ECHAA *Policy Seminar* series

ECHAA Policy Seminars

ECHAA is a partnership between a group of universities and state research institutions:

- DuCHA: an autonomous unit within TNO, the Netherlands state Organisation for Applied Scientific Research (www.tno.nl/ducha)
- HaCIRIC: a collaboration between existing research centres at a number of British universities – Imperial College, Loughborough, Reading and Salford (www.haciric.org) – and supported by the Engineering & Physical Sciences Research Council
- [IFROSS: a research and teaching institute in the law and management of health systems, part of the Université Jean Moulin Lyon 3 (www.ifross.com) – under negotiation]
- [Institut für Technologie und Management im Baubetrieb, Universität Karlsruhe (http://www.fmk.uni-karlsruhe.de) – under negotiation]

Its purpose is, by means of comprehensive and rigorous analysis, to support and promote evidence-based policy decisions on the contribution of the built environment to the European health sector. The focus of the Centre is on long-term issues of sustainability and appropriateness of the estate – service planning, architecture/design, finance, construction and operation of hospitals and other healthcare facilities.

The Centre's Policy Seminars series is designed to generate and disseminate understanding about topical and policy-relevant health and healthcare issues, especially those linked to the estate and to capital investment. ECHAA's belief is that there is a strong and unmet demand for new knowledge generation and transfer in this area. The seminars:

- Bring in leading international thinkers representing a mixture of government, industry and academia capable of developing or interpreting an intellectual theme (not just "latest knowledge"), and establishing a common vocabulary for the day. Correspondingly, the seminars are based on a combination of masterclass analysis and problem-solution debate

- Are designed to foster audience-speaker interaction, including use of "Chatham House Rules" (no attribution, outside the room, of ideas discussed inside it) when appropriate

- Rely on networking to attract an invited, committed and informed audience, including front line decision-makers.

The next Policy Seminar is this series will be held in autumn 2010.

This event will be invitation only, but those with an interest are suggested to contact ECHAA's Executive Director, Steve Wright (tel. +352 320892; steve.wright@echaa.eu)

Policy Seminar No.2

Comparative PPP models in a time of recession: the options for decision-makers

Berlin, November 26th 2009

One trend over the last decade or so has been the encroachment of market mechanisms into what has traditionally within Europe been a state-driven sector, and specifically via private sector financing and provision of healthcare facilities, equipment and services. Often this has been by partnership instruments, with different geometries, between the public and private sectors.

At present, however, such long-term developments are being complicated by the credit and economic crisis. This ECHAA/European Observatory invitation-only seminar aimed to review the issues and future prospects. It involved a substantial review of the situation of the finance sector and PPPs, together with a judgement on PPPs as a contractual structure. Secondly, it involved a series of discussions of the evidence for the performance of the various existing PPP models which public administrations could adopt to bring private sector expertise or capital into the health sector.

The main purpose of the seminar was to explore the various PPP models which have been used in Europe and elsewhere (just buildings, or hospital services, or other healthcare, and with differing payment types), and to tease out the advantages and disadvantages of each model.

The event was hosted by the *Technische Universität Berlin* on behalf of the European Observatory, and supported by TNO. ECHAA would like to express its gratitude to each for their support.

All the presentations are available on the ECHAA website.

The registered attendees are listed in Annex 1.

Executive Summary

1. The main learning points from the Seminar with a bearing on policy were:

- The availability of funding will resume from the **financial markets** for infrastructure PPPs in the future, both for "economic" purposes (such as transport and water, typically chargeable to consumers) and "social" purposes (such as health and education, typically chargeable to government). Banks can arrange such projects and provide up-front financial resources but they are not a good source of long-term money. This should rather come from the **bond** markets, where there is a liquidity match between the two sides. Governments will have to take a bigger role as nursemaid for both organisational and procurement aspects.

- Governments will continue the trend to **delegation** of economic and social activities to the private sector. PPP is one example of this, characterised by **risk management** between the public and private sectors. PPP involves long-term private financing, and **bundling** of different activities across time phases. There are different incentives on the

parties over time, and bundling aligns these incentives, removing the externality, and it also helps ensure appropriate management of risk. PPPs will probably ensure cost control (usually contractible) but the **trade-off** against quality (more difficult to specify) must be managed. Those services which do not have a bundling effect should be excluded, for simplicity.

- In the health sector, the potential alignment of incentives on the parties is increased by by **extending the role** of private actors from accommodation-only models (PFI) to accommodation and hospital clinical services or hospital plus community health services. This increases the potential alignment of incentives on the parties but at the cost of rising complexity and loss of public control. This is another of the **trade-offs** in structuring a PPP.

- Payment systems can be **closely linked to the PPP** structure (e.g. performance and availability fees), or appropriation of some proportion of income generated by standard health sector measures - such as fee for service, case-mix linked/DRG and **capitation**. The latter seems to offer the best prospects of aligning short- and long-term incentives between the two sides.

- Administrations should only enter into use of PPP instruments when there is **mutual buy-in** on political, bureaucratic, social and clinical objectives. This amounts to saying there should be true partnership rather than just a contractual relationship.

- A core area where many health PPPs fail is maximising **innovation and flexibility** (quality is one element) throughout the contract term. "**Leadership**", although difficult to define and still more to design in, is essential to deliver such intangible features.

2. Overview and speaker contributions

Elisabetta Iossa: Delegation by government of public services will continue to increase. PPP is not about the commonly-mentioned private sector efficiencies, cheap finance or taking expenditure off government balance sheet. It is rather risk management (reduction of risk premiums, risk transfer), bundling activities through life, and locking in private finance. There is a trade-off between contractible cost control and less-contractible quality assurance. PPPs appear to be financed by limited-recourse funding but if things go seriously wrong the public sector pays anyway. Services which do not contribute to bundling should be excluded from the project scope.

Discussant *Geert Dewulf*: PPP tends to have a lot of political noise around it, concerning loss of political control. There should be caution in using the instrument where each contract is bespoke, without scale economies.

Gershon Cohen: PPP tended not to be criticised against the standard of what it has replaced, but it should only be considered as an instrument when the client really understands the risks. Infrastructure (economic and social) is a global asset class which will regain attractiveness. Before the crisis, there was a lack of financial market realism and discipline. The current situation is having difficulty recovering from this. In the future, the banks should arrange PPP deals but not fund them long-term – this is the role of infrastructure bonds. Governments will need to be more active in facilitation the industry and gathering expertise. Maybe the health sector is too dynamic and political for PPP to be the right solution.

Discussant *David Clark*: The multilaterals have a major role to play, including in structuring bond solutions. The public capital markets are much bigger than the PPP sector, so there is no reason why the industry will not come back.

Michael Clarke: The UK's PPP programme in hospitals (PFI) and the community (LIFT and eLIFT), and even arguably the independent providers (ISTC), delivered in quantitative terms what had been asked for. The hospitals are good quality, and much of the maintenance backlog has been removed. There are now only 7 acute PFIs remaining in the Department of Health's list, and some mental health provision. It is not clear how the health system will react to the growing numbers of dependent aged people, and the capital provision for this needs thought.

Bárbara Costa Pinto: Portugal has a long tradition of concession systems but the real breakthrough in health was 2 series of new-build PPP hospitals. The first wave – now in construction – used twin-SPV (infra + clinical) models, the second wave (still at an early stage) a more conventional PFI structure. The first wave schemes have innovative payment systems – per patient treated with volume quotas; they have created major value for money savings, largely in the clinical services side. The second wave projects have much lower VfM, and interestingly are no quicker in procurement despite their apparent greater simplicity. Both waves are being treated as pilots, and it is not clear which system governments will choose in future.

Carlos Trescoli: The building of the La Ribera Hospital met a long-standing commitment to the local area. It was a full-service PPP, all single rooms, and with a novel capitation payment stream. The company ran into financial difficulties but the local administration chose to reform and expand its scope to cover community health, again paid for by a capitation system. The model is providing security in terms of the cost to the Region, quality is good, and the local population's satisfaction with it is high.

Matti Lehto: From about 10 years ago, there were worries developing about provision of endoprosthetic work across Finland including in Tampere region. The workload is rising but individual hospitals were not doing enough work to achieve low cost or acceptable clinical quality. Coxa is a PPP with several public and pseudo-private shareholders; its activity is focused only on joint replacement; it has a regional revision and national referral role; close links to the university hospital; rigorous use of clinical pathways; bulk contracts with the local municipalities. The results have been successful, with quality high and costs low. The mono-specialty model is being rolled out to other clinical areas.

Thomas Mansky: The growing role of private hospitals is taking place in a changing German healthcare market. The number of hospitals is falling and, even though there is considerable over-capacity, the availability of state funds to pay for the new capital investment which is required is too limited. It is impossible to get a license to open a new hospital in the strictly-regulated German hospital system, and private companies are responding by buying partial or total shareholdings in failing public hospitals (in order not to get the buildings but rather the license). Private operators maintain services (a regulatory imperative) and make money by increasing quality. They have closely-aligned business and clinical models, and invest as reauired by the competitive situation that they face.

Annette Schmiede: Healthcare in Australia is complex, with roles for the Federal and State governments, charities and the private-for-profit sector. Private insurance is poor, so the market is dominated by state control. A variety of PPPs have been developed, some with clinical services, but in a programme driven not by health ministries and operating bureaucracies but rather by finance ministries and asset management branches. Many of the facilities have had financial problems – because of over-bidding (bidder's curse) or change in the political environment. The hospitals are not innovative. In general, there has not been a clear role for PPP, with agreed objectives on both sides. A number of PPP hospitals is under way now (all PFI type), and it seems certain that the public sector will need to draw in private resources. There are lessons to be learned otherwise the results will be no better than in the past.

Further reading

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Barlow, J., Köberle-Gaiser, M. (2009) Delivering innovation in hospital construction. Contracts and collaboration in the UK's Private Finance Initiative hospitals program. California Management Review 51(2), pp.126-143.

Commission on Public Private Partnerships (2001). Building Better Partnerships. Institute for Public Policy Research.

Iossa, E.; Martimort, D. (June 2008); The Simple Micro-Economics of Public-Private Partnerships. University of Bristol Centre for Market and Public Organisation Working Paper No. 08/199.

National Audit Office (UK). Numerous reports, by sector and theme.

McKee, M.; Edwards, N.; Atun, R. (2006). Public Private Partnerships for Hospitals. Bulletin of the World Health Organisation, 84.

Rechel, B.; Wright, S.; Edwards, N.; Dowdeswell, B. and McKee, M. (2009). Investing in hospitals for the future. World Health Organisation on behalf of the European Observatory on Health Systems and Policies.

Rechel, B.; Erskine J.; Dowdeswell, B.; Wright, S. and McKee, M. (2009). Capital investment for health. World Health Organisation on behalf of the European Observatory on Health Systems and Policies.

Wright, S. (August 2009). Is PFI funding built to last? *Health Services Journal*.

Presentation 1 Elisabetta Iossa (Professor of Economics at Brunel University and Università degli Studi di Roma "Tor Vergata")

"Contractual issues in PPP – bundling, contracts and adaptability"

Professor Iossa's starting point was that governments had increasingly been looking to delegate responsibilities to the private sector across a whole range of economic activities, including via PPP instruments. This is near-universal across the EU (clearly the UK's PFI is the classic example) but 20% of investment in developing countries uses some sort of PPP vehicle and the mechanism is common in other markets such as Canada and Australia.

PPP is characterised by a number of features: risk management, long-term private finance and bundling. The revenue stream supporting such investments can be user fees paid by individuals (e.g. road tolls) or charges such as availability/performance paid by government.

The advantages of PPP are often stated to be private sector efficiency (but this is not by any means always valid), cheaper finance (rarely so, since the funding markets' risk premium for a company is higher than for a state), and moving commitments off the government's balance sheet (unlikely to be true because the argument is an accounting rather than real resource one, and anyway rules such as those from Eurostat increasingly preclude it). In fact, the key potential advantage of PPP lies in risk management. This constitutes two different factors – minimising project risk *premium*, by passing the risk to the party which is least risk-averse and will therefore charge least to carry it (this may actually be the public sector); and risk *transfer*, placing the risk with the party best able to manage it. It is not worthwhile allocating *all* risk to the private sector – only that which fits these two factors.

A notable feature is that contracts are inevitably "incomplete" (not all future contingencies can be specified). The critical way round this suggested by theory is by means of "bundling" different project phases together, which has the effect of internalising the externality of issues over time which are otherwise separate between parties. Side effects of bundling are higher transaction costs because of contract incompleteness - probably amounting to about 5-10% of contract value - and longer tendering procedures.

A conceptual disadvantage of PPP is the trade-off throughout the duration of the contract between (usually contractible) cost savings and (often non-contractible) quality gains. Further, there is a loss of control by the public sector over the asset. Other issues which can be mentioned are reduced procurement competition (made worse if there is collusion), loss of flexibility which is potentially solvable with benchmarking (although there tends to be a lack of data) and market testing (as long as there is a secondary market for the asset concerned). Informal agreements in a PPP setting can add flexibility to what otherwise looks like a rigid instrument, but at the cost of lack of discipline.

The results in the UK (c.f. reports from the National Audit Office) indicate that more projects are completed on time, and there has been less contract renegotiation.

It is worth bearing in mind that if a service is really essential, any disruption will be correspondingly very expensive, and the public sector will eventually pay for this (in fact, twice - once to avoid it with the contract risk premium, and once in the event of problems in bailing out the contractor). In practice, the public sector underwrites 80% of the debt.

To develop PPPs successfully requires institutions (for dispute reconciliation), monitoring effort (resources) and transparency (to avoid important information being suppressed apparently for commercial reasons). It is not clear that inclusion of soft-FM services is at all necessary for PPPs to be effective – these services have no real bundling effect.

Discussant Geert Dewulf *(Professor and Head of the Department of Planning and Development, University of Twente)* noted that the debate over PPPs was charged politically, particularly in the UK; the media don't discuss private finance technicalities but rather control and accountability, and this may tendency be more apparent given the size now of governments deficits. Risk management is a negotiation between parties (for example, 'competitive dialogue'), and if there is no market company willing to take it on, a PPP will fail. In some sectors, such as education, there are evident economies of scale in grouping projects together but this is not clear for hospitals, which cuts away from the rationale for using PPP. The "bundling" that is at the heart of a PPP in fact covers a range of different services, and many are not that related to the core asset.

Contributions from the floor:

- PPP should be about an efficient procurement technique, but there does indeed tend to be a lot of noise around private control of state assets – in reality it doesn't happen because the state retains public ownership.
- It is worth recalling that traditional public procurement was often dreadful (so don't compare actual PPP experience with idealised public procedures).
- In many cases (e.g. in Italy), PPP leads to a transparency which wasn't there before, because the impact of individual projects is made visible. And there is the issue that the public sector has often been poor at ensuring adequate maintenance is carried out.
- With respect to the health sector, the concept of bundling (and risk management) should cross outside of the major capital projects e.g. to include primary care alongside hospitals, such that the overall performance of the sector as a whole is improved.

Presentation 2 Gershon Cohen (Head of Project Finance, Lloyds Banking Group) "Recession and after: finance markets and limited-recourse funding"

Mr Cohen felt it was important to state that he was not a defender as such of PPP but rather had an interest in where the instrument is going. His team is responsible for major PFI lending and investment, with EUR30 billion of projects among which are 20 hospitals (including, for example, the Royal Infirmary Edinburgh).

Key areas to think about are construction (where the public sector has historically not been strong and did not adequately measure its performance), long-term maintenance (where the public sector neglected it, and noting that the value streams concerned are much bigger than capital expenditures), and change management (we need to be careful here because changes in project specification tend to be expensive). Not all procurement should be by PFI; and none where the client does not understand the risks. Since the economic crisis, it is clear we need to expect "black swans" (unprecedented events, normally defined away). "Infrastructure" is a global asset class for investors – split between "social" (such as schools and hospitals) and economic (transport and water). The basic infrastructure support systems of countries are a vital link to their productivity, so need to be continually updated.

The finance industry has passed through phases in recent years. There was a "before" (the crisis) phase, when money was chasing deals; it will take many years to clear up the result. In particular, just before the crisis broke, the industry was intensely aggressive, norms of acceptable return and risk were diluted, and the easy markets drove pricing down. "Now", it will be difficult to close even deals already started, and clients are finding that pricing is too high. There continues to be a big appetite to provide equity for infrastructure investment, but with a differential in attitude between social and economic infrastructure. The former is perceived as less risky, because of government guarantee; this is unfortunate because social infrastructure is a much smaller sub-class. Over coming years, what will not change is the desire by governments to delegate, so privately-financed infrastructure, although never large as a proportion of the total (10%), will increase.

In the "after the crisis" situation, there will be challenges. The financial product range is limited – effectively, just banks and the capital markets, and the latter are now closed. This is not healthy - banks should not be lending for 25 year durations ("liquidity mismatch"). Banks are good at assessing and holding construction risk, but not the long-term risks of asset management. Infrastructure bonds, such as have been used for many years in the US municipal markets, are the main way forward as the crisis recedes. On the other hand, the monoline insurance companies were just alchemy, so although their role was useful, the solution will have to be better. Non-bank financial institutions will enter the market.

There is a need for the role of the authorities to develop their role. Some facilitators such as Partnerships UK exist, but in general there is not much centralised expertise available nationally and to handle cross-sectoral issues. The multi-lateral institutions such as the European Investment Bank and the German state bank *Kreditanstalt für Wiederaufbau* are now and will become increasingly important, partly for their financial commitment and partly because of expertise. One can envisage whole-business securitisation, where diverse cash flows are bundled together, but transparently, to create a low-risk pool for investors. There could be a role for new governmental organisations, recalling the National Enterprise Board in the UK in the mid-1970s; the NEB had been expected to control big projects, including fostering economies of scale and innovation. Equally, governments could use tranches of finance to create guarantee funds. A central procurement unit could create infrastructure bonds with regulated returns (the British government took steps towards this in June 2009). The health sector is dynamic, and political: those features suggest it should not be financed by PPP! If flexibility is important, then rigid contractual structures are not ideal.

Discussant David Clark *(Managing Director, Belair Advisers and past Finance Division Chief at European Investment Bank)* affirmed Mr Gershon's point about the catalytic role of the multilaterals, based on his experience at the EIB, where financial instruments were created to match funding from the capital markets against a project's financing needs. This was a "constant real annuity" bonds, and in the case concerned they were all bought by one or two insurance companies. There is a mismatch concerning the role of the commercial banks in financing long-term assets; they should not be doing this activity, whereas the EIB and other similar institutions can do the necessary matching. Public capital markets are much bigger than the flows needed for PPP, so there should be no reason why infrastructure finance will not be available if projects can be appropriately structured.

Contributions from the floor:

- The virtues of PFI in UK health was always exaggerated, and returns for investors were effectively subsidised. And this in the process of creating too much capacity (too many hospitals – we need to reduce in the UK by around 30%). The acute sector needs retooling.

- We shouldn't be frightened by the business of structuring financial instruments to match PPP needs. The underlying cash flow tends not to be as risky as other assets, and typical PPP arrangements such as index-linking automatically create relatively constant annuity streams. Given that outfits like the EIB also take out a dependable cash flow, the residual will have a higher risk profile – but not excessively so.

***Michael Clarke* (Health Sector Manager, Willmott Dixon)**
"Accommodation PPP: UK PFI"

- One problem in UK health PFI is that the process is largely led at the level of the hospital, and the vast majority of unit managers in the public sector have never managed more than once a large project.
- The NHS Plan was to procure 100 hospitals. The achievement was 102 from PFI and another 34 through public capital. Quality of the buildings and services from them are seen as good. The backlog of maintenance on the estate was sharply reduced. In other words, the programme achieved its goals, and more.
- The "LIFT" (Local Improvement/Investment Finance Trust") initiative has received less attention but has also delivered, for the community and primary care setting, with 47 Liftcos having procured more than 250 buildings, through the investment of more than £2 billion. LIFT involves mixed vehicles, where the public sector takes 40% shareholding with the concomitant responsibilities and rewards. The system is now moving to doing more eLIFT, where there are pre-approved partners available to be selected in order to speed up the development process.
- Procurement of PFI is now by means of "competitive dialogue", which absorbs significant amounts of time, effort and - for the bidders – cost. There are only 7 full-scale PFI hospitals remaining on the Department of Health's list (2 in Liverpool, 2 in Cambridge, 3 in NW London and 1 near Birmingham) but these are essentially in-fill schemes. Otherwise, there are no plans for major private capital in the acute hospital sector. Some mental health facilities will be needed because facilities across England are poor.
- The balance sheet treatment, and affordability, of PFI will be difficult as a result of accounting changes. There are also questions about the role of Foundation Trusts which have some financial independence which could worry investors.
- The Independent Sector Treatment Centres were a solution to one problem (elective care waiting lists) but for a variety of reasons, including their own activity, the problem has gone away and the take-or-pay provisions in their contracts are now seen as unnecessarily favourable to the private sector partner. There had been a political vision of competing providers, where the building was ancillary to delivery, but this has faded.
- The underlying problems of the health sector will change with ageing demography – in particular, the increase in the dependent old.

Contributions from the floor:

- PFI was predicated on a Life-Cycle Costing philosophy. However, whenever information is sought to validate this, the information is not available, supposedly because of commercial confidentiality, or inconsistent with it.
- The NHS often does not know what assets it has, and so maintenance can be reactive rather than planned, even for PFIs where there happen to be legacy assets.
- There is a big advantage in bringing in parties with a dedicated focus on building management and life-cycle analysis. However, we should never lose sight of the fact that the primary process is medical (n.b. in the UK, the modelling during PFI procurement is of the estate, although 35% of the eventual assessment mark between competing bidders concerns clinical functionality).

***Barbara Costa Pinto* (Director, Banco BPI)**
"Portuguese single and twin SPV PPPs"

- BPI has been advising Parcerias Saúde (the PPP unit of the Ministry of Health). Concessions of a variety of types have a long history in Portugal. In health, the move towards concession mechanisms took place in a National Health Service which was established in 1979, and gives state assurance of full population access. There was an initial PPP in 1995, with a public hospital and its services including medical ones licensed to a private company.
- The real breakthrough was two series of PPP new-build hospitals started in the early years of this century – the first wave with both infrastructure and clinical services (4 hospitals – Cascais and Braga, then Loures in December 2009 and Branco expected in 1st quarter 2010), the second wave with just infrastructure, that is, close to a PFI model (2 hospitals – Gaia being prepared and Oriente at an early stage). It is noticeable that the reduction in organizational complexity in moving to the infrastructure-only model is not generating an improved speed of procurement. In general, the system in Portugal has many stages and is rather bureaucratic.
- The 1st wave hospitals have an innovative PPP structure, with 2 SPVs and 2 payment streams (project finance for the infrastructure and corporate finance for the clinical services), to make the risks attached to the two entities independent; there are contracts between the 2 SPVs. The ClinCo contract includes soft FM and medical equipment. The term is shorter because there are smaller investment needs to be defrayed over time, and the uncertainties mean that it is more difficult to write long-term specifications. Repayment is per patient treated, indexed by inflation and with a mark-up, though emergency services are paid on availability with a service payment. Production is negotiated annually and patient selection is not allowed. The InfraCo is paid on a conventional PPP system of availability and performance.
- The 2nd wave hospitals are like PFI, including soft FM on a 7 year duration. Availability and performance deductions can reach 100%. There are some volume deductions.
- The 'Value for Money' result for the 1st wave showed very big savings, but it was much more limited for the 2nd wave. The explanation is twofold: clinical services dominate the calculation, having a significantly greater savings potential – more than 2/3 of total costs even over 10 years or so - than FM, which is already contracted out in Portugal. Secondly, the financial crisis has led to a stiffening of financial terms, hitting the (recent) 2nd wave schemes.
- It may appear paradoxical that Portugal is moving away from the twin-SPV model although the VfM is so much more favourable for the 1st wave, but both waves are regarded as pilots and it is not clear what format will be chosen by the political system in the longer term.
- For the ClinCos, there is a complex system of allocation of clinical risk – infection and death rates, falls…). These are evaluated by base rates plus improvements levels, and benchmarked against comparable public hospitals. There was one established clinical provider in the market originally, but with the programme other groups have been formed and some of these have invested as well in private hospitals, creating an element of competition.

Contributions from the floor:

- Portuguese hospitals have traditionally employed up to twice the staff of those in other countries, so it is not surprising if there are big efficiency savings feasible by bringing in competing clinical providers.

***Carlos Trescoli* (CEO, Hospital de la Ribera)**
"Full population service model"

- A hospital had been promised since 1982 in the La Ribera area of Valencia. In 1999, an "Administrative Concession" with private infrastructure and service provision was initiated, where the SPV was a venture between a private insurer, savings banks and a building contractor. There was an 18-month build period, with a capital cost of EUR 68 million, 301 beds all in single rooms, and with free access for the population (no cream-skimming).
- The only revenue stream was capitation, starting at EUR204/person with 70% of the tariff indexed at CPI. The concession was for ten years, with the asset to return to the public sector afterwards. "Money follows the patient", so if the patient went elsewhere, the hospital paid 100% at DRG rates, but if a patient came in from another area, the hospital received only 80% of the rate.
- The hospital realised that the single setting they controlled was a limitation – some interventions such as prevention were much cheaper in community provision. This coincided with financial problems for the company. However, rather than abandoning it, the model was renewed in 2003 to have a whole-population service function. There was € 78 m. new investment in the hospital but more particularly in the community – 4 big "integrated" health centres offering 24-hour A&E and imaging cover and designed to prevent emergency admission to the hospital, 10 major urban health centres, and 25 health "points" in rural areas. IT systems extend from the hospital to primary care (but not yet vice-versa). There are clinical and non-clinical pathways across both settings. The capitation fee was increased to €379/head.
- GPs are paid at equivalent salary levels to secondary care doctors, and across the company doctors earn 25% more than the Spanish NHS average. Hospital activity is thought to be similar to a teaching hospital of, say, 750 beds. Population satisfaction is very high, with broadly no awareness of the nature of the ownership of the facilities. Medical results are also very good, with risk-adjusted mortality being low. There are Disease Management Programmes for a number of specialties – COPD, heart failure, dementia.
- At present, average length of stay (ALS) is not declining, the result of offsetting trends where the number of birth deliveries is rising (short ALS) but complexity of medical treatment is rising with an ageing population.

Contributions from the floor:

- It isn't clear why such a successful model hasn't been widely repeated in Spain or elsewhere!

***Matti Lehto* (Professor, Tampere University Hospital)**
"Whole system limited companies in a national health system"

- Finland has highly decentralised healthcare, with 415 municipalities running from 0.5 million people down to very small. There are many fewer (20) hospital districts, and only 5 university hospitals.
- About 10 years ago, questions started about organising the sector more efficiently, with two main triggers – the increased need for healthcare services flowing from an ageing society, together with productivity, cost-effectiveness and clinical quality issues, and in the public sector the growing shortage of trained staff leading to the need to provide an attractive working environment otherwise staff are competed away.

- In the Tampere region, 5 hospitals were doing endoprosthetic work, with about 100 operations a year each (too few for cost- and possibly clinical-effectiveness). The number was increasing, as was the number of revisions. The situation did not appear satisfactory.
- In setting up the Coxa facility, there was a number of features: a limited-company PPP with several partners (public hospitals, cities, SITRA), focused activity (joint factory), close links to the community for preparation and rehabilitation, a regional revision and national referral role beyond the district, outsourcing of non-core services to the university hospital on the site of which Coxa is located, bulk contracts with the municipalities for work, customer satisfaction money-back guarantees.
- Although a successful medical facility, Coxa also has a strong reputation for its research (several doctoral theses and 109 peer-reviewed articles) and education role.
- The biggest single obstacle to surmount in establishing the hospital was the negotiation with potential collaborators – local hospitals, the doctors…;
- As an index of quality, infection rates are low, even for a specialist orthopaedic facility. This is an example of rethinking clinical pathways and governance – patients come straight from home, scrub nurses are heavily trained, the theatres are laminar-flow etc. and very modern.
- The mono-specialty model is being rolled out for other disease areas (cardiac), but still on the same site and therefore with shared common services. This is leading to a sort of new style of pavilion hospital.

Thomas Mansky ***(Head of the Department for Medical Development, Helios Kliniken)***
"Regulated privatization in Germany"

- The background to the growing role of private, for-profit hospitals in Germany is a changing hospital sector. The number of hospitals has been falling since 1992 (though some of this is artificial since it reflects multi-site mergers rather than closures), the availability of public capital via the 4% *Fördermittel* contribution is too little to pay for investment required by the estate, public investment costs are 150-200% of the private sector and there is massive system over-capacity (which means that estimates of a €51 billion backlog of capital expenditure are wrong since investing anything like this would further boost over-capacity).
- As a result of the over-capacity, licenses to operate hospitals are impossible to get except by take-over. The private hospital groups are therefore buying hospitals for their licences, not for the buildings. New construction can be on the existing site, or can be a plot donated by the public sector as part of the deal. Given that public sector management are lucky to build one facility in a career, the hospital companies, with programmes of construction, are likely to be more efficient.
- "Full" privatisation is not always chosen. Public shareholdings typically are 5%+, 25%+ or 49%+. If the public shareholding is over 50%, this typically comes with greater regulatory strings attached. Sometimes, public sector partners get a stake and assist in negotiation with the regulators but without needing to contribute to the investment.
- The private operators earn money by increasing quality – this pays for itself within a case-payment system.
- The license and contract specify that services must be maintained, and this would prevent for example wholesale closure of departments, but there is still flexibility to adapt facilities and services. Helios as a company prefers to augment turnover organically at, say, 3-4% p.a., not by takeover, so will try to maintain services if possible.
- The accounting life of assets is regulated but might be, for example, 15 years+ for a building. Clearly, equipment, even items like scanners, can be much shorter. Since the

hospitals are in a competitive market, they may have to reinvest even if the depreciation life has not been reached.

Annette Schmiede ***(Adjunct Associate Professor, Menzies Centre for Health Policy, Medical School, University of Sydney)***
"Overseas experience: the case of Australia"

- The health sector is complex in Australia – 70% funded by the public sector but 70% of services delivered by private providers, and with a mixture of responsibilities between the states (funding and operating hospitals and community health) and the federal authorities (funding GPs). One of the planks of the incoming Federal government was major reform, and there have now been 2 years of Commissions and reports. The global financial crisis has made decisions harder.
- There is a very poor private insurance product. Private hospitals, split between for-profit and charity, offer only elective care, and do little teaching.
- The PPP hospital sector has been developed over many years, with policy shifts such that each project and its contract structure is different. Their introduction was driven not by considerations of health policy but rather by ministries of finance and treasury, and for political reasons. There is a variety of service categories and tariffs (activity-based/DRG, per diem for rehabilitation and sub-acute, fixed budget, direct billing, teaching and infrastructure grants…).
- Many of the hospitals have run into financial problems – bidder's curse resulted in their bids for services being discounted to the price paid by government, demand risks have been increasingly shifted to the operators, operating budgets proved to have been badly estimated yet increasingly capital recovery was dependent on this budget, price indexation problems have taken up executive time etc. There have been political difficulties (opposition from Labour state governments) and bureaucratic ones (projects were developed by asset management departments but operated by policy and service ones). The hospitals were pretty ordinary in terms of their design and quality.
- The lessons to be drawn from a not very happy story are that policy intent should be clear, driven by health (bearing in mind whole-systems needs) and not by treasury, and the community must be supportive. There is a need for clarity about the role of the private sector in the overall health system, and knowledge of the real costs of providing government services, capital and operating. The capacity of the private sector to participate must be understood, and risk allocation must be equitable. Finally, goodwill and commonsense are important!
- The PPP instrument is, however, still being used, with at least 9 hospitals under development, all without clinical services (i.e. similar to UK PFI), including a co-located private hospital on the site of the Sunshine Coast University Hospital in Queensland. Government money is being spent as a response to the global financial crisis, but for the foreseeable future private resources will be needed too.

Contributions from the floor:

- Management systems in the public sector need to be changed;
- The move to accommodation-only PPP raises a danger of losing sight of whole-system care.

Annex 1 – Delegate list

First name	Surname	Title	Affiliation
	ANO		Partnerschaft Deutschland
Alessandra	Badellino	Economist	European Investment Bank
James	Barlow	Professor	Imperial College Business School
Fred	Bisschop	Head of Economics	TNO Dutch Centre for Health Assets
Reinhard	Busse	Professor & Head of Department Healthcare Management	Technical University Berlin
David	Clark	Managing Director	Belair Advisers
Marilyn	Clark	Corporate Secretary	Hepatitis B&C Summit Conferences Association
Michael	Clarke	Health Sector Manager	Willmott Dixon
Gershon	Cohen	Head of Project Finance	Lloyds Banking Group
Daniela	Cornelius	Head of Health Strategy	Munich Health
Bárbara	Costa Pinto	Director	Banco BPI
Geert	Dewulf	Professor & Head of Department of Planning & Development	University of Twente
Karin	Diez	Researcher	Institut für Technologie im Baubetrieb, Karlsruhe University
Rostislava	Dimitrova	Policy Officer	DG SANCO
Barrie	Dowdeswell	Director of Research	ECHAA
Just	Eijkman	Head of Research & Development	TNO Dutch Centre for Health Assets
Jonathan	Erskine	Executive Director	EuHPN
Sean	Fitzpatrick	Advisor	European Investment Bank/European PPP Expertise Centre
Pascal	Garel	Chief Executive	European Hospital & Healthcare Federation
Angel	Gimenez	Medical Director	Hospital de la Ribera
Colin	Gray	Professor Emeritus and Project Director HaCIRIC	University of Reading
Johan	Groop	PhD Researcher	Helsinki University of Technology/HEMA
David	Hall	Researcher	PSIRU Business School, University of Greenwich
Elisabetta	Iossa	Professor of Economics	Brunel University & University Tor Vergata
Ivan	Jekic	Senior Adviser	Clinical Center of Serbia
Matti	Lehto	Professor	Tampere University Hospital
Kunibert	Lennerts	Professor & Director	Institut für Technologie im Baubetrieb, Karlsruhe University
Georgios	Margetidis	Senior Project Officer	European Agency for Health & Consumers

Stanislav	Medvedev		Munich Health
Thomas	Mansky	Head of Department for Medical Development	HELIOS Kliniken
Paolo	Matreno	Coordenor-Adjunto	Parceries-Saúde
Jens	Roehrich	Research Associate	Imperial College Business School
Annette	Schmiede	Professor	Australian Hospitals & Healthcare Association
Carlos	Trescoli	Chief Executive Officer	Hospital de la Ribera
Erkki	Vauramo	Professor	Helsinki University of Technology/Sotera Institute
Marinus	Verweij	Chairman	ECHAA
Siegfried	Walch	Professor & Study Leader	Management Center Innsbruck
Steve	Wright	Executive Director	ECHAA
Stefan	Wunderlich	Senior Engineer	European Investment Bank