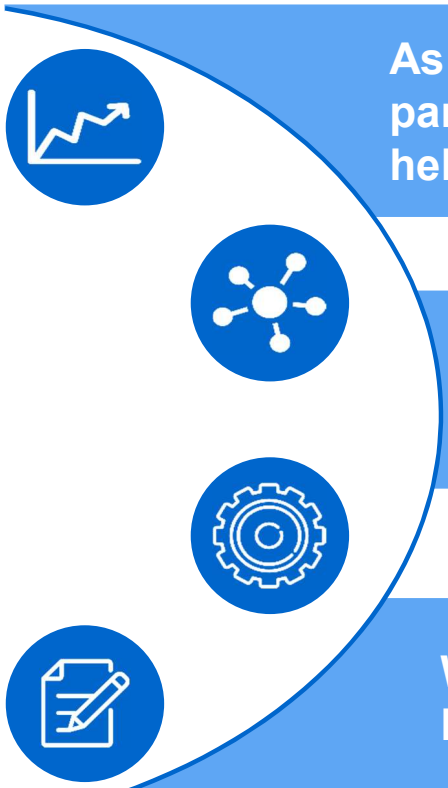
Public – Private Partnerships in Health

Presentation

February 2020

Three main questions

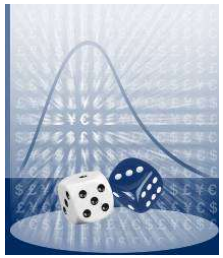


As health systems face increasing fiscal pressures, how can partnerships between public and private organisations (PPPs) help improve quality and reduce costs?

What else can these type of partnerships offer beyond the core?

What does it take to be successful based on learnings from PPPs globally?

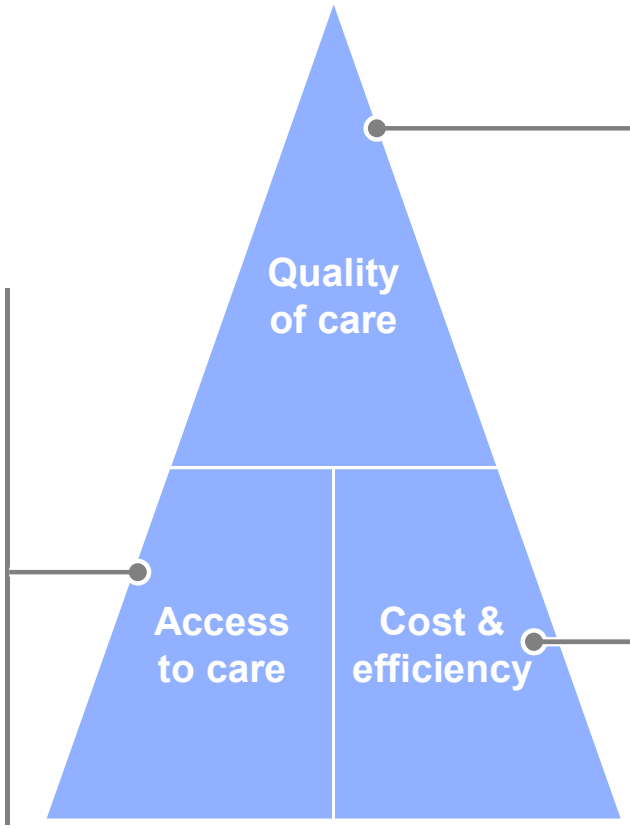
Governments typically consider PPPs in order to address some of the following priorities:

	Rationale:
 **1. INCREASED EFFICIENCY**	▪ Financial interest of private players to deliver on time and on budget ▪ Ability to optimize life-cycle cost ▪ Competition of potential providers may lead to lower cost/spend
 **2. APPROPRIATE RISK ALLOCATION**	▪ Risk reallocation and reduction, by redefining relationship between parties ▪ Quality of service maintained
 **3. PUBLIC SECTOR REFORM**	▪ Separation of regulatory oversight from service delivery and operations ▪ Ability to break up large systems and allocate parts to best owners
 **4. NEW SOURCES OF FINANCING**	▪ Injection of private capital ▪ Ability to make projects affordable where borrowing may be limited

SOURCE: Team analysis

In Healthcare, governments may look to PPPs to deliver improvements in access, service efficiency or quality

- Private sector seen as partner **for broad spectrum of services in Population Health Management**
- Private sector may fill specific gaps in **public sector provision**



- **Structural impact**
  - Increasing availability of services, e.g. reduction in waiting lists / waiting times
- **Clinical impact**
  - Improving patient experience
  - Improving quality in specific services, e.g. through reduction of infection rates
- **Process impact**
  - Improving service lines and day-to-day operations

- Injection of **private capital**
- **Competition** between bidders with potential to reduce prices and public spend
- **Reallocation of risk**

SOURCE: Team analysis

3 common archetypes of Healthcare Public-Private Partnerships

Discrete clinical or non-clinical services

- Private partner is **contracted to deliver specific services**. Can be clinical support or specialty care as well (e.g. dialysis service)
- May include delivery of **non-clinical services** (e.g. laundry, cafeteria)
- More advanced projects include **delivery of clinical support services often end-to-end** (e.g. radiology, laboratory services, end-to-end delivery of T1 Diabetes service)

Infrastructure-based model

- Private partner is contracted to **design, build, finance, and maintain hospital facilities,** but not to provide clinical services

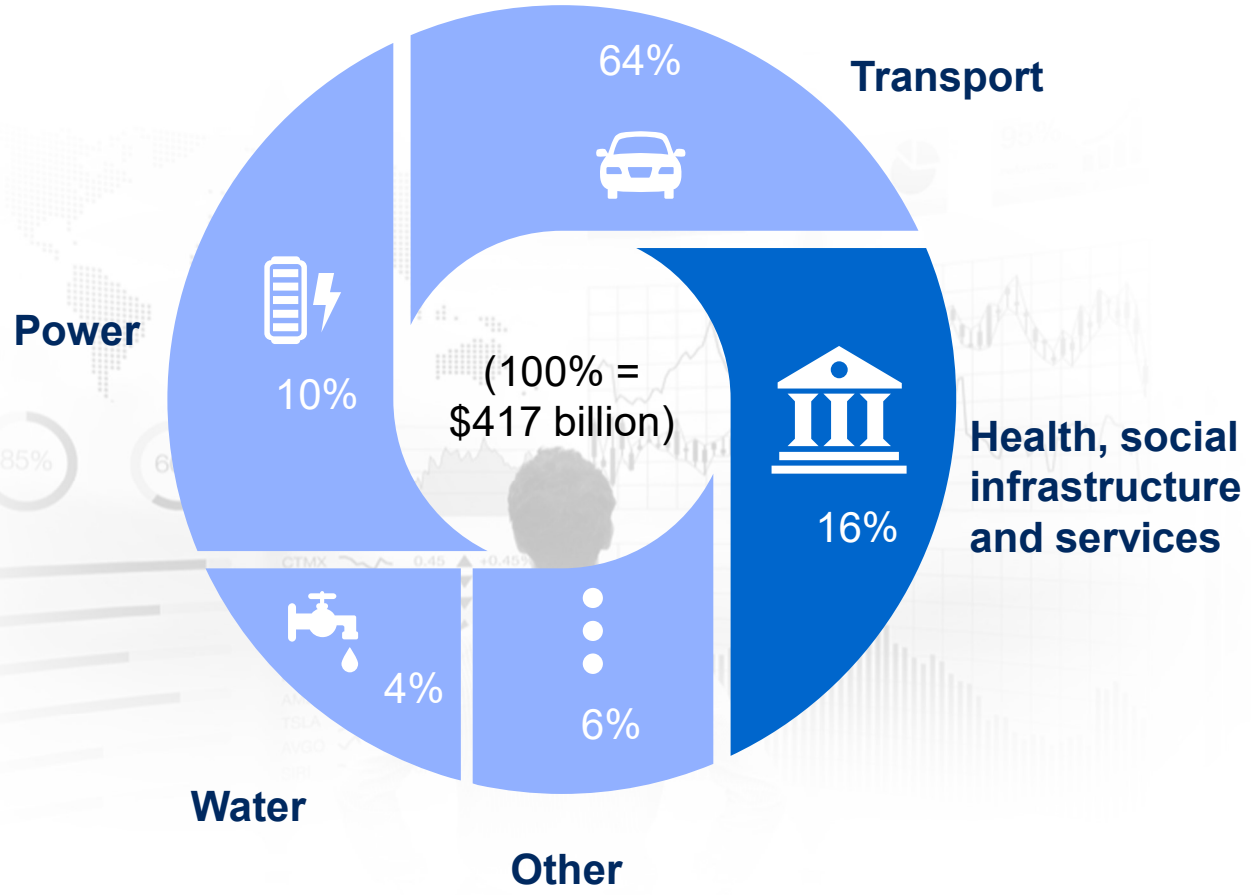
Integrated PPP

- Private partner is contracted **to design, build, finance, operate facilities and deliver non-clinical and clinical services**
- May include **managing population health efforts on a capitated basis**

SOURCE: Team analysis

PPP deals in social infrastructure account for 16% of the overall PPP space

2010 – 2017 Global PPP Deals (% of total)



SOURCE: Based on 2017 closed deals data from IJ Global (https://ijglobal.com)
Other includes projects related to telecom, defense, justice, leisure, civil defense, prisons, other social welfare programs

International case examples: impact of PPPs to-date

	Country	Impact observed
Access	India	▪ Improved access to pathology services for 3.5M people through PPP centralized lab
	Spain	▪ Shortest waiting time to see a specialist in Valencia (38 d vs to 57 d Spain average)
	UK	▪ Dialysis for 20% of NHS patients through 50 partnership clinics (75,000 treatments/year). Opening satellite units improved ease of access
	S. Arabia	▪ First proton therapy center in GCC
	Egypt	▪ 78,500 unique patients to receive specialized tertiary care through new facilities
Efficiency	UK	▪ 78% of PFI projects delivered on budget, 76% on time (27% and 30% for non-PFI)
	Brazil	▪ 5 days bed turnover rate compared to 3 days at directly managed hospitals, 1 day decrease in average length of stay discharge rate by 30%
	Australia	▪ 43% decrease in cost of hospitalization with new PPP holistic care center
	Spain	▪ 25% lower cost per capita in Alzira model compared to cost for regional health system; ALOS 4.7 days compared to 7.6 in public hospitals
	Sweden	▪ 10% lower cost/birth at Maternity Ward at Danderyd Hospital vs other private wards
Quality	Brazil	▪ 37% lower mortality rate than directly managed hospitals (5.3 vs. 3.3)
	Sweden	▪ 50% less errors in delivery compared to Sweden average

SOURCE: Team analysis

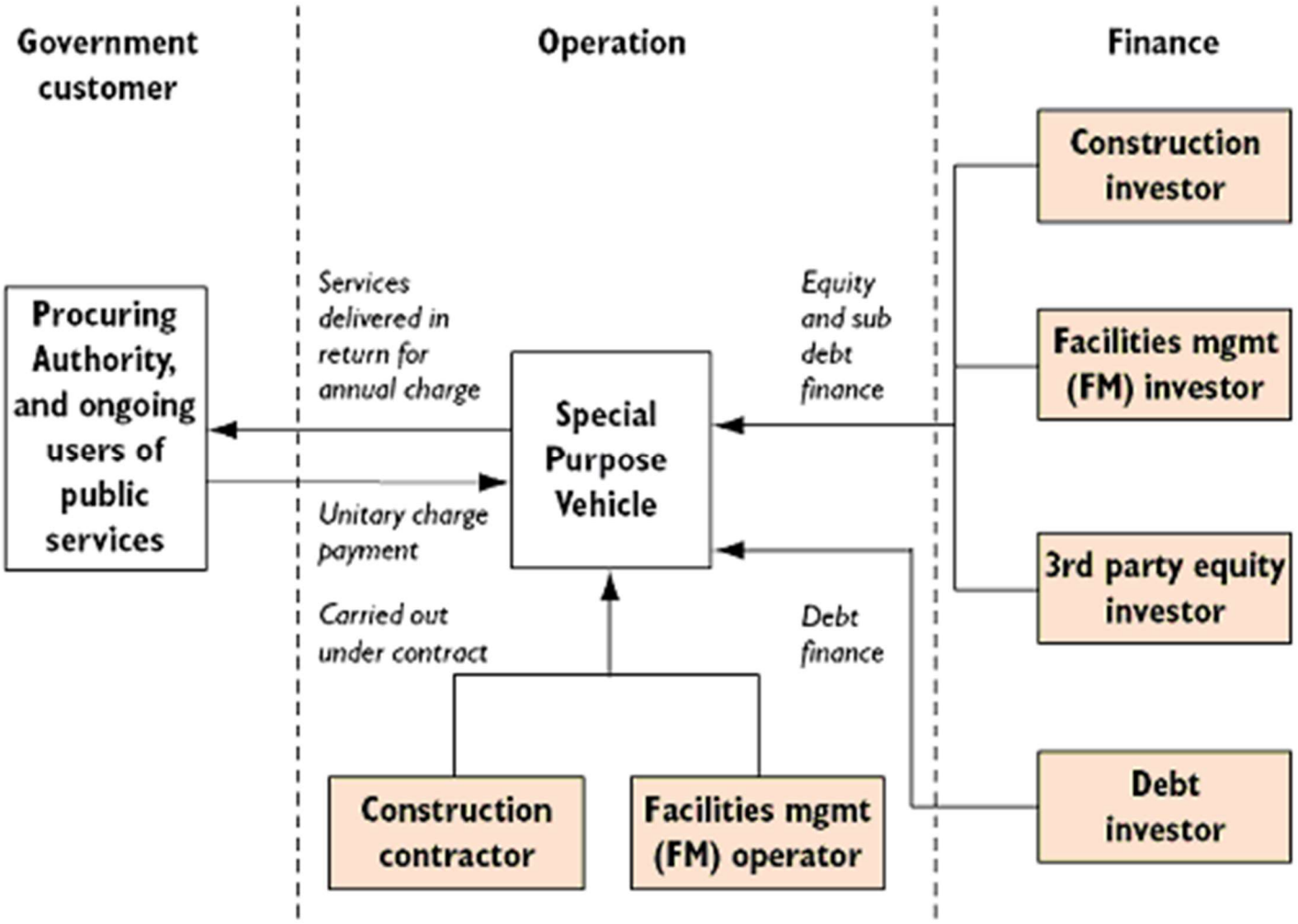
Examples: 1. The UK has delivered over 700 PPPs using the PFI contract model

	PFI Overview
Contract Length	▪ Typically around **30 years**
Contract Model	▪ The contract normally **requires the private sector to design, build, finance and operate** a new asset (or refurbish an existing asset) ▪ In most cases the contractor is a **specially created company** for that contract (SPV) ▪ The **shareholders** of the SPV are **often the main contractors** involved in the contract and may include a financier. ▪ The SPV **borrows funds** to finance construction of the asset it then operates and maintains for the contract duration ▪ The main sectors using PFI are **hospitals and schools**. PFI is also used to build roads, light rail, offices, libraries, defence equipment, waste facilities, housing and street lighting. ▪ Since 2003, PFIs are only used for projects **valued at over £20 million**
Payments	▪ The public sector pays the SPV a Unitary Charge providing the SPV delivers the contracted services. ▪ These payments should cover financing and operational costs and provide the SPV with a profit.

SOURCE: PFI: Meeting the investment challenge (HM Treasury)

1. Most of the UK PFI contracting companies are structured using an SPV

The UK PFI consortium company SPV model



SOURCE: PFI: Meeting the investment challenge (HM Treasury)

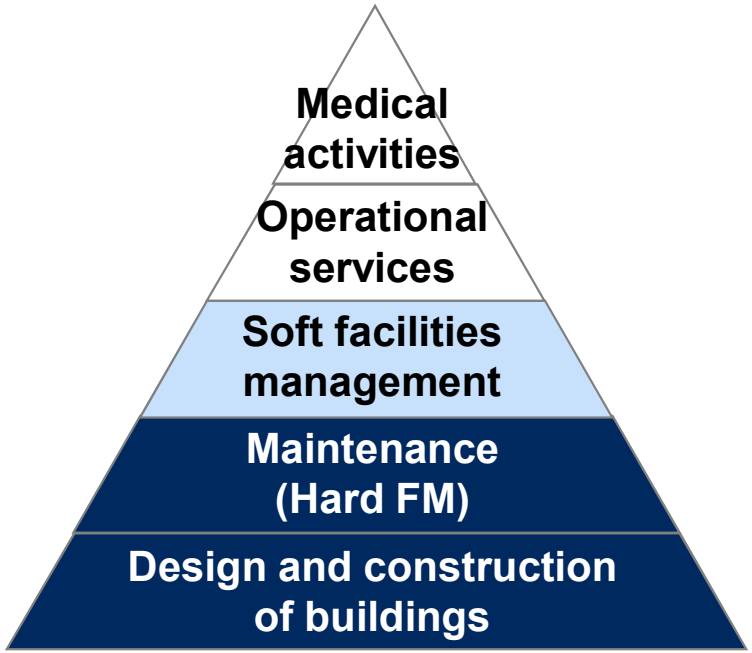
2. Caen Hospital in France is a typical PPP in including construction, maintenance and some limited 'soft' Facilities Management (FM)

Caen Hospital PPP – key facts

- 25 year contract
- ~€100 million project (345 beds)
- Located in Normandy, France
- Launch – July 2004, Close – March 2006, Operation – April 2009
- Winning bidders – ABN Amro (90%), Bouygues (10%)

Elements of the PPP

- Design and construct the hospital buildings
- All maintenance, excluding medical equipment
- Water treatment and control
- Cleaning of windows, offices, but not hospital wards
- Security and safety
- Energy control and volume warranty on gas for heating and electricity for cooling
- Medical services, equipment (incl. beds) were excluded from the PPP scope in both construction/provision and maintenance



Source: World Bank PPP seminar

3. Spain: Ribera Salud's Alzira model, Valencia

Ribera Salud Model: Key facts

- Leading Healthcare Management organisation in Spain, dedicated to the PPP model since 1997
- Valencia programme included: La Ribera Hospital (300 beds), 4 Integrated Healthcare Centers, 46 Primary Care Centres, covering 250,000 people, at cost 25% per person below other Valencia regions. Broader Ribera Salud programmes covered ~750,000 population across 4 health districts in Valencia
- Key enablers: Primary Care and MH integration; digitalisation
- Programme delivered:
  - Higher control of CVD, higher nursing and at home care
  - -28% Hospital admissions and -26% Hospital readmissions
  - -16% Emergency attendances
  - -9% First specialized consultations

Elements of the PPP

- PPP manages the integrated Health Districts of Alzira, Torrevieja, Denia and Vinalopó in Valencia
- Model combines Design-Build-Operate-Transfer (DBOT) models with facilities management, clinical services delivery and population health management on a capitated basis (i.e. payment on population basis, not activity), through integration of primary and hospital care and IT systems
- In Madrid, Ribera Salud operated the Management company of the Central Laboratory Service of San Sebastian de los Reyes, covering 6 public hospitals
- Other PPP efforts included D/BOT, FM and patient electronic records design and management

Source: Ribera Salud; press review; team analysis

4. Spain: Community of Madrid PPP capitated model

Madrid Model: Key facts

- PPP collaboration between the Community of Madrid (Metropolitan area) and Quirónsalud, Spain's largest private hospital chain
- Collaboration includes 4 Hospitals: Hospital Universitario Fundación Jiménez Díaz (tertiary/high complexity), Hospital Universitario Rey Juan Carlos, Hospital Universitario Infanta Elena de Valdemoro and Hospital General de Villalba (new built)

Elements of the PPP

- Hospitals remain under public ownership but the private provider undertakes costs of running the hospitals (incl. payroll) and delivering services on a capitated basis
- Model combines Design-Build-Operate-Transfer (DBOT) models with facilities management, clinical services delivery and population health management on a capitated basis (i.e. payment on population basis, not activity), but unlike Ribera Salud, does not to-date include integration of primary and hospital care
- Digital enablement and Advanced Analytics/Big Data a key part of managing demand and focusing on primary and secondary prevention,,as well as increasing patient satisfaction

Source: press review

International case examples of healthcare PPPs offer key lessons learned on factors of success and potential risk/pitfalls

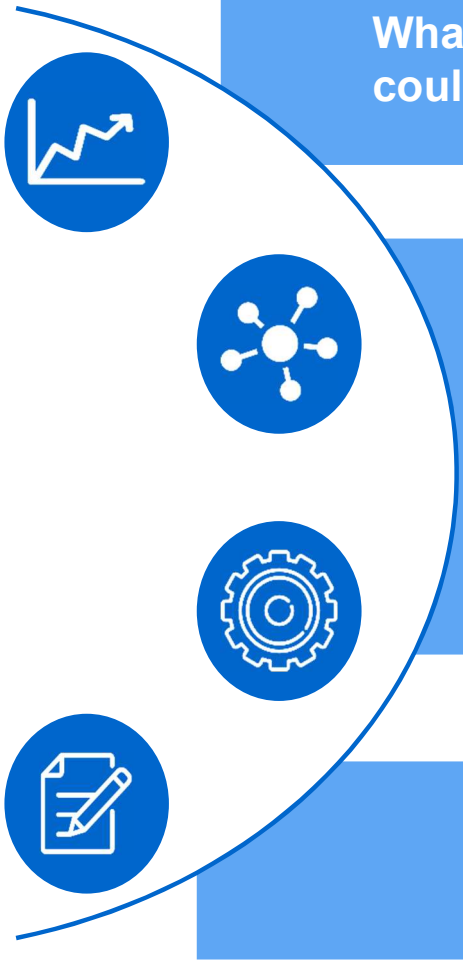
Key success factors for successful PPPs

- Transparent payment mechanism and process with performance incentives
- Dedicated resources for contract performance management supported by robust information flows
- Clear definition of scope and volumes for services
- Autonomy in day-to-day operations
- PPP offering must build on existing landscape

Key potential risks/pitfalls

- Payment mechanism and amount not set carefully
- Unpredictable and highly variable levels of patient demand/activity
- Misaligned incentives between multiple parties involved
- Lack of integration between clinical models and infrastructure design
- Lack of political and regulatory alignment on how to structure PPPs

Key questions for discussion



What could be the core areas where a public and private collaboration could deliver most impact?

What should be the focus? E.g.

- Service specific - clinical or non-clinical?
- BOT model, potentially with Facility-Management elements?
- End-to-end – service, population or geography-based?

How could such partnerships be structured to deliver most value for public spend and best possible outcomes in terms of service quality, and patient access and experience?