that go beyond private investment in hospital buildings and maintenance (such as private finance models) to encompass ongoing management and provision of clinical and support services. They bring private providers into health systems as long-term partners with governments to build capacity and strengthen health services delivery to large portions of the population, not just those who can afford private care.

7. While the potential rewards of PPIPs are significant, PPIPs can be complex and challenging to initiate and manage. Private partners face risks of guaranteeing return on investment in low-income and unstable settings; while public partners face risks of negotiating long-term purchasing agreements with lock-in clauses, and the need to develop strong contract management expertise.

8. There are successful experiences in several OECD and middle-income countries of PPIPs, and a notable and innovative program being introduced in Lesotho using the PPIP model. Section II of this report describes these and other experiences in greater detail. These are highlighted in the next section, followed by lessons learnt. The final section of the report identifies some potential next steps and conclusions.

## **Case Studies**

9. The conference explored several case studies of long-term private investment in health systems in a range of countries. The first segment of this section highlights innovative PPIP experiences; while the second section outlines models that could provide a foundation for the development of PPIPs. More information on these cases is provided in background papers and articles posted on the Wilton Park 909 website.<sup>1</sup>

### **A. High-, Middle- and Low-Income Country examples of PPIPs: Spain, The Turks & Caicos Islands, and Lesotho**

10. Three models emerged as cutting-edge examples of innovative PPIP experiences, demonstrating implementation in high-, middle- and low-income country settings. The three vary in terms of their implementation phase: Spain's model is almost ten years old, while those in the Turks and Caicos Islands and Lesotho are just being put into place.

#### ***Spain***

11. The "Alzira" PPIP is an established partnership between a consortium of private companies, led by Adeslas, a private health insurance company, and the Valencia government in Spain. Starting in the late 1990s, the government of Valencia embarked on the PPIP model in an attempt to control costs while upgrading access and quality of health services. In 1999, the private consortium, which also includes a construction company, built the €61 million Hospital de La Ribera to serve as the cornerstone of this PPIP, to provide a full range of primary through tertiary care services to a catchment area of 250,000 persons, at an agreed capitation rate. The contract between the Government and Adeslas is for a period of 15 years with a clause that allows for renewal. A specific stipulation in the contract limits Adeslas' return on investment to 7.5%. The PPIP encompass a €60+ million integrated hospital and primary care delivery system. A unique feature of this PPIP is that the "money follows the patient" in that residents within the catchment district are given freedom to choose where they receive care. Visits are tracked via electronic medical record identification cards, and if patients

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<sup>1</sup> <http://www.wiltonpark.org.uk/themes/environment/pastconference.aspx?confref=WP909>

choose to seek care outside of the Alzira district health network, Adeslas must pay an agreed-upon Diagnostic Related Group (DRG) fee from the capitation it receives, to the provider that treats the patient. This model ensures that Adeslas provides high-quality care and service to those in the catchment area, since they have a real choice to seek other providers. A benchmark study completed in 2007 showed that Alzira's operational costs are 25% less than the Valencia regional average for the same basket of services. Benchmarks show that Adeslas has an average length of stay in hospital of 4.8 days compared to between 6-7 days for the area's government-run facilities. Additionally, patient satisfaction is very high with a rating of 87%. The model clearly demonstrates that the private sector has delivered a higher quality of service at a lower cost to the population of Valencia than the publicly run facilities. The success of the Alzira model has prompted the government of Valencia to initiate several more PPIPs in the region.

### ***Turks and Caicos Islands***

12. The Turks and Caicos Islands (TCI) are an overseas territory of the United Kingdom, located southeast of the Bahamas in the North Atlantic Ocean, with a population of approximately 35,000 spread across several islands. Health services have traditionally been publicly financed through general revenues and managed by the Ministry of Health. The poor and limited infrastructure of the current facilities and growing health needs of the population made it increasingly difficult for the government to provide the level of quality and access to health care that its population requires and expects. To upgrade its delivery of health services, and provide care at international standards, the Turks and Caicos Islands Government (TCIG) sought a private partner. The resulting PPIP consists of a partnership between Interhealth Canada Limited (ICL) and TCIG to build and operate two integrated primary, secondary, and tertiary care facilities on different islands over a period of 25 years. The new facilities will be operational in April 2010. To support the operation of these facilities, the government is also implementing a mandatory national health insurance plan to cover its entire population, which will be funded through employer and employee contributions and subsidized through general revenues. The health insurance plan will be operational in 2009 to allow it to accumulate sufficient funds to ensure financial sustainability for the health care system. The hospital buildings and facilities management services will be paid by the government through a set unitary payment over the life of the contract.

Clinical services will be paid based on a capitation formula which will be determined by accumulating two years of data from actual experience on utilization and costs once the facilities are operational. At the outset, a critical consideration for TCIG was to ensure that the majority of staff, including physicians, at the existing hospitals would transfer to ICL once the new hospitals were built. ICL has already begun a process to assess staff and provide extensive training to upgrade staff skills and build long-term capacity on TCI. Quality assurance is an important component of this PPIP. The arrangement provides for a detailed set of key performance indicators based on international standards with which ICL must abide. The agreement requires that the Canadian Council on Health Services Accreditation accredit ICL facilities; maintaining accreditation is a prerequisite for payment. The government will also provide ongoing monitoring of quality and access through the creation of a Health Regulatory Agency to monitor all health care on the islands.

### ***Lesotho***

13. Lesotho is a land-locked country, surrounded by South Africa, with a population of 1,804,000 and an aging health systems infrastructure. As part of a national healthcare strategy to improve the quality of services provided to its population, the Minister of Finance and of Development Planning spearheaded development of a \$500 million PPIP to replace the country's 100 year-old main referral hospital in the capital city of Maseru, and provide all clinical services. A key reason for pursuing a PPIP model was to improve the management of health services delivery. Analysis of current facilities showed that by making an incremental increase in the resources devoted to these facilities, several thousand more patients could be seen through a public-private investment model. Demonstrating a clear plan for improvements in access and quality (i.e., clear value for money) reduced opposition to the model by physicians, staff, and others. In addition, government skepticism about the involvement of the private sector was overcome through an examination of public-private partnerships in other sectors of the economy which have shown a high level of success. The contract, which was signed in 2007, is an 18-year partnership between Netcare, a South African healthcare company, and the Government of Lesotho to replace the existing hospital and operate two feeder clinics, providing the full range of primary, secondary, and tertiary care to the population. The government worked with the International Finance Corporation arm of

the World Bank Group for technical assistance and was also able to secure a political guarantee from the World Bank's Multilateral Investment Guarantee Agency (MIGA)<sup>2</sup> to allay fears by the private sector about investing in a low-income country. All funding for the PPIP will come through government resources; expenditures are not expected to exceed health sector budget projections. This PPIP approach is being led by the Finance Ministry in partnership with the Ministry of Health in order to introduce the private sector as a long-term partner in health services delivery in a low-income setting.

## **B. Long-term private investment models that could establish a foundation for PPIPs**

14. In addition to the examples mentioned above, several other countries are also bringing in long-term private investment to build health institutions and provide a range of facilities management services.

### ***Egypt***

15. Egypt's population of 76.5 million is served by a comprehensive, but insufficient, publicly funded health system. Recent policy changes, including the implementation of universal health coverage and the initiation of the Takamol Project to incorporate a range of social components within existing clinics, have led naturally to a large-scale move to expand and update the health service infrastructure. The Egyptian government is undertaking this expansion through a range of public-private partnership modalities. Procter & Gamble and PricewaterhouseCoopers, for example, are supporting the system through their corporate social responsibility initiatives. The Al Bank Al Ahly Hospital, financed by the National Bank of Egypt, is a Private Financing Initiative (PFI) being used to expand tertiary care infrastructure. Although political and social opposition to engagement with the private sector remains a challenge, the initiatives have moved forward due to ministerial support, facilitated by the increasing autonomy being granted to all public hospitals, allowing local initiatives and collaborations to be entrepreneurial and adaptive to local opportunities.

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<sup>2</sup> [www.ifc.org](http://www.ifc.org); [www.miga.org](http://www.miga.org)



## ***Mexico***

16. Over the past 60 years, Mexico's population of 102 million has undergone a significant epidemiological transition. In 1940 infectious diseases were the main causes of illness; today, cardiovascular disease and accidents are the most important drivers of morbidity and mortality. To address this change the national health systems is undergoing broad restructuring, building new health networks centered around regional specialty hospitals. Much of the infrastructure for the new networks is being built through PFIs, with both Mexican and international private partners. Engagement of the private sector for facility construction and management has allowed the public sector to concentrate on clinical service provision. Outcomes have been generally positive, although organizational and financial barriers remain. Decentralization of national health budgets to the State level was one of the primary facilitating factors in the growth of PFIs.

## ***Papua New Guinea***

17. Over 80% of the population of Papua New Guinea (PNG) lives in isolated subsistence farming communities, however migration to both urban centers and mining areas is common and increasing. The PNG mining industry provides a significant revenue stream for the PNG Government and is an important provider of health care in many parts of the country. Ok Tedi Mining Limited began to provide community health services in 1970, establishing the only hospital for 70 kilometers. Beginning in 2004, Ok Tedi began planning for a transfer of the hospital ownership, management, and financing to the provincial government prior to the mine's expected closure in 2012. Throughout the negotiation process around the transfer the engagement of a third party, JTA International, has been important in bridging the expectations of the two sides and maintaining an effective and positive relationship between the public and private partners.

## ***China***

18. Sir Run Run Shaw Hospital in Hangzhou was established in 1994 as a privately subsidized, high-tech, provincial hospital. Funded jointly by Hong Kong philanthropist, Sir Run Run Shaw and the Zhejiang Provincial Government, the hospital uses private

donations and a collaboration with Loma Linda University Medical Center of California to maintain high levels of quality while still operating within the Provincial health system. Overall budgets are largely dictated by provincial allocations; however the private collaborators of the hospital bring new ideas and innovations which have kept management in line with international best practices. The hospital has received national and international recognition for this. For example, average length of stay in the hospital is low in comparison to other Province facilities and continues to decrease; bed occupancy, outpatient visits, and number of inpatient stays are all rising.

### ***South Africa***

19. Primary health care in South Africa is nominally free but often inaccessible for poor communities. The private sector is an important participant in all areas of health in South Africa, and at least two private care models supplement the care available from government with a particular focus on filling the gap in low-income primary care. The first is the *Primary Care Network Model* using health maintenance organization (HMO)-style contracting with both health insurance plans (for payment) and general practitioners (for provision of care) to provide defined access to primary care services. Primary Care Network Models serve 500,000 people, or 7-8% of the insured population. The second model is the *Primary Care Clinic Model*, which provides health services through chains of purpose-build primary clinic facilities. Although smaller in coverage than the Primary Care Networks, Primary Care Clinics are supported by at least two companies and are profitable. As with the first model most patients of the Clinic Networks are covered by private insurance. Both private care models offer a cost-effective opportunity for the government to engage in partnerships that would extend existing primary care services.

### ***United Kingdom (UK)***

20. The UK's National Health Service (NHS) is often held up as a global model, centrally funded and with little participation by the private sector. Beginning in 2003, however, the Independent Sector Treatment Program (ISTP) was created to generate competition through contracting out specialist diagnostic and treatment centers to private providers. Companies from the UK, North America, and South Africa bid for and were awarded contracts. The ISTP has inspired significant change by showing glaring

differences in patient outcomes between public and private providers, particularly in relation to ambulatory surgery. This Program has forced the NHS to re-assess itself and to be more productive, not only as a result of the actual competition it faced, but also based on the threat of that competition. A further benefit of the introduction of the private sector into the NHS has been a significant increase in the availability and transparency of outcome, output, and cost information data. Benchmarking with private providers has become a recognized driver of systemwide improvements.

## **Lessons learned**

### *Advantages of PPIPs Over Other Forms of Investment*

21. The option of combining private sector investment with both existing and future public sector strategies is a potential solution to many health systems challenges; the examples of such investments examined during the conference varied in the level and scope of infrastructure-building, service delivery and management oversight involved. Although many examples involving the building of facilities offer significant benefits to countries and communities, these solutions do not address simultaneous service infrastructure gaps, including staffing, supply chain management, and hospital leadership. For countries considering entering into partnerships to (re)build infrastructure, there is a potentially significant advantage to going one step further and including service delivery and management oversight in the contractual arrangement.

### *Accountability through Shared Risk*

22. A key feature in the structure of PPIPs is the element of shared, long-term risk, and thereby a shared interest in successful outcomes. By involving private sector partners in the long-term management of facilities and services, with return on their investment coming over time and based on performance, PPIPs provide incentives for the private sector to achieve performance goals, and make it harder for private sector partners to walk away from the partnership. Similarly the public sector, having involved external partners in the provision of care, and committing long-term funding, has a strong incentive to remain closely involved in the project.

### *The Counterfactual*

23. Health systems across the developing world are in crisis; significant interventions are needed to reverse the downward trend. Affecting large-scale improvements in health systems will require innovative approaches that address a multitude of infrastructure, access, service delivery, and management challenges. Although PPIPs involve risk and there are as yet few models in place to learn from, with greater risk comes the chance of greater reward, in terms of significantly improved health outcomes for the long term. Indeed the greater risk to countries is if they and the international community do *not* pursue innovative approaches to solving the crisis, and continue to pursue their current path.

### **Critical Success Factors for PPIPs**

#### *Trust between Sectors*

24. A challenge for PPIPs will be overcoming the pervasive mistrust between the public and private sectors that exists in many countries. The public sector often views the public good and commercial gain as mutually exclusive. There are many pre-existing ideologies surrounding the concepts of “profit” and the “private sector,” as well as a concern that profit-maximising will outweigh providing the public with the most high-quality service possible. Simultaneously, private sector partners often view the government as bureaucratic and unreliable. They are hesitant to work with the public sector for fear of political instability and the possibility that a new government will not honour a contract entered into by a previous government. While there is a sense that these perceptions are slowly changing, more needs to be done to build trust in advance of, and as part of, PPIP discussions. Possible vehicles include: the use of third party facilitators, continuous open dialogue, increased transparency in terms of data and processes, and the gathering and sharing of evidence from successful PPIPs to serve as models.

#### *Political Will and Feasibility*

25. Although few would dispute the need for change in many countries’ health systems, creating that change requires strong government leadership and sustained political will.

For a PPIP to be initiated, let alone be successfully implemented, an enterprising, internal champion within the public sector will be required, to lay out a vision, overcome skepticism, bring actors together within the government and across sectors, foster an environment that makes public-private collaborations viable, and influence change among multiple constituencies. This champion could come from the Ministry of Finance, the Ministry of Health, the Prime Minister's office, or elsewhere.

### *Informed Parties*

26. The process to design and implement a PPIP is complex, and brings together partners that have historically not worked together. For it to succeed, it is crucial that all parties be well informed about the business at hand, and about each other. The public sector must become greatly more informed about private sector partners and options for engaging them, as well as the many components of a PPIP agreement. Expertise needs to span from basic language and communication to avoid misunderstandings, to the intricacies of legal contracts. In many cases the knowledge base about the health systems needs and financing, as well as examples of how to engage the private sector, may be spread across the Ministries of Health and Finance; therefore these two departments will need to work with and educate each other, in order to present a common voice to external partners. In many cases, potential private sector partners will also need to become better informed about the country, and the health systems and social and political environment that they are seeking to enter.

### *Third Party Assistance*

27. While third party facilitators can be costly for a public partner, most country examples show that they play an essential role as the "glue" between partners in one form or another. Third parties are needed to facilitate complex stakeholder management, lessen the mistrust between sectors, "translate" or "interpret" between sectors as needed, and help the government be as informed as possible so that it can be more skillful and negotiate more effectively with private consortia. Different organizations can fill this third party role, including private consulting firms, foundations, international NGOs, and/or donor agencies.

### *Coordination between Ministries*

28. The roles and accountabilities in structuring and overseeing a successful PPIP are shared across the Ministries of Health and Finance. For example the Ministry of Finance ultimately must approve the PPIP agreement, whereas the Ministry of Health will both benefit from the additional health infrastructure and be charged with managing the private partner. The PPIP agreement must strike a balance between determining costs and establishing quality metrics, and the two ministries must engage in dialogue to do so. It is therefore essential that the two ministries collaborate with each other. The Lesotho and Turks and Caicos Islands examples offered two among many possible models.

### *Integration into Larger Systemic Goals*

29. To be as successful and sustainable as possible, PPIPs must be seen as part of a country's national strategy: there must be a clear national definition of the goals a government wishes to achieve within the health sector before a PPIP occurs. Significant amounts of planning, coordination, and communication must take place to ensure maximum scalability.

### *Obtaining Buy-in from the Community*

30. Whether directly or indirectly, assuring the understanding and support of the population being served by a PPIP is crucial for success in most instances. While the Alzira Model in Valencia, Spain, was implemented without involving the community in the management change, individuals' preferences are ultimately integrated into the model through the "money follows the patient" mechanism that renders the private sector partner responsible for their opinions and needs. Other systems may be more sensitive and require more direct engagement from citizens. In particular, there is a strong role for civil society within healthcare delivery in sub-Saharan Africa. Civil society preferences must have an impact on the organization and structure of PPIPs.

### *Data Collection & Evaluation Systems*

31. Current health systems, especially those in low-income countries, suffer from a lack of transparency and available data. More data on existing public-private partnerships,

as well as on health systems outcomes themselves, will be helpful to push the PPIP concept forward within a country and quantify its economic impact. The evidence available on current PPIPs needs to be compiled and made available to Ministries of Health, private sector partners, and the donor community (a challenge will be that much of the information sought by potential private sector partners in terms of cost and profit margins is commercially sensitive information, and therefore not widely publicised). Obtaining data will help to improve dialogue and trust between sectors, and provide a cost benchmark for countries to use in their analyses. Going forward, it is critical that both sectors improve the transparency of health systems to encourage data sharing.

### *Flexible, Long-Term Contracts*

32. The PPIP concept has not yet been fully tested in low-income country settings; therefore in these cases contracts should allow for added flexibility to allow for changes and to anticipate failures in immature markets. Longer-term contracts are preferable; however, they cannot be so complicated that they are unworkable. Because PPIP agreements are part public, contracts must be written to allow for protection of public funds. To overcome the challenge in long-term contracts with lock-ins between governments and those with potentially different priorities, PPIP contracts need to be flexible, and address predictions for the evolution of technology, the amount of capital required, the number and size of partners, the allocation of risks and incentives, and the limitations and challenges of donor funding cycles.

## **Potential Weaknesses of PPIPs**

### *Transaction Costs*

33. A major transaction cost in establishing and implementing a PPIP is the legal burden it places on countries. A second is the potential personal opportunity cost for the Ministers of Health and other public sector champions and stakeholders. While the legal and other transaction costs are high, they are often justified on large projects by the savings or return on investment of the project. An option to help reduce legal transactional costs is to develop model contracts that countries could then adapt for their projects.

### *Scalability*

34. For low-income countries, the financing and structuring of the PPIP contract is critical. In the context of fragmented existing infrastructure, developing integrated projects, and incorporating primary, secondary, and tertiary care with referrals between, may be the best way both to strengthen facilities, and assure that the benefits of new projects are shared equitably across the full population. Incorporating training, management sharing, and other collaborations are also important components of contracts that can maximize the scale of impact from a PPIP.

### *Regulation*

35. Best practices for regulating PPIPs in low-income countries are only being developed now, as these projects grow in number. Some common principles regarding capping after-tax profits, requiring external quality assessment, and assuring transparency of project indicators are shared among all projects. A compendium of regulatory experience is needed to better inform ongoing and future PPIPs.

### *Lack of Typologies*

36. Additional standardisation is needed regarding the types of products, services, and deals that comprise different healthcare service delivery mechanisms, including PPIPs. Other healthcare industries such as pharmaceuticals have done this well. Having to start from scratch for each PPIP can be time and resource consuming.

### *Risks for the Public Sector*

37. By signing a long-term contract, a government is locked in to a single provider for a significant period of time. This decreases competition and discourages the entry of other providers into a market. Further, if a PPIP involves contracting for the only hospital in a particular region and the PPIP does not succeed, the region faces a systemic risk that will be much harder to resolve. To help mitigate these risks, governments should consider engaging entities such as the International Finance Corporation and the World Bank's MIGA.



### *Risks for the Private Sector*

38. The long-term PPIP model imposes additional risks for the private sector compared to other short-term contracts for non-clinical services. In particular, capitation models shift risk from the public sector to the private provider. PPIP financing arrangements create a large up-front investment in infrastructure; therefore if a PPIP fails, it is not easy for the private sector partner to walk away. Limited information on patient load and patient mix makes long-term forecasting of service demand unreliable. There are ways to diversify the risk, for instance by limiting publicly-purchased investment to 50% and selling the remainder on the market. Involvement of agencies such as MIGA can also help to mitigate the significant political and financial risk private sector companies' face in unstable low-income countries.

### **Next Steps and Conclusion**

#### *Need for Further Information and Evaluation*

39. There is a clear need for collection and rigorous evaluation of data and evidence on PPIPs and similar vehicles. There is also a need for a repository to house this information where it can be readily accessed by governments, donor and financing agencies, and potential private sector partners. Finally, there is a need to circulate all findings to ensure maximum uptake of the promising practices found.

#### *Countries Should Not Wait*

40. Countries interested in PPIPs should begin to foster an enabling environment that can make PPIPs easier to implement, including developing trust in and from the private sector, and actively coordinating between the ministries of finance and health. Countries that are considering PFIs, in particular, should consider PPIPs as an additional option.

#### *Consider the Need for a Healthcare Development Company*

41. The global health community could consider establishing a health version of InfraCo, a donor-funded infrastructure development company that would focus specifically on stimulating greater private investment in healthcare infrastructure. InfraCo acts as a neutral broker seeking to create viable infrastructure investment

opportunities in low-income countries, and as a principal, shouldering much of the upfront costs and risks of early stage development, thereby reducing the entry costs of private sector infrastructure developers.<sup>3</sup>

42. Current approaches to resolving the health systems crisis in the developing world are inadequate, and fail to address the key element of management of facilities and services. Ministries of Health and countries at large are seeking new solutions to this challenge. As the role of the private sector in health systems strengthening is increasingly recognised, governments are looking for strategic opportunities to collaborate, through a variety of public-private partnerships. PPIPs should be considered as a long-term, bold solution that should be considered, as the majority of health systems expenditures are not in infrastructure, but in clinical care. There was general consensus that change is needed, and PPIPs present an important option for countries to explore.

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<sup>3</sup> [www.infraco.com](http://www.infraco.com)