New global healthcare PPP developments: a critique of the success story

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Abstract

Healthcare PPPs where clinical services as well as infrastructure are delivered by the private sector are coming under the spotlight as governments seek to achieve value for money in health budgets. Existing examples are being reported as successful, however this article urges caution as a closer look at the evidence shows that handing over control of service delivery to the private sector is difficult to monitor and evaluate, carries cost implications which remain largely unquantified and can create additional risk.

Global provision of public infrastructure is under increasing scrutiny as governments grapple with rising costs and declining budgets. In this context Public Private Partnerships (PPPs) continue to be attractive to both governments and investors, despite the problems with debt financing caused by the financial crisis. Whilst transport infrastructure remains most popular (PwC 2010), in other sectors the private sector is moving beyond infrastructure to engage with what until recently has remained the preserve of the public sector – the delivery of core public services. Because of their potential size healthcare services are especially attractive. In OECD countries, where health spending as percentage of GDP is expected to increase from 9.9% in 2010 to 14.4% in 2020 (PwC 2010, p9), infrastructure projects represent only 5% of health spending. A shift to also deliver clinical services will open up a significantly wider market worth \$68.1 trillion (PwC, 2010, p5).

Such a move changes the fundamental nature of the relationship between the public and private sectors, with the public sector becoming just a commissioner of services provided and delivered in full by the private sector. This means that, although the public sector remains responsible for provision, control over delivery passes to the private sector, which in the case of healthcare means that clinical services become marketised.

Recent New Public Management (NPM) rhetoric further emphasises this shift, being increasingly focused around the need to ‘transform’ traditional models of public healthcare provision to ensure ‘sustainability’ of services in the future. Consequently governments around the world are looking seriously at greater private sector involvement in clinical service delivery. Australia, Lesotho, Portugal, Romania, South Africa, Spain and the Turks and Caicos Islands have entered into contracts which pass control of clinical healthcare services over to the private sector (The Global Health Group (TGHG), 2010).

In Spain a report has been published on the 25th anniversary of its National Health System that calls for significant management reform in hospitals and a move to a market-based system (Fundación Bamberg, 2011). In the UK the Coalition government has considered selling some hospitals to the private sector.

Such actions presuppose the effectiveness of private sector delivery in this area. TGHG claims that such a model is 'potentially transformational for poorly performing government-run health systems' (2010, p7), as it is cheaper than equivalent government-run services whilst providing better service quality. But systematic evaluation of how well this model actually performs in practice together with the related risk implications is lacking, despite the fact that a small number of projects have been in operation for over 10 years. By examining a Spanish healthcare PPP and also drawing on evidence from schemes in Australia, Portugal and the UK, this article seeks to draw out a range of common issues. In contrast to the successes that have been claimed, these issues demonstrate that handing over control of service delivery to the private sector is difficult to monitor and evaluate, carries cost implications which remain largely unquantified and creates additional risk.

The Spanish healthcare PPP, known globally as the 'Alzira model' after the town where it is based, has been in operation since 1999. Here the pro-NPM Valencian regional government has entered into a long term contract for up to twenty years, with the operator designing, building, financing, operating and managing both the clinical and non-clinical services at the new hospital and the specialized health care of the corresponding health area, all paid for through a capitation fee. There has been overwhelmingly positive promotion of the 'Alzira model' as an international success story (Rechel *et al.*, 2009; TGHG, 2010; PwC, 2010).

However an examination of the underlying evidence shows significant government involvement, issues about the true level of costs and beneficial financing arrangements. Initially the contract, covering the provision of hospital services only, was unviable, leading to a government bailout and new contract in 2003. The contract scope was extended to also include the primary healthcare services for the surrounding healthcare area, thus passing control of patient referral to the private sector partner. In addition, the payment mechanism for calculating the capitation fee was revised to link it to the (at the time) more generous increases in the Valencian health budget, rather than the Consumer Price Index. These changes led to the contract becoming viable from 2003 onwards. However the Valencian Regional Audit Office (2002) was highly critical of the government's role in the contract renegotiation, as although a premium was paid by the private partner for the new contract, the government paid compensation for lost profit on the first contract.

The Valencian government has claimed that the 'Alzira model' costs 20-25% less than comparable public sector institutions (Bes, 2009, p892), however the precise level of cost savings achieved has never been subject to public scrutiny and remains controversial, with a true like-for-like comparison impossible. Acerete *et al.* (2011) identify several problems that are generic in relation to the global privatisation of healthcare PPPs. First, some of these savings may be due to changes in labour contracts and staffing. The private sector contracts of employment may have worse terms and conditions, including less job security, lower pay scales and longer working hours. Second, there is an incentive for these PPP managers to 'cherry-pick' the most profitable medical and surgical specialities. Third, there may be costs which are still borne by the public sector, such as out-patient pharmacy and transport. Finally, there may be 'invisible' monitoring costs paid for by the public sector. These issues lead to an understatement of the full cost to the public purse of providing healthcare services accessible to all.

A further issue in terms of understanding the 'Alzira model' is peculiar to Spain, in that the shareholders of the private sector special purpose vehicle (SPV) set up to run the contract are heavily dominated by Spanish savings banks (see Table 1).

Insert Table 1 about here

This creates a beneficial relationship between the private sector partner in the form of its regional savings banks' equity investments, and regional politics, as politicians can hold up to 50% of the votes in the banks' governing body, therefore creating the opportunity for politicians to dominate bank strategy. This strong political influence has meant that in this case the regional savings banks not only provided equity capital (at 25% in total it is well above the usual proportion of 1-5% for PPP projects), but also supplied debt at preferential rates of interest to the private sector partner, in some years below the equivalent rate of interest for a Spanish public debt 10 year bond. The result has been further obscuring of the full cost of the PPP.

Finally, the financial crisis calls into question the long term sustainability of these PPPs. For example, Alzira profits fell in 2009, and annual increases in the capitation fee have fallen from a high of 10.1% in 2005 to below 2% for 2010 and 2011, reflecting the much lower increases in the Valencian government healthcare budgets since the financial crisis. This means that there is unlikely to be sufficient cashflow generated to pay back the investment made by the SPV in both primary and secondary healthcare facilities. Such a situation increases the political risk to the Valencian government, as its readiness to bail

out the first contract together with its close political links with the regional savings banks indicate very clearly that rather than risk transfer being achieved, there is instead a political lock-in of the regional savings banks to the long term investment, which in turn is supported by government.

Despite this risk, commitment to this model continues. The Valencian government has entered into a further four similar healthcare contracts with the regional savings banks acting as equity investors in each case, although other members of the SPV differ. The pro-NPM Madrid regional government also has three similar hospital contracts, although the private sector partner consortium does not involve the regional savings banks, instead being led in each case by a major provider from the private healthcare sector. Furthermore, the regional savings banks have sought to extend the 'Alzira model' into Portugal, and two hospitals using this model have opened. Significantly the Portuguese contract structure differs from the 'Alzira model' in that there are two separate contracts in place, one for the infrastructure using availability mechanisms, and another for clinical and non-clinical support services, including soft facilities such as catering and laundry, using a capitation fee. This split has therefore allowed different contract lengths and payment mechanisms to be used, in an attempt to take better account of the different risks involved in each contract. However projected value for money savings at 9% and 14% have been much smaller than the published figures for the 'Alzira model' (TGHG, 2010, p27, p31). The process has been controversial, with one project being cancelled in 2005 due to bidding problems, and the Portuguese government instructing later projects to be tendered on the basis of infrastructure provision only. This indicates that negotiating suitable contracts for the private sector delivery of public clinical services is not straightforward.

Whilst NPM proponents are currently promoting the 'Alzira model', similar models using slightly different payment mechanisms have been used in Australia since the late 1990s. There have been mixed results. In Western Australia the Joondalup Health Campus has been open since 1998. Payments are made using a fixed availability charge for the infrastructure element and a base caseload service unit price for clinical services. Upside demand risk is managed through additional units purchased having a lower average unit cost, whilst downside risk is covered by a government guarantee regarding minimum usage. Early reviews noted that there was a lack of evidence in terms of cost savings for the public service and pressure to negotiate lower costs in some areas (Auditor General Western Australia, 1997, 2000), however there have been no further reviews of the operational stage, perhaps because the hospital, operating at a high level of capacity, is generally regarded as a success story.

The Joondalup experience contrasts with failed contracts for the Port Macquarie Hospital in New South Wales (NSW) and the Latrobe Regional Hospital, Victoria. The Port Macquarie Hospital (contract signed 1992) was the first such PPP arrangement in Australia, and was expected to deliver significant savings. However both construction and operational costs increased significantly, the contract was terminated by the NSW government and the hospital brought back under public management in 2004 (NSW PAC, 2006). In the case of the Latrobe Regional Hospital underestimation of costs and a lack of understanding of the funding regime left the private contractor with huge losses and therefore unable to deliver the clinical services required (English, 2005). In 2000 the Victorian government had to take the hospital back under public management. In another scheme, payments had to be increased so that the private operator would continue the contract (Senate Community Affairs References Committee, 2000). As a result, Victoria ceased to permit the inclusion of clinical services in PPP contracts.

Although the UK has been a global pioneer in the use of Private Finance Initiative (PFI) hospitals, it has less and more limited experience in contracting out healthcare service delivery. One relevant example is the commissioning of Independent Sector Treatment Centres (ISTCs) whereby the NHS paid the private sector to carry out routine diagnostic and electives procedures in order to reduce waiting lists. The programme started in 2002, but remains 'an anecdote-rich but research-poor area' (Bardsley and Dixon, 2011, p1), as there have been failures in collecting and storing data (Pollock and Godden, 2008; Pollock and Kirkwood, 2009), and the Department of Health has refused to supply analysis of potential effects on NHS finances on the grounds of commercial confidentiality (Health Committee, 2006). Furthermore the first wave was controversial in that under a 'take and pay' mechanism the NHS retained the demand risk that fewer procedures than expected would be performed, thus making this initial wave extremely costly. A lack of data makes it difficult to tell whether the second wave has offered better value for money, although Bardsley and Dixon (2011) state that it is the responsibility of NHS Commissioners to ensure that future contracts are priced appropriately, so that the factors such as 'cherry picking' healthier (and therefore lower cost) patients can be properly taken into account.

In conclusion, the limited evidence available suggests that these projects do not offer the global panacea claimed by NPM proponents. In all cases the true cost of the project is not transparent and costs have risen beyond those expected. Furthermore, account needs to be taken of specific national features, such as the 'Alzira model's' beneficial financing arrangements, which has had a significant influence on the successful operation of the model over the long term, but which would not be available in different

jurisdictions. Finally the political implications should not be overlooked, as the political risk of being unable to let the contracts fail has meant additional cost to government.

Given the doubt raised in relation to the long term sustainability of the 'Alzira model', the Australian and Portuguese failures and the unanswered questions in relation to the value for money of the UK's ISTCs it appears that, instead of offering the transformation of public healthcare schemes, these projects have rather the potential to create large affordability and risk issues for their respective governments. While the proponents of this new development claim successes, we argue that more work is needed to collect and share appropriate cost data from existing projects, and evaluate overall performance on a like-for-like basis with publicly managed healthcare service systems. Only then can governments entering into such contracts be fully aware of the risks and costs involved in passing control of clinical service delivery over to the private sector whilst retaining responsibility.

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Table 1 Equity Shareholders of the 'Alzira model' SPV

	PARENT COMPANIES	EQUITY SHAREHOLDING	NOTES
SPV	Adeslas	51%	The majority shareholder is Agbar S.A., which in turn had La Caixa, the leading Spanish savings bank, as one of its controlling shareholders
	Ribera Salud	45%	Jointly controlled by Valencian regional savings banks Bancaja and CAM
	Dragados and Lubasa	4%	Construction companies