

The role of public-private partnerships in health systems is getting stronger

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The past three decades have seen a steady growth in the private sector's role in the health systems of high-income countries in the Commonwealth. And, as cross-country research studies have been undertaken, it has become clear that the private sector plays a major role in financing and producing health care in low- and middle-income countries (LMICs). In addition, theoretical and empirical research has pointed to the potential contribution of the private sector to reforms aimed at enhancing the quality and accessibility of health systems (Harding and Preker, 2003).

In 2010, the World Health Assembly passed a resolution calling on countries to 'constructively engage the private sector in providing essential health-care services' (WHO, 2010). In addition, the UK Department for International Development (DFID) – the European Union's largest donor in global health – has, since the change in government in May 2010, reoriented its health systems financing strategy away from governments and not-for-profit organisations towards private sector and market solutions (DFID, 2011). This new approach is strongly supported by supranational institutions such as the World Bank and International Financial Corporation (IFC), and multi-donor agencies such as HANSHEP, a group of organisations and countries working together to improve health-care delivery to the poor.

The partnerships agenda

One outcome of this is the increasing focus on public-private partnerships (PPPs) as a means of increasing capital finance and improving the efficiency and quality of service provision. Under this model, a public sector organisation enters into a long-term contract with a private sector consortium, in which the latter accesses private capital to build or renovate health facilities and agrees to deliver a package of services over the length of the contract. The detailed contract is structured around a stated specification of the required output and defines the financial, operational and (where applicable) clinical standards that the private partner must meet. The government retains its role as the ultimate funder of health care, making periodic payments to the private sector in return for the services delivered.

In the UK, 123 Private Finance Initiative (PFI) contracts for hospitals have been agreed between National Health Service (NHS) authorities and private consortia, representing new investment of £15.9 billion in 2011 prices (HM Treasury, 2012). Equivalent programmes are underway in Australia and Canada. These models are controversial; indeed, in the UK the coalition government is currently reviewing the PFI. But the key attraction of private finance – its ability to provide investment over and above what is available through formal capital budgets and from outside the scope of official estimates of government debt –

indicates that the PFI will continue in some form (Hellowell and Vecchi, 2012).

Meanwhile, in the emerging economies of the Commonwealth, some governments are taking bolder steps with PPPs by bringing the private sector in for both *infrastructure renewal* and *delivery of clinical services* in what Sehri, Feacham and Ni (2011) have called 'public-private integrated partnerships' (PPIPs). These projects have now been implemented in a number of countries, including India, Lesotho and South Africa. In principle the potential for better performance through PPIPs ought to be greater than in the more limited contractual approaches adopted in high-income contexts. Health care is a notoriously labour-intensive industry, with clinical and ancillary services absorbing 80–90 per cent of expenditure in most health systems. Thus, by integrating clinical services with the provision of capital infrastructure, PPIPs present opportunities for higher efficiency gains.

Integrated partnerships and the limits of contracting

The PPIP model is likely to be most appropriate in situations where the existing provision of care is inadequate in terms of productive efficiency or quality. These partnerships provide a 'bundled' solution in which the private consortium is involved in every aspect of the health-care production process, from designing, financing, building and maintaining health-care facilities to the delivery of clinical services. Because of the extent of private sector involvement, PPIP implementation is likely to incorporate most or all of those challenges associated with the more limited forms of partnership pursued in high-income countries, in addition to some extra complexities. It is therefore important that the lessons are learned from the experiences of Australia, Canada and the UK. Fortunately, a rich theoretical and empirical evidence base exists in relation to these mature programmes, enabling an intelligent assessment of the likely costs, benefits and risks of the PPIP model.

In making this assessment, one central fact needs to be borne in mind: there is no evidence to support the conclusion that the private health-care sector is *inherently* more efficient or productive than the public sector. A review of 317 econometric studies found that, across the world, publicly owned health-care organisations outperform both not-for-profit and for-profit providers (Hollingsworth, 2008) – findings that reiterate earlier comparisons (Hollingsworth, 2003). Though these findings may reflect many confounding factors, including the possibility that public and private enterprises may provide a different level of service, it is clear that an across-the-board presumption in favour of private sector solutions is not evidence-based. If, in a given jurisdiction, the private sector is superior, this is due to contextual factors and

is not inherent in the structure of ownership among care providers.

In general, if PPIP is to enhance health system performance, the procurement process and the structure of contracts must generate the right incentive framework. One of the central arguments in favour of exposing providers to market forces is that, in a functioning market, competitive forces lead to a more efficient allocation of resources than is the case with command economy or non-market solutions. Therefore, the structure of the market to which organisations are exposed has a critical influence on their incentive to deliver high quality at low prices. In a PPIP (or a conventional PPP), market competition takes place only during the bidding process. Once contracts are signed, the relationship between the public purchaser and the private provider is a bilateral monopoly in which formal competition is absent and, because of the multi-decade length of the contract, the prospect of an incumbent losing the right to provide due to sustained underperformance is a distant one.

Therefore, creating meaningful competition during bidding is essential to ensure that the procurer gets a good combination of low price and high quality from a contract. Yet, even in the UK where institutional capacity to manage contracts is relatively high by global standards, procurements have often been managed badly, and contract prices have been higher than 'should-cost' benchmarks would suggest (Hellowell and Vecchi, 2012). The complexity of this form of contracting and the need to raise finance from third parties mean there will always be a limited number of providers with the balance sheets and the competences to bid. And given the novelty of PPIPs, combined with the political and counter-party risk associated with contracting in LMICs, it is likely that market appetite will be limited, at least in the programme's early years. Thus, generating an appropriate level of competitive tension in procurement will be a challenge for health-care procurers in LMICs.

Once contracts are signed, it is up to the public sector to ensure that the standards of quality outlined in the contract are delivered and that, where this is not the case, the private sector bears a financial cost. It is by placing the provider's capital and revenues at risk that the PPIP model creates the incentives that lead to good performance. However, it should be recognised that a contract written today for a complex range of services to be delivered over an extended period of time will always be incomplete. This creates the possibility that providers will behave opportunistically, taking advantage of gaps in the contract to provide a lower standard of service than the procurer requires. For example, if contracts are incomplete it may be profitable for providers to reduce their operational costs, to the detriment of service quality. Even if contracts are complete, inadequate monitoring arrangements may generate moral hazards and also lead to the weakening of quality standards.

There is good evidence from some LMICs that health-care providers do behave opportunistically when information asymmetries of this kind exist. An examination of the experiences of patients in the Vietnam health sector using household data from a national health survey found that private providers were able to induce demand for unnecessary health care through, for example, inappropriate prescribing practices (Nguyen et al, 2011). The findings also suggested that regulation and checks from a third party, whether it

is an authoritative body in charge or an insurance agency, provide only an imperfect guard against such opportunistic behaviour in the health-care market.

The financing challenge

In addition to the difficulties associated with contracting, policy makers need to consider the liquidity position of the financial institutions from which private partners will source their capital. Changes in global banking regulations (including the Basel III framework) and concerns about the quality of assets held by commercial banks have led to restrictions in long-term lending. As a result, there has been a strong trend away from the traditional 'lead arranger' model in which a bank manages a transaction, underwrites the debt and syndicates part of it to other banks to reduce exposure to project risk. The absence of liquidity and the concentration of risk have increased interest rates on project finance to historically high levels. The result has been a reduction in the ability of PPPs to generate economic value for health-care purchasers and a related diminution in the level of political support for these programmes. Only in Canada, where large, well-resourced and competent pension funds have replaced the role of banks, has the credit crunch in infrastructure finance been resolved. Of course, LMICs do not have the capital markets to enable such an approach.

Conclusion

To achieve the full rewards of public-private partnerships, it is evident that governments need to invest significant financial and human resources in identifying and mitigating associated risks. Although these partnerships have strong advocates in academia, Western governments and supranational donors, there is no existing empirical evidence in relation to their performance in LMICs while they are clearly associated with substantial implementation challenges. Their economic value in high-income contexts is heavily contested by scholars and it will be some time before their appropriateness for the health systems of developing countries can be intelligently assessed. Policy makers also need to consider whether the productivity gains secured by transferring the risks of construction and service delivery to the private sector can realistically offset the high price of private finance in the wake of the global financial crisis.

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