PPP: Global Snapshot

Public sector rationale for PPP

- Avoidance of cost overruns on delivery of capital projects – “their risk”
- Favouring innovation – “the service will be different”
- Management/organisational change – “the service will be better”
- Value for money / Cost effectiveness – “the service will be cheaper”
- Accelerated provision – “the service will be provided more promptly”
- Financial stability and economic viability - “budget nightmare over”
- Outsourcing capital financing – “going off the books / off balance”
- Operational effectiveness – “they will always deliver”
**COXA - Finland**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Coxa Hospital for Joint Replacement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisational form:</td>
<td>Limited company</td>
</tr>
<tr>
<td>Ownership</td>
<td>Pirkanmaa Hospital District (PHD) 35 %, Tampere City 20 %, Terveysrahasto Oy 20 %, Orton Hospital 5 % and four Pirkanmaa municipalities 5 % each.</td>
</tr>
<tr>
<td>Business idea:</td>
<td>Providing PHD with endoprosthetic surgery and nation-wide services in the area of demanding endoprosthetic reoperations.</td>
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<td>Volume (2003); (2014):</td>
<td>1494 endoprosthetic surgeries. Turnover 12.7 million €. Employs 11 specialised doctors, 46 nurses and physiotherapists 7,500 endoprosthetic surgeries Turnover 41.3 million Euro</td>
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<tr>
<td>Planning started:</td>
<td>1998</td>
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<tr>
<td>Description of innovation:</td>
<td>Outsourcing of all joint replacement surgery from the PHD into a limited company servicing patients from the Pirkanmaa region and private patients.</td>
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</tbody>
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**What’s the matter?**

- **The problem for the Region**
  - Increasing waiting times for treatment
  - Shortage of capital
  - Health inequalities
  - Joint replacements in all major hospitals - duplication

- **The problem for the hospital**
  - Joint replacement unit embedded within teaching campus, competing for resources
  - Poor quality outcomes
  - Capital hunting
  - Uncertainties on staff retaining
The PPP solution

- Proactive move out of State system via an innovative PPP model – creation of a limited private company with Public and private shareholding such as Municipalities, Other hospitals, Private equity
- Total freedoms on capital and workforce strategies
- Acceptance of risk
- Concept – quality driven integrated, whole systems, (regional) care
- Viability, dependant upon:
  - Role sharing within other ‘competing’ local hospitals (‘territories’)
  - Competitive tendering (cost and quality)
  - Adequate debt servicing (capital and equity)

Case performance

- Operating procedures increase, 1494 in 2003 to 8,000 in 2016
- Reduced length of stay
  - 3 day stay
  - 90% same day operation
  - 90% of patients are transferred for rehabilitation to primary care led facilities and services
- Complication (infection) rates < 1%
- Finnish Occupational Health Study (Work and Health of Finnish Staff) rated Coxa, “outstanding” for workforce satisfaction
- Finnish national health and social welfare institute rated, Coxa as “exemplary for patient satisfaction”
- Financial security has allowed price reductions and self-financed sustainable capital development
Critical success factors

- Concept based on proven clinical principles
- Quality and Responsiveness
- Transparent clinical governance
- PPP added value to the concept:
  - Financing freedoms
  - Workforce rewards (2009: Award for Best workplace in Finland!)
  - Public participation
  - Open dialogue - transparency
  - Generated from within the public system
  - Management competency

NHS Treatment Centres – Mixed feelings?

- NHS outsourcing through concession with secondary care technical units
  - Increase elective capacity in routine service areas e.g. cataracts – no deep level analysis of need
  - Reduce spot prices in private sector
  - Increase patient choice
  - Stimulate innovation
  - Reform through competition
- DH organised tendering and licensing (28 centres)
  - Most are stand alone practices
  - Employment of NHS staff were prohibited at first (6 month quarantine)
- Local hospitals had no say / no involvement in their establishment
Why it didn’t work so well after all

- Parliamentary select committee report
  - No major contribution to increasing capacity
  - Measurable price effect on other private sector providers
  - Increased patient choice, but no information on quality
  - Evidence of good practice
  - No discernable systematic transfer of good practice and innovation to the NHS
  - Concerns that preferential financial status has adversely impacted on NHS hospitals

- NHS Commission report
  - Comparable clinical quality – but evidence of selectivity
  - Poor quality and inconsistent data – poor reporting of adverse incidents
  - Poor integration of the process of care and poor relationships between ISTC and NHS staff

Insider view (Prof. B. Dowdeswell, Former NHS)

- Top down imposition
- Guaranteed contract and prices
- Likely to prove short term respite for waiting list pressures
- Has not created a breakthrough in public / private ‘success’
- Has not set higher clinical and performance standards
- May have destabilised some local hospital finances
- Notable absence of reliable evidence based comparability – a problem of transparency
- New wave of centres scaled down by Minister…
PFI - renewing hospital through capital investment and inclusive services

- Inclusive models for a global non-clinical service delivery (BOOT, DBFO)
- « Selling like hot cakes » in the UK and in Australia during end 90’s and 00’s (over £2,500 M in capital investment in 2001 with 105 projects and £1,300 M 2014 with only a few major hospitals in the UK);

- Taking on worldwide:
  - Barts and the Royal Hospital (London)
  - Port MacQuarie (Australia)
  - Roubaix General hospital - maternity unit (France)
  - Prezeva Regional hospital (Greece)

- Typical arrangements provide design, financing through capital investment, building, operation and maintenance of facility (with ownership – leasing arrangement and a transfer provision to the public sector at the end): BOO(T), DBFO, DBFOM

Pros and cons in a nutshell

- Positive results
  - Building costs reduced by 20% to 25%
  - Quality Comparable - Public / PPP
  - High performance values e.g. bed occupancy rates
  - Quicker access - reduced waiting time
  - Systemising the care pathways
  - Using systemised care pathways as the basis of hospital design
  - High rates of investment in technology

- Negative outcomes – (typically 3 to 4 years later)
  - Quality decay (contracts not sustainably viable)
  - Cost spiral
  - Unrealistic pricing from the start (to undercut public rate)
  - Contract trading
  - Undermined public confidence (an hardened opposition)
Case study: UCS – Skopje Hospital

- UCS scattered over 30 sites
- Relocation / Greenfield site?
- EIB project: hidden agenda?
- International co-ordination: overlapping with WB PPP projects (military hospital reconversion)?
- DBFO?
- O&M?
- Ancillary services, concession?
- What about public capacities?

FYROM

Project promoters (or 4 grantees) under Concession Law 2008
- Government
- Municipalities of Skopje
- Public entities

- Other types of PPP
  - Under Concession Law 2008
  - Civil works concessions
  - Service concessions
  - Private concessions
  - Public entity concessions
  - Procurement of goods, services

"Traditional Procurement" under Public Procurement Law (PPL, 2007)

Private contractors under PPL Act 2007 & Concession Law 2008
Legal foreign entities on domestic registered companies as per article 2 of Concession Law 2008 (Public entities are specifically excluded of the concession awards)
Snapshot: Egypt

- Alexandrie Governorate – Design / Construction of a 100 bed oncology centre (contract duration: 20 years)

- Cairo Governorate – Design / Construction of a 100 bed rehab centre (contract duration: 20 years)

- Beheira Governorate – Design / Construction of 3 100-bed central hospitals (contract duration: 20 years)

- Plus 5 more DBFOM projects
- Plus setting up of a strong PPP unit
- Plus innovative PPP in the pharmaceutical sector (with Eli Lilly)
- Plus European Commission support (TAIEX 24988)

Overview: India (bilateral only!)


- India - West Bengal, (KfW: 2007 - 2008) Promotion, Marketing and Advocacy Support for PPPs in PHC

- India - West Bengal, (KfW: 2007) Capacity Building for Management of PPPs


- India - West Bengal, (DFID: 2006 - 2007) PPP Design for Setting up Fair Price Pharmacy Shops in Medical Colleges and District Hospitals

- India - West Bengal, (DFID: 2007) PPP Design and Operationalization Support for Increasing Access to Institutional Delivery Services (Ayushman Scheme)

- India - Delhi, (2008 - 2009) PPP Design and Operationalization Support for Pre Hospital Emergency Response (Ambulance) Services


Karolinska, PPP forward?

Shoukran Jazilan!

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