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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”*

<h2>COXA - Finland</h2>		
Name:	Coxa Hospital for Joint Replacement	
Organisational form:	Limited company	
Ownership	Pirkanmaa Hospital District (PHD) 35 %, Tampere City 20 %, Terveystieteiden tutkimuskeskus Oy 20 %, Orton Hospital 5 % and four Pirkanmaa municipalities 5 % each.	
Business idea:	Providing PHD with endoprosthetic surgery and nation-wide services in the area of demanding endoprosthetic reoperations.	
Volume (2003): (2014):	1494 endoprosthetic surgeries. Turnover 12.7 million €. Employs 11 specialised doctors, 46 nurses and physiotherapists 7,500 endoprosthetic surgeries Turnover 41.3 million Euro	
Planning started:	1998	
Start date:	Company established in January 2001 Operations started in September 2002.	
Description of innovation:	Outsourcing of all joint replacement surgery from the PHD into a limited company servicing patients from the Pirkanmaa region and private patients.	


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<h2>What's the matter ?</h2>
<ul style="list-style-type: none"> • The problem for the Region <ul style="list-style-type: none"> ▫ Increasing waiting times for treatment ▫ Shortage of capital ▫ Health inequalities ▫ Joint replacements in all major hospitals - duplication • The problem for the hospital <ul style="list-style-type: none"> ▫ Joint replacement unit embedded within teaching campus, competing for resources ▫ Poor quality outcomes ▫ Capital hunting ▫ Uncertainties on staff retaining


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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

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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 licencing (28centres)
 - 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



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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



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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)

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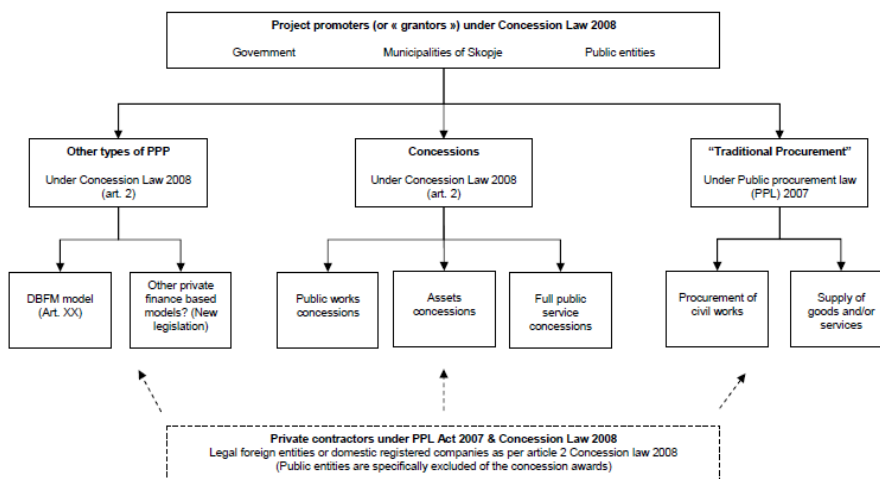
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Case study: UCS – Skopje Hospital

- 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



Snapshot: Egypt



- **Alexandrie Governorate – Design / Construction of a 100 bed oncology centre (contract duration : 20 years)**
Project launched in Dec. 2008, awarded in Dec. 2009 (operational in Dec. 2011) – Independent oncology centre – DBFOMT
- **Cairo Governorate – Design / Construction of a 100 bed rehab centre (contract duration: 20 years)**
Project launched in Sept. 2008, awarded in Sept. 2009 (operational in Dec. 2011) - DBFOMT
- **Beheira Governorate – Design / Construction of 3 100-bed central hospitals (contract duration : 20 years)**
Project launched in Sept. 2008, awarded in Sept. 2009 (operational in Dec. 2011) - DBFOMT
- 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)

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Overview: India (bilateral only!)



EPOS
Health - India

- India, Policy for Public Private Partnerships for State Governments in India (Haryana -2003, Himachal Pradesh - 2004, West Bengal - 2005, Uttar Pradesh - 2008)
- India - West Bengal, (KfW: 2003 - 2008, DfID: 2006-2007) Design and Management support for PPP for emergency Transportation Services and Diagnostic Services in Rural Hospitals
- India - West Bengal, (KfW: 2003 - 2008) Design of PPP for Management of Primary Health Centres and Fair Price Medicine Shops in Rural Hospital
- 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, (KfW: 2007 - 2008) Design and Pilot of Voucher Scheme for Ensuring Safety Net for Emergency Transportation Services
- 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 (Ayushmati Scheme)
- India - Delhi, (2008 - 2009) PPP Design and Operationalization Support for Pre Hospital Emergency Response (Ambulance) Services
- India - Uttar Pradesh, (2008) PPP Design and Operationalization Support for Management of PH Facilities
- India - Himachal Pradesh (2004) Developing the Operational Framework for PPP in Health
- India - Haryana (2004) Developing the Operational Framework for PPP in Health
- India - Rajasthan, (2007) Contracting Framework for PPP and Support for Development of PPP Cell within the Government Department

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Karolinska, PPP forward ?



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