# PUBLIC-PRIVATE PARTNERSHIP AS A NEW WAY TO DELIVER HEALTHCARE SERVICES

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Public-Private Partnership is expanding rapidly as an alternative for the provision of goods and services by governments. This paper analyses PPP phenomenon and focuses on relevance as regards healthcare services. Methodology is centred on literature review and a detailed description of the Private Finance Initiative in the United Kingdom as a case study. Our findings corroborate a clear predominance of healthcare services provided in recent years through PPP schemes in the UK and in most other European countries as well. We also confirm that in the UK only 2% of capital value of PFI healthcare projects is scored on the departmental balance sheet. Consequently, while better value for money is demonstrated, affordability and budgetary risk must be carefully surveyed. Cautionary risk factors and benefit potentials should be balanced against each other when governments initiate a PPP strategy.

Keywords: Public-Private Partnership, healthcare services, public regulation

### 1. Introduction

Models of delivery of public goods and services can be understood as a continuum of formulas which has its two polar ways in the direct provision by governments and the full privatization of that. The growing financial pressure on public accounts has prompted the expansion of new formulas that allow the channelling of alternative resources, so that Governments that previously both produced and provided services now tend to rely increasingly on the market for either inputs to government production and provision or for direct provision of goods and services. This move has occurred for ideological reasons as well as to better obtain value for money, i.e. how to improve the use of resources. Public-private partnership (PPP) is part of this trend. Through PPP the government enters into a long-term contract with a private partner to deliver a good or service. The private partner is responsible for building, operating and maintaining assets that are necessary for delivering the good or service.

Although private firms have been involved in public service delivery for a long time, the introduction of PPP in the early 1990s established a mode of public service delivery that redefined the roles of the public and private sectors. Throughout the 1990s and early 2000s, PPP has expanded in terms of the number of countries where it is used and in terms of the number of sectors and projects funded through this partner-

ship as well. Governments introduced PPP for various reasons: to improve the value for money in public service delivery projects, or because PPP had the potential of bringing private finance to public service delivery. Although, governments increasingly admit that PPPs are an instrument to improve value for money, they do not necessarily consider them as an additional source of finances. Nevertheless, there is still a lack of clarity about the definition of PPPs as well as the relationships between affordability, budgetary limits and access to private finance.

After the early experience of PPP in United Kingdom, in general Europe has embraced PPP as provision model, but countries have not gone at the same speed or in the same direction in terms of the development of PPP projects (European PPP Report, 2007). Especially successfully and speedily have been Spain, France and Germany, where a long term concession operator groups have existed and been accepted as an important part of the economic environment for many years. In these cases, PPP for the concession groups has been a natural extension of what they have been doing for a long time.

The development of PPP also raised a series of political and economic questions. Firstly, at issue would be the reasons for an active participation of the private sector in the provision of services that have been traditionally provided by the public sector. The answers to this question involve economic and political choices that depend in a given country on the relative efficiency of public services, on the potential availability of capital, and on the social consensus about acceptable ways of delivering certain services. The public and social acceptability of such partnerships is often a key factor. The economic questions concern issues such as contract management and risk sharing which pertain to maximising value for money. A number of tests are involved, relating to affordability, risk sharing and competition as well as the provision of a benchmark with a public sector comparator. In these decision processes and tests, budget decisions are a key factor. In the opinion of some public authorities PPP may be seen as a way to shift part of the public debt off their books, particularly when they are faced with fixed ratios of acceptable public sector indebtedness.

At a more general level, engaging in a PPP process will require governments to define clear legal and policy frameworks and to make certain that the appropriate capacity exists within the government to initiate and manage PPPs. Ensuring an enabling environment for PPP also has implications from the perspective of public governance, such as that the public sector needs to establish itself as a credible partner with appropriate regulatory and oversight mechanisms. This condition is particularly important, as public-private partnerships are often managed by decentralised authorities or local governments that must deal with major private sector participants.

In 2005 the European Commission published the Green Paper on PPP (EC, 2004). This Green Paper discusses the phenomenon of PPP from the perspective of Community legislation on public contracts and concessions. Community law does not lay down any special rules covering PPP. It nonetheless remains true that any act, whether it be contractual or unilateral, whereby a public entity entrusts the provision of an economic activity to a third party must be examined in the light of the rules and principles resulting from the European Community Treaty, particularly as regards the principles of freedom of establishment and freedom to provide services (Articles 43 and 49 of the Treaty), which encompass in particular the principles of transparency, equality of treatment, proportionality and mutual recognition. Moreover, detailed provisions apply in the cases covered by the Directives relating to the coordination of

procedures for the award of public contracts. These Directives are thus "essentially aimed at protecting the interests of traders established in a Member State who wish to offer goods or services to contracting authorities established in another Member State and, to that end, to avoid both the risk of preference being given to national tenderers or applicants whenever a contract is awarded by the contracting authorities and the possibility that a body governed by public law may choose to be guided by considerations other than economic ones."

The Green Paper makes a distinction between:

• PPP of a purely contractual nature, in which the partnership between the public and the private sector is based solely on contractual links, and

• PPP of an institutional nature, involving cooperation between the public and the private sector within a distinct entity.

This distinction is based on the observation that the diversity of PPP practices encountered in the Member States can be traced to these two basic models.

In the next section we present a summary of the main highlights found in the specialised literature on PPP. This review is structured around three relevant topics to our work, definition and concept, development and trends, and those particular aspects of PPP in health services.

In section 3 we present a descriptive analysis of the Private Finance Initiative in the United Kingdom. This analysis was carried out utilising the list of signed projects offered by HM Treasury and stresses the role played by investment in this new model for contracting healthcare facilities and infrastructures. Finally, in Section 4 we offer our conclusions. Then, furthermore, with special emphasis on the risks and critical visions published by various authors, we offer a warning about the risk that PPP could entail for the public provision of healthcare services.

# 2. Background

#### 2.1. PPP: definition and types

Public service provision does not imply that government also has to be the producer of the services. Most government services are provided with assets that governments procure from the private sector or through contracts where private companies build the assets, usually according to government specifications. These assets may include buildings, computers, dams, roads, hospital equipment or military equipment. Governments may also contract private companies to supply certain services such as maintenance or advisory services. However, none of these arrangements may necessarily qualify as a public-private partnership. They could all still be categorised as traditional public procurement.

There is currently no clear definition of what constitutes a public-private partnership; the literature offers several possibilities:

The OECD (OECD, 2008) defines a public-private partnership as an agreement between the government and one or more private partners (which may include the operators and the financers) according to which the private partners deliver the service in such a manner that the service delivery objectives of the government are aligned with the profit objectives of the private partners and where the effectiveness of the alignment depends on a sufficient transfer of risk to the private partners.

According to the International Monetary Fund (IMF, 2006), public-private partnerships (PPPs) refer to arrangements where the private sector supplies infrastructure assets and services that traditionally have been provided by the government. In addition to private execution and financing of public investment, PPPs have two other important characteristics: there is an emphasis on service provision, as well as investment, by the private sector; and significant risk is transferred from the government to the private sector. PPPs are involved in a wide range of social and economic infrastructure projects, but they are mainly used to build and operate hospitals, schools, prisons, roads, bridges and tunnels, light rail networks, air traffic control systems, and water and sanitation plants.

For the European Commission (EC, 2004), the term "public-private partnership" is not defined at the Community level. In general, the term refers to forms of cooperation between public authorities and the world of business which aim to ensure the funding, construction, renovation, management and maintenance of an infrastructure for the provision of a service. The following elements normally characterise PPPs:

• The relatively long duration of the relationship, involving cooperation between the public partner and the private partner on different aspects of a planned project.

• The method of funding the project, in part from the private sector, sometimes by means of complex arrangements between the various players. Within this mix, public funds –in some cases rather substantial– may be added to the private funds.

• The important role of the economic operator, who participates at different stages in the project (design, completion, implementation, funding). The public partner concentrates primarily on defining the objectives to be attained in terms of public interest, quality of services provided and pricing policy, and takes responsibility for monitoring compliance with these objectives.

• The distribution of risks between the public partner and the private partner, to whom the risks generally borne by the public sector are transferred. However, a PPP does not necessarily mean that the private partner assumes all the risks, or even the major share of the risks linked to the project. The precise distribution of risk is determined case by case, according to the respective ability of the parties concerned to assess, control and cope with the particular risk.

Standard and Poor's definition of a PPP is any medium- to long-term relationship between the public and private sectors, involving the sharing of risks and rewards of multi-sector skills, plus expertise and finance to deliver desired policy outcomes (Standard and Poor's, 2005).

For the European Investment Bank (EIB, 2004), "public-private partnership" is a generic term for the relationships formed between the private sector and public bodies often with the aim of introducing private sector resources and/or expertise in order to help provide and deliver public sector assets and services. The term PPP is thus used to describe a wide variety of working arrangements from loose, informal and strategic partnerships, to design-build-finance-and-operate (DBFO) type service contracts and formal joint venture companies.

Table 1: Definitions of public-private partnerships (OECD, 2008)

Given that public-private partnerships occupy a middle ground **between traditional public procurement and privatisation**, it is necessary to distinguish them clearly from those two. It is also necessary to distinguish PPP from concessions (though they are closely related). To define PPPs and to distinguish them from all other forms of public and private sector interaction, it is necessary to first understand the main reason for implementing public-private partnerships.

The main reason is to improve service delivery –that is, to create better value for money in comparison with a government delivering the service (i.e. the case of traditional public procurement). Thus, even if delivery through traditional procurement is effective, the service may neither be of high quality nor delivered efficiently (i.e. at least cost). Thus governments may decide to conclude PPP contracts and draw on the capacity of the private sector to efficiently deliver quantity and quality. However, although private sector participation in PPP frequently contributes to higher levels of **efficiency**, the mere participation of the private sector in the delivery of the service is not sufficient to guarantee improvement in service delivery and efficiency. Such improvements depend crucially on a sufficient transfer of risk from the public sector to the private partner. In the absence of a sufficient transfer of risk, service delivery could still be viewed as public procurement even if a private company is involved. Therefore, the distinguishing feature that determines whether a project is defined as traditional public procurement or as a public-private partnership should be whether or not a sufficient amount of **risk** has been transferred.

If a PPP contract implies that the private partner will maximise its profit by delivering a service efficiently and effectively, then the contract constitutes a partnership, in view of the fact that both parties –the government and the private partner– will achieve their objectives. This broader definition of the term "partnership" helps to distinguish PPP from privatisation. Privatisation involves no strict alignment of objectives since it usually means that the government is not involved in the output specification of the privatised entity.

PPPs are situated between traditional public procurement and full private provision. Usually the government sets the quality and quantity requirements, and allows the private partner to design and build the asset and service aspects (Corner, 2006). In contrast to traditional procurement, the government does not buy the capital asset directly from the private partner. Rather, it buys the stream of services that the private partner generates with the asset. To the government, value for money represents an optimal combination of quality, features and price, calculated over the whole of the project's life. The United Kingdom government (HM Treasury, 2006) defines it

as: "...the optimum combination of whole-life cost and quality (or fitness for purpose) to meet the user's requirement".

There is one remaining question: what distinguishes PPPs from concessions?. The OECD (2006b) sets out the defining features of a concession:

• A concession grants the right to a private firm to operate a defined infrastructure service and to receive revenues from it.

• The concessionaire usually pays the concession-granting authority a fee to obtain this right.

• The concessionaire carries the bulk of the risk.

• The asset involved in the delivery of the service remains the legal property of the government, though the private firm has the right to operate it and use it to generate income. The private firm is also typically responsible for the maintenance of the asset.

• According to the *strictu sensu* definition of concessions, the asset must be transferred to the government at the end of the contract term.

The two distinguishing characteristics concern risk and payment:

• The level of risk transferred, especially that of demand risk, might in general be higher in the case of a concession. The distinction between supply and demand risks is important since the presence of externalities and the public good nature of some goods create demand risk due to the "free rider" problem. The extent of demand risk might be such that a private operator is unwilling to deliver unless the government (and not the direct recipient) remunerates it for its services.

• Concessions usually depend on user charges for the majority of their income, and many do not receive any payment from the government. In fact, instead of the government paying the private operator for services delivered, in the case of a concession the private operator pays the government for the right to operate the asset.

Having made this distinction, it should also be mentioned that much of the literature does not draw a clear line between PPP and concessions regarding affordability and value for money.

#### 2.2. Recent evolution of PPP

During the past two decades, some countries have seen a huge increase in the use of private-public partnership as a mode of public service. In the experience of most countries, the trend has been to begin with PPP in the transportation sector and then move gradually into other sectors. Other services that governments deliver through PPP in the early stages of their use are water and waste management and healthcare (PricewaterhouseCoopers, 2005). The majority of the projects undertaken by OECD countries so far have been various ones within the transportation infrastructure such as airports, railroads, roads, bridges and tunnels. Other projects include public utilities and services such as waste and water management, educational and hospital facilities, care for the elderly, and prisons. In addition, governments of both OECD member and non-member countries have often used PPPs to build new assets or upgrade deteriorating ones. Despite the rather extensive rollout of publicprivate partnership in some countries, it should not be seen as a mechanism that will largely replace public procurement in the future. For a number of years in the United Kingdom, private finance initiative deals (PFI) have made up a mere 10-15% of the total annual public investment expenditure, that is, a small proportion in the country with a relatively extensive use of public-private partnership.

Between 1985 and 2004, worldwide public-private financing occurred in 2096 projects and totalled nearly USD 887 billion AECOM (2005). Of this total, USD 325 billion went to 656 transportation projects. Several developed countries as well as some emerging market economies increasingly engage in public-private partnership to deliver services that were previously delivered through traditional procurement (Grimsey; Lewis, 2005).

Developed countries with extensive PPP experience include Australia and the United Kingdom. Recent large players include Korea, Portugal and Spain, while countries such as France, Germany, Hungary, Italy, Japan and the Nordic countries also have experience with public-private partnership. Table 1 lists the top ten countries engaged in PPP/PFI project finance deals in 2004.

Rank 2004	Country	Value USD mil- lions	Deals	% share
1	United Kingdom	13,212	81	32.6
2	Korea	9,745	9	24.1
3	Australia	4,648	9	11.5
4	Spain	2,597	7	6.4
5	United States	2,202	3	5.4
6	Hungary	1,521	2	3.8
7	Japan	1,473	15	3.6
8	Italy	1,269	2	3.1
9	Portugal	195	2	2.7
10	Canada	746	3	1.8

Table 2: Top ten countries with the largest PPP/PFI project finance deals, 2004. Source: Dealogic, quoted in OECD (2006a), "Interim Report on the Role of Private Participation in Major Infrastructure Provision", GOV/TDPC/URB(2006)5, OECD, Paris, page 57.

The European Investment Bank (EIB, 2004) reports that, by 2004, the United Kingdom had 650 projects of which 400 were in operation. Total capital expenditure was GBP 48 billion or approximately 12% of total annual capital expenditure (KPMG, 2007). The list of signed private finance initiative projects of HM Treasury as of July 2008 shows 628 projects with a total capital value of GBP 58.56 billion, or GBP 40.96 billion if the three London Underground projects with the value of GBP 17.6 billion are excluded. These three contracts constitute the largest PPP arrangements in the United Kingdom. Of the remaining contracts, the two largest PFI projects concern defence (the largest with a total capital value of GBP 1.26 billion, and the second largest with a value of GBP 1.08 billion), while the third largest is a health contract (with a total capital value of GBP 1 billion) (HM Treasury, 2008).

Korea has recently accelerated its PPP initiatives. It has followed a similar path to other OECD countries, starting off with transportation infrastructure projects, after which there has been a gradual expansion into schools, hospitals, and public housing projects (Park, 2006).

Public-private partnerships in Spain focus on transportation, with private sector participation set to be a key element in the 2005-20 transportation plan of the government. That plan entails an investment of EUR 248 billion over the 15-year period, of which the private sector is supposed to contribute approximately 20% (Sevilla, 2008).

In 2001 the French government concluded a 62-year concession contract with ALIS (Autoroute de Liaison Seine-Sarthe) to design, build, finance and operate a 125 km motorway in the northwest of France at a total cost of EUR 900 million (OECD, 2006a). The motorway opened in October 2005. In addition, the French government announced 35 PPP projects that include part of the TGV Rhine-Rhone high-speed train line (train grande vitesse), the renovation of the zoo at Vincennes, and the rebuilding of the Maison d'arrêt de la Santé (Santé prison) in Paris (OECD, 2006a:58). The French government also plans to use public-private partnerships to construct 18 prisons and for 30 schemes in healthcare (Poulter, 2005).

In Germany, the federal government as well as several of the Länder became interested in using public-private partnerships, in particular to deliver infrastructure services (OECD, 2006a). In addition, several municipalities in Germany also use PPPs to deliver local government services; ten new projects with the value of EUR 500 million entered the market in 2005, with the total market estimated to be worth EUR 1 billion (OECD, 2006a).

Portugal has also extensively expanded partnership projects across various sectors. With a ratio of between 1.2% and 1.3% of GDP, Portugal has the highest PPP-to-GDP ratio in Europe (nearly double the United Kingdom ratio of between 0.6% and 0.7%) (PricewaterhouseCoopers, 2005). In addition to several large transportation projects, Portugal also initiated PPP projects in water and waste management.

In addition to transportation projects, Ireland has seen several water and waste projects (PricewaterhouseCoopers, 2005). The Irish government also announced PPP deals in relation to prisons, courts, and the health and education sectors.

In Italy, PPP projects focus especially on transportation, but there are also projects regarding health, water and central accommodation (PricewaterhouseCoopers, 2005:38).

In Australia, the largest toll road is the Mitcham-to-Frankston scheme (called Eastlink), with the value of AUD 2.5 billion; it includes a 40 km road in Melbourne (PricewaterhouseCoopers, 2005:54). Other projects include the Sydney Harbour Tunnel, the M2, M4 and M5 motorways, the Eastern Distributor, the Western Sydney Orbital and the Lane Cove Tunnel (Brown, 2005).

The countries using public-private partnerships are not limited to developed countries, but also include several emerging market economies such as Brazil, Chile, China and South Africa. In some of these countries, the implementation of PPPs is well underway, though some of them are having problems. The initial PPP experience in China highlights the fact that traditional joint venture frameworks were badly prepared for PPP implementation (Bellier; Zhou, 2003).

In contrast to developments in Turkey and China, Chile and South Africa are having a more positive experience with PPP, primarily because the legal frameworks in both countries have been adapted to deal effectively with public-private partnerships (IMF, 2006).

In essence, a public-private partnership is a mode of service delivery that attempts to improve the value for money of government service delivery compared to traditional public procurement. According to the European Commission, value for money must be a primary objective in the PPP design. The Commission associates VFM (value for money) with reduced life-cycle costs, better allocation of risk, faster implementation, improved service quality, and generation of additional revenue (EC, 2003). Nevertheless, simply concluding a contract with a private operator to deliver a service is in itself no guarantee that value for money will improve.

Affordability and VFM are the benchmarks for PPP viability. Because of the offbalance sheet nature of PPP, its use has led to some misconceptions regarding impact on the affordability of projects. Though PPPs may enable some projects to become affordable, this does not stem from their off-balance sheet nature. Affordability is not only related to public-private partnerships, but to government expenditure items in general. A project is seen as affordable if government expenditure associated with a project, be it a PPP or other mode of delivery, can be accommodated within the intertemporal budget constraint of the government.

A public-private partnership can be said to be affordable if the present value of the future revenue stream of the government equals or exceeds the present value of the sum of expected future interest payments and the present value of the government's expected non-interest expenditure, while a portion of such future expenditure streams is allocated to such a PPP. The problem is how to assess the affordability of a PPP in an environment where the planning horizon is not very long. As with other government activities in such an environment, a PPP project is affordable if the expenditure it implies for the government can be accommodated within current levels of government expenditure and revenue and if it can also be assumed that such levels will be and can be sustained into the future. This working definition allows for the detailed use of present value calculations when estimating the cost of a public-private partnership versus that of traditional procurement (using a public sector comparator), but in an environment with a short planning horizon.

Thus, PPPs can allow the government and government entities to undertake projects that are affordable in terms of the overall intertemporal budget constraint of government, but cannot be undertaken through traditional procurement because of the existence of budgetary limits, fiscal rules or limits to the budgetary allocations of entities from a central budget. In such a case, value for money is not the only thing that a government or government entity should consider when deciding whether or not to

take the PPP route. Moreover, since failure to get a project "off the government books" may imply that the government cannot undertake the project, the danger exists that the drive to get the project "off the books" might be strong enough to cause the government to ignore or neglect the VFM considerations. Thus, value for money should receive more attention when PPPs are undertaken because of budgetary limits and budgetary allocations that preclude traditional procurement.

Risk plays a fundamental role in the success of a public-private partnership. Indeed, whether or not an activity is deemed to be a PPP or traditional procurement primarily depends on who bears the bulk of the risk. The key to understanding the role of risk in a public-private partnership is the link between the carrying of risk and the efficiency of the project. The main rationale to enter a PPP agreement is the possible improvement in service delivery and efficiency by the private partner relative to what traditional procurement can deliver.

In accordance with economic theory, a distinction should be made between three kinds of efficiency: allocative efficiency (i.e. the use of resources so as to maximise profit and utility), technical efficiency (i.e. minimum inputs and maximum outputs), and X-efficiency (i.e. preventing the wasteful use of inputs) (Fourie; Burger, 2000). The decision by a government to deliver a service in the first place, irrespective of whether this is done through traditional procurement or a public-private partnership, involves allocative efficiency. Once a decision about delivery is made, the government must decide on the mode of delivery: whether to deliver it through traditional procurement or through a PPP. The choice largely involves considerations about technical and X-efficiency.

Although the finding cannot be generalised to other countries, a number of examples in Australia and the United Kingdom support the improved efficiency of PPP. A note of caution is nevertheless in order: when government departments identify projects for delivery through PPP, they may pick projects where they are more assured of achieving value for money, i.e. projects that are expected to cause fewer technical difficulties or other problems.

### 2.3. Healthcare services and PPP

Privatisation of public services became more widespread in the 1980s with the emergence of a neoliberal consensus that sought to reduce the role of the state. In the health sector, however, comprehensive privatisation was rejected because of the existence of market failure. Instead, various quasi-market solutions were developed, typically the separation of purchasers and providers within the public sector. The logical next step was to move the delivery of healthcare out of the public sector. This was seen as a means to increase value for money, innovation, and responsiveness to users.

Yet the better performance of the private sector is not borne out by the evidence. Australian research showed that, after adjusting for case mix, public hospitals are more efficient than those that are privately operated,(Duckett SJ; Jackson TJ, 2000) possibly due to the more intensive management of patients in private hospitals. A systematic review identified 149 comparisons of for-profit and not-for profit health facilities (of various types) undertaken over the past two decades in the USA. Of these studies, 88 concluded that non-profit facilities performed better with respect to cost, outcomes of care, access and social mission, 43 studies found no difference, and 18 reported for-profit facilities to be better (Vaillancourt Rosenau P; Linder SH, 2003).

Public-private partnership in the health sector can take a variety of forms with differing degrees of public and private sector responsibility and risk. They are characterized by the sharing of common objectives, as well as risks and rewards, as might be defined in a contract or manifested through a different arrangement, so as to effectively deliver a service or facility to the public. The private sector partner may be responsible for all or some project operations, and financing can come from either the public or private sector partner or both.

In practice, several key types of PPP are frequently encountered in the health sector:



Fig. 1: Key types of public/private partnerships and collaboration in health sector. (Nikolic; Maikisch, 2006)

Private Financing Initiatives (PFI), which normally involve a concession contract, have evolved in practice as a distinct means of funding major capital investments in the health sector through financing provided by private partners. In the United Kingdom's PFI, which is probably the best known example, private consortia enter into long-term contracts with the government to finance, build, and, less frequently, manage new projects (e.g., a consortium may finance construction of health facilities that are then leased by public partners). PFIs have been a subject of an ongoing costbenefit debate, their applicability and use need to be evaluated carefully both as a matter of policy and on a case-by-case basis (e.g., by assessing the need for the project overall, using up-to-date public comparator methodology).

The specific format of PPP in any given situation will depend on the regulatory framework, which often needs to be adjusted to accommodate new types of partnerships and collaboration. Beyond enabling PPP, the regulatory framework plays a critical role in assuring and promoting the quality of healthcare services resulting directly or indirectly from any such arrangements. That may include establishing or revisiting quality assurance policies and indicators, monitoring and enforcement mechanisms, accreditation and licensing systems, a patient rights framework, as well as other related regulations (e.g., effective oversight structures, labour regulations to help facilitate performance-based staff management).

In general, partnering with the private sector implies potential benefits. These potential benefits can include reduced government spending (e.g., eliminating large upfront investments of scarce public funds), greater efficiency (e.g., due to private partners' operational efficiency), or better healthcare management (e.g., of hospital services and infrastructure). In the health sector, partnering can also be particularly valuable as a method of leveraging technical or management expertise (e.g., performance-based monitoring and incentives), and spurring technology transfer, all of which can lead to quality improvements.

There are also important risks to be managed. Planning an effective PPP involves careful review of the allocation of financial risks and rewards, decision-making mechanisms and responsibilities, and the applicable regulatory and contractual framework. Appropriate monitoring and managing of quality and performance are particularly important in healthcare PPPs and PPC. Monitoring and evaluation mechanisms, performance indicators, targets and outputs, as well as any performance bonuses should be discussed upfront, built into contracts, and refined at the pilot stage if possible. It is critical that the public partner have sufficient capacity for oversight and for making timely adjustments as needed. In ensuring continuity in the monitoring and managing of quality and performance, it is helpful for a single task force, advisory board, and/or project management office to be established for the duration of the project.

In practice, the options for utilising PPP significantly differ between contracting for hospital facilities and services, and contracting for auxiliary services (e.g., catering). The former tend to be far more complex than the latter and involve a distinct set of actors (e.g., key ministries or payers for hospital facilities and services vs. hospital management for auxiliary services). Thus, contracting for hospital facilities and services often presents greater challenges for the public partners than other forms of PPP. Nikolic and Maikisch (2006) offer nine brief case studies to provide an overview of some of the relevant recent experiences in Europe:

1. Privatisation of Dialysis centres in eight hospitals in the Republic of Romania in 2003

2. Hospital catering management contract in Germany (The Charité, Campus Clinic Virchow)

3. Contracting-out of the sterilisation support service for three hospitals in Vorarlberg, Austria

4. Development of the national e-health portal in Denmark

5. Partnership to establish a nationwide health telematics framework, and to enable a nationwide introduction of the electronic patient card, electronic prescription system, etc. in Germany

6. Emergency hospital transformation into a modern holistic care centre through a public-private partnership in Austria

7. Privatisation of a major public general-service hospital through a PPP in Stockholm (St. Goran's Hospital, Sweden)

8. Transformation of a large public hospital in Germany through a PPP (State of Berlin, The Charité University)

9. Major scale PPP program launched in 2001 in Portugal's National Health System (NHS), involving the construction, replacement/ refurbishment, and private management of over ten hospitals and several specialised centres.

In the **United Kingdom**, the Private Finance Initiative (PFI) is the main model of Public Private Partnership in the National Health Service (NHS). It is not simply about the financing of capital investments, but about exploiting the full range of private sector management, commercial and creative skills.

PFI schemes involve creating partnerships between the public and private sectors. In the health sector, the NHS will continue to be responsible for providing high quality clinical care to patients. But, where capital investment is required, there will increasingly be a role for a private sector partner in the provision of facilities.

Major PFI schemes are typically DBFO (design, build, finance and operate). This means that the private sector partner is responsible for: designing the facilities (based on the requirements specified by the NHS); building the facilities (on time and at a fixed cost); financing the capital cost (with the return to be recovered through continuing to make the facilities available and meeting the NHS's requirements); operating the facilities (providing facilities management and other support services). Moreover, because the PFI partner's capital is at risk, they will have strong incentives to continue to perform well throughout the life of the contract.

NHS Trusts will continue to be the employer of clinical staff. PFI in healthcare should ensure that the facilities in which they work are as modern, efficient and cost effective as possible by placing responsibility for their provision on specialist managers who are expert at providing them. The NHS can then concentrate upon the provision of healthcare.

The essence of PFI is that the NHS defines its needs in terms of "outputs", i.e. the nature and level of the service required, and invites private sector bidders to present their solutions to meet these service needs. Typically, for a large scheme, the private sector partner will be a consortium whose members may include a construction company and a facilities management provider, amongst others. The private sector partner obtains finance for the project, constructs the hospital, and provides services to the NHS Trust as specified in the contract agreed on between the NHS Trust and the private partner. The terms of the contract set down the range of services to be provided and the performance standards required of the consortium. No payments are made by the NHS until services are provided up to the agreed standard. Thereafter, the standard must be maintained to ensure full payment.

Any PFI scheme must demonstrate value for money (VFM) for expenditure by the public sector. In order to achieve the optimum combination of whole life costs and benefits, the guidance "Public Private Partnerships in the National Health Service: The Private Finance Initiative" (1999) details the phases of the NHS PFI process, alongside the procurement process set out in HM Treasury's Step by Step Guide to the Procurement Process. This guidance provides practical advice for NHS bodies involved in, or contemplating, PFI schemes, highlights the main issues and procedures in PFI procurement, and indicates what is required at various points in the process. The guidance applies to both small and large schemes involving the provi-

sion of facilities and services. It may also be useful to the private sector as well, and can be accessed via the internet at <u>www.doh.gov.uk/pfi.htm</u>.

The French experience in PPP healthcare project must be also highlighted. The basic picture is that PPP in **France** is currently in its early stages in comparison with developed markets such as the UK. Domestic law has not, until very recently, provided sufficient flexibility to encourage proper development. PFI healthcare and prison projects currently lead the field in France. The first sector to take advantage of a recent wave of liberalising legislation, the healthcare sector has now produced its first completed PPPs and continues to produce new deals as part of the French Government's ambitious investment programme, "*Hôpital 2007*".

The *Hôpital 2007* programme was launched by the Ministry of Health in 2002 to provide a much needed boost to investment aimed at improving service provision and optimising economic performance by modernising and reorganising healthcare facilities. The aggregate capital value of this scheme is estimated at approximately 6 billion euros of which around 1,4 billion euros in total relate to some 35 PPP-based projects, some of which comfortably exceed the €100 million mark. The basic contractual structure for hospital PPP projects under the *Hôpital 2007* programme is that of the long term administrative lease (between 18 and 99 years), arranged at a local government level, that allows the lessee to temporarily own buildings on the public domain, subject to the obligation of returning such assets free of charge to the healthcare authorities at the end of the period.

Amongst the highlights of deals completed the latest years are the Douai Logipôle project and the Quinze-Vingts research institute, the first two PPP projects to be completed under recent legislative reforms. Douai involved the design, build, finance and maintenance of a logistical support platform (*Logipôle*) at the Douai Hospital in the North of France. This project was sponsored by members of the Bouygues Group together with ABN AMRO and marks the first PPP project to be implemented under the French healthcare investment programme "*Hôpital 2007*". In similarity to the Quinze-Vingts, Douai is structured around a long term administrative lease. The Quinze-Vingts project involves the design, financing and creation of a clinical and biomedical research institute on the site of the *Centre Hospitalier National d'Ophtal-mologie (CHNO) des Quinze-Vingts* (Central Eye Hospital) in Paris. It the first important healthcare sector PPP outside the "*Hôpital 2007*" Programme to be awarded and was sponsored by the Caisse des dépôts, the Caisse d'Epargne and Icade.

Apart from the others previously mentioned, Andriani, Lignières, and Ratledge (2006) identified 26 additional projects (representing the vast majority of the *Hôpital 2007* programme) which procurement processes are currently underway. Among the key deals that are expected to be tendered in the near future in the healthcare sector we may note the implementation of the Electronic Medical Record (Dossier médical personnel).

In introducing PPPs, **Spain** was facilitated by its multi-level governance structure, particularly suited for the implementation of these types of contractual arrangements. Besides the effectiveness of central administrations in providing public services and assets, regional authorities, the so called *comunidades autónomas*, also have the power to implement projects, including PPPs, in their areas of competence. As a result, PPP initiatives could be tailored to the specific needs of local communities and also led to the creation of cross-regional projects, monitored by the government itself.

Among other sectors, PPPs are also booming in the health sector: the programme "*Madrid Nuevas Infraestructuras Sanitarias 2007*" has projected nine new hospitals in Madrid (Renda; Schrefler, 2006). In 2005 there were 15 signed PPP healthcare projects (16.5 % of total projects), which concentrated 8.4% of total capital value invested by means of this contracting mode (Allard; Trabant, 2007).

# 3. **PFI and healthcare services in the United Kingdom**

The Private Finance Initiative (PFI) is a form of public-private partnership (PPP) in which local authorities can gain access to new or improved capital assets (most commonly, but not always, buildings). Unlike in the practice of traditional procurement, the public sector does not buy the assets, but rather pays for their use, together with associated services (for example, security, cleaning, etc). Capital investment in the assets is made by the private sector, which recovers its costs over a long contract period (often 25 years or more).

In the UK Her Majesty's Treasury publishes an updated list of PFI projects. The last published list (accessed in July 2008) contains a total of 628 projects signed until April 2008. For each project it provides information on the Department, Commissioning Body, Project Name, Location, Constituency, Region, Data of Financial Close, Is Operational Project, Is Capital Value Scores On the Departmental or Off Balance Sheet, Total Capital Value, Period of Operational Contract, and Annual Payments from 1992 to 2060.

In order to analyse in a systematic manner the information provided in the list, we have distinguished three groups of signed projects: projects related to the provision of health services, projects promoted by local authorities, and other projects. In the third category projects promoted by the Police Departments, the Ministry of Transport (Highways Agency), the Ministry of Defence, and the Ministry of Justice, among others are grouped. This category brings together 32% of the total projects included in the list. The remaining 68% are split between health projects (25%) and local projects (43%).

Twenty Departments have promoted 628 projects in total, although the participation of many of them is merely symbolic. Eleven departments grouped more than 95% of the projects [Department for Children, Schools and Families (119), Scottish Government (103), Health (98), Department for Communities and Local Government (54), Ministry of Defence (53), Department for Transport (51), Northern Ireland Executive (35), Home Office (25), Welsh Assembly Government (24), Ministry of Justice (22), Department for Environment, Food and Rural Affairs (18)].

In health projects, the Health Department and the Scottish Government concentrate the majority of the projects. In the group of projects promoted by local authorities, activities developed by three Departments must be highlighted (Department for Children, Schools and Families, Department for Communities and Local Government, and the Scottish Government). Finally in the group of "Others" the Ministry of Defence is the Department with the greatest number of projects, 53 of the 199 included in this group.

In absolute terms, the Department with the largest number of projects is the Department for Children, Schools and Families (119 projects), followed by Health (97 projects). Schools and hospital building are the star projects within the variety of contracts, more than one third of the projects included in the list pertain to one of these two categories.

The relative importance of the three identified groups of projects changes considerably when we analyse their capital value. Projects included in the list of those signed (628) total a capital value of 58,560 million pounds.





Fig. 2: Signed PFI Projects and Total Capital Value

The group of "others" projects enhances significantly its relative share when we consider the capital value of projects. The health group is the only one that remains relatively stable, the gain of the "others" group comes at the expense of the group of projects promoted by local initiative, which reduces its share from 43 to 22%.

The Departments most active, such as in the local area (Department for Children, Schools and Families, 39%) and in the health group (Health, 88%), remain the same when we use the capital value of projects such as variable grouping. However, in the group of "others", the group's leadership passes to the Department of Transport (63%), relegating the Department of Defence to second position.

Globally computed, the Department of Transport (38%), Health (18%), and Defence (10%) account for 67% of the total number of signed projects.

Table 3 shows the breakdown by number of projects, amounts and unitary amounts of projects signed in each group.

Туре	Total Capital Value (£ millions)	Number of pro- jects	£ millions / project
Health	11,957.23	159	75.20
Local	12,720.43	270	47.11
Others	33,882,45	199	170.26
Total	58,560.10	628	93.25

Table 3: Health, Local and Others PFI in the UK 2008

In addition to the average values, it is interesting to observe the relative size of projects promoted by the most active Departments within each group. In the case of the health group, the Department of Health offers an average capital value of £ 108.16 million. In the local group, the average capital value of the Department for Children, Schools and Families amounts to £ 41.53 million. Finally, in the group "others", the average values are affected by the high value of the Department of Transport (£ 763.16 million). However, the Department of Defence, which has a greater number of projects, presents an average value of 114.65 £ million. These values and those in Table 3 show the lowest amount of capital value for the projects promoted by local authorities.

At any rate, there is no relationship whatsoever between the number of projects initiated by each Department and the average number of them. This lack of relationship shows that the average number of projects depends more on the type of project than on the activity of each department.



Fig. 3: Number of PFI projects and £ millions/project

In the group of projects promoted by local authorities, nearly half of the projects of the group are furthered by localities with fewer than 300,000 inhabitants, typically known as small and medium-sized cities. In terms of capital value, these initiatives represent just over 37% of all local projects.

The comparison of the resident population in the localities with the value of capital projects initiated in each of them shows the complete absence of correlation between both series. The graph below displays the relationship between the size of cities and the capital value of projects undertaken by their local authorities. In principle, we are able to distinguish three areas with different density of projects. In the area closest to the axes, enclosed with yellow line, we observe the highest density of projects. Cities of less than 400,000 inhabitants and projects with a capital value less than 100 million pound are located in this area.



Fig. 4: Relationship between the size of cities and capital value of PFI projects

Regarding the situation of operational projects, with respect to the number of active projects, approximately 80% of the projects are in an operational phase. The situation is very similar when we use capital value of operational projects as a grouping variable. The only notable exception is found in health projects where the capital value of functioning projects represents 45% of the total. That state of affairs can be described as exceptional and is due to there being a small number of projects with a high capital value that will become operative in 2010.

This leads us to wonder about the implementation trajectory of PFI projects. Taking as reference the "Year of Financial Closed" we note that this type of initiative was begun in the early nineties. Until 1995 PFI experiences were merely occasional, al-though since 1996 there has been a sharp ascent that has stabilised since 1998 with a figure of between 50 and 60 new projects annually. Although the number of projects has remained very stable from 2000, figures of annually bidden capital show an evolution rather more unstable. In the group of health projects the growing and sustained trend should be highlighted, observing maximum numbers hired annually. This observation is equally valid in local projects although the beginning of the PFI experience had a later start than 1995. Despite criticism that this practice has received from some sectors, evidence shows a strong upward trend in its use as a new form of financing and delivery of public services involving a large component of physical assets.

One of the reasons often argued to justify the use of PPP is the hiring investment linked to the public sector that is not reflected in public budgets, and thus does not enlarge the public debt. The Departments of Transport, Justice and Defence are the ones that recorded their PFI projects in their departmental budgets. This phenomenon can be analysed from one of the fields of the database of PFI signed projects in which the question of whether "Value Capital is ON or OFF the Scored Departmental Balance Sheet" arises. Overall, 86% of the projects fall outside of departmental budgets, although in terms of capital value the proportion is reduced to 59%. This percentage is distributed unevenly among the three groups of projects that we have been differentiating. 98% of capital employed in local and health projects is not registered on departmental budgets, whereas projects classified in the group of "others" present a high percentage of official recording that amounts to 70% of capital employed.

Table 4 presents the geographical distribution of the contracted amounts and the number of PFI projects at a regional level. Depending on bidden capital value, the regional sets which show a certain similarity have been coloured with different intensities. It should be noted that the leading position is the London area, which concentrates almost half of total capital value contracted. The primacy of the London region is not observed in either local or health projects. Projects grouped in these two categories are distributed much more uniformly across regions.

REGION	Signed Projects	CAPITAL VALUE (£m)
London	84	24.762,93
National/More than one region	34	5.926,83
Scotland	110	5.498,36
West Midlands	39	3.478,57
North West	46	2.921,62
Yorkshire & The Humber	42	2.659,78
South West	44	2.429,98
South East	48	2.397,20
East of England	27	2.165,64
East Midlands	35	1.958,01
North East	41	1.787,01
Northern Ireland	35	1.288,71
(n.a.)	14	667,78
Wales	29	617,67
Total	628	58.560,10

Table 4: Regional distribution of PFI projects

One of the specific characteristics of PPP that differentiates it from traditional public procurement is the long-term nature of relationships between the public sector and private partners. With regard to the length of signed contracts, the high frequency of contracts with an operational period of 25 and 30 years should be noted. Figure 5 shows the frequency of these two periods in UK signed deals.



Fig. 5: Operational period of PFI contracts

A total of 376 projects amounting to 36,443 million pounds have been signed for 25 or 30 years. As is shown in the chart, distribution of total projects between the two periods is very homogeneous. When we break down the database into various groups of projects, this homogeneity is segmented, and it is possible to distinguish between health projects in which 30 years dominate and local projects where 25 year deals prevail.

The main criticism raised against the public-private partnership mode is the potential financial overload that this practice may impose on public finances in the future. Figure 6 presents the evolution of "Charge Unitary Payment (£ million)" in the coming years. Taking into account all PFI projects as a whole we can observe a peak in the expected payments for the period 2017-18. This maximum is different for each of the various groups of projects (health 2030-31, local 2023-24, others 2010-11).



Fig. 6: Temporal distribution of PFI payments

A major concern for the European Commission is the guarantee of the free market principle and the intra-community competition in PPP projects. The list of signed PFI projects in the UK does not allow for analysing this phenomenon as a research objective because, although almost all of the projects have been awarded to British companies, it is logical to assume that bidders have a subsidiary operating in the UK. In addition, since the database does not provide information to identify the number and origin of bidders for each project, we can only find out the names of the holders that have proved to be successful tenderers.

In most projects there is a clear dominance of the award going to 1 or 2 holders. In the case of local projects most of the holders have a share of 100%.

One of the main demands that we must impose on the PPP model as a new formula for financing investments in health funding is its profitability. To analyze this requirement we compare the capital value of each project with a total amount of annual payments provided. On average, once having selected only those projects for which we had the amount of annual payments, we found that the total of annual payments collected in the signed contracts exceeds 5.54 times the amount of investment involved. This multiplier is surpassed slightly (5.62) in the case of health projects, those closest to the average value. The projects that offer a more favourable financial relationship were initiated by local authorities (4.45). The projects listed in the category of "others" presented a factor well above average (6.19).

Figure 7 shows the relationship between financial leverage and the number of PFI projects promoted by each department. The distribution points in the graph indicate a certain learning effect, so that the two departments (the Department of Health and the Department of Children, Schools and Families) with a greater number of projects offer the smallest financial multipliers.



Fig. 7: Departmental financial leverage

The average internal rate of return (IRR) for the total of signed projects is 16%. Projects promoted by the Department of Health offer an internal rate of return of 15% and projects from the Department of Children, Schools and Families are at 13%, both below the overall average, although well above the price of money in monetary markets.

## 4. Conclusions

In Germany where PPP is already well established, the German Institute of Urban Affairs (Difu) has carried out a study on behalf of the PPP Task Force at the Federal Ministry of Transport, Building and Housing (BMVBW). This study is a comprehensive and up-to-date review of public private partnership (PPP) projects at federal, Land and municipal level. It includes information on the distribution of PPPs, project types, investments, obstacles and prospects of success. The survey's main focus was on projects which had been planned or implemented since 2000 (http://www.difu.de/english/occasional/06ppp.pdf).

The survey's most important findings revealed that PPP infrastructure projects are now widespread in Germany, particularly at municipal level. PPP projects have been around for many years, but such cooperation has only really taken off since around 2004. Despite the growing popularity of PPP projects, their share of total public fixed investment remains low (PPP investment averaged 2% of municipalities 2000-2005 fixed investment). Expectations of PPP regarding higher efficiency and faster implementation go a long way towards explaining the increase in the number of PPP projects. Thus, the survey did not find much evidence to suggest that PPPs are primarily seen as instruments to bridge widening gaps in public finances. Municipalities that have anticipated greater efficiency as the main advantage from PPP projects are not generally disappointed by the result. Using a method of calculation which considers the interest and compound interest effects of future payment flows, average efficiency gains are 10%.

In accordance with the results of our empirical work on British PFI, the conclusion drawn from the German case could be perfectly valid for most European countries where the PPP practice offers expansive expectations and a beneficial image in the upgrading of facilities related to public services. Until now, most of the tests carried out on PPP have been concerned with ensuring proper management of contracts, especially through the dissemination of good practice models and guides which provide the necessary requirements at each stage of the contractual process. However, this new model of public service delivery can result in major problems for public finances, which could bring about a limitation on the actual level of provision. Therefore, let us finish this work by presenting the existent critical views about PPP in the healthcare sector that emphasise the risk assumed by governments and citizens with such practices.

Although in contrast with conventional public procurement PPP seems to offer greater returns, potential PPP disadvantages should also be carefully considered:

• The fixed-price turnkey construction contracts used in PPPs appear to be more expensive ex-ante than standard quantities-based.

• The additional skills and financial resources needed to set up a PPP may restrict the potential bidders, reducing competition and increasing prices.

• Using PPPs to accelerate a large-scale construction programme may, in some cases, create an increased demand for construction work which itself pushes up prices.

• The time taken to set up the contractual arrangements for a PPP, and to reach financial close, may increase the project implementation time.

As was shown previously, since 1992 the British government has favoured paying for capital works through the private finance initiative (PFI) —that is, through loans raised by the private sector. For hospitals this means that a private consortium designs, builds, finances, and operates new hospitals. In return the NHS trust pays an annual fee to cover the capital cost, including the cost of borrowing, and any non-clinical services that the private sector provides over the 30-60 year contract period.

This approach differs from the conventional public procurement model in which a public authority engages an architect to design new facilities and a construction contractor to build them. Under this approach, capital works are financed directly by the central government, with money raised through taxation and/or the issuing of Treasury gilts. The buildings are owned and operated by the public sector.

This policy has been controversial because of the high costs and association with cuts in clinical services. Despite this, the PFI programme in England's NHS is being expanded. As of July 2008, there were 159 signed PFI contracts in the Health Service, with a combined capital value of £12 billion. Under current plans, the Depart-

ment of Health will procure a further 41 schemes, bringing the total capital value of PFI schemes to £15.5 billion (Hellowell; Pollock, 2007).

The existing PFI schemes are a source of financial difficulty for NHS trusts. Prior to contracts being signed, NHS trusts prepare business cases which purport to show that their PFI plans are 'affordable' within projected budgets. Since PFI costs are higher than historical capital costs, all business cases contain plans to sell assets and cut service capacity to offset the shortfall.

But, as Hellowell and Pollock, 2007 have shown, these cuts have been insufficient to bridge the funding shortfall. The cost of PFI contracts for most trusts is greater than the capital they are provided with through the NHS resource allocation mechanism. This under-funding has led to the emergence of crucial financial deficits, and, under government pressure to balance the books, plans for further cuts to services.

The current system of resource allocation for England's NHS is called Payment by Results (PbR). Under PbR, trusts receive the bulk of their income through a standard tariff for each patient that receives treatment. This standard tariff for treatments includes an element for capital costs, designed to equal the average capital cost across all English trusts, based on 5.8% of trust income. However, the capital costs of trusts with PFI schemes average 8.3%, with the result that they are under-funded. The problem is even more serious for trusts with large or multiple schemes. Trusts with operational PFI schemes with capital values of over £50 million have average capital costs of 10.2% - a shortfall in income of 4.4%. This under-funding has created serious financial difficulties for many trusts, which can only be reconciled by further service reductions.

It is important to note that, for future schemes, figures for capital values, unitary charges and availability charges are likely to be significant underestimates. There is a well-established tendency for the capital value, unitary and availability charges to increase considerably during negotiations with the private sector. This tendency was observed by the Audit Commission in a recent study of NHS deficits (Audit Commission, 'Learning the Lessons from Financial Failure in the NHS', pp.27 July 2006, London). The Commission commented:

"The attraction of the big building project, both to local NHS management and across the wider community, makes it difficult to withdraw from negotiations or reshape the vision once strategic approval has been gained and detailed discussions are underway. This carries a clear risk of commitment to spending levels based on optimistic future income assumptions, ambitious savings arising from improved operational efficiency, or both".

From a different perspective McKee (2007) identifies four other key issues regarding PPP in healthcare services: cost, quality, flexibility and complexity. Drawing on the experience of countries such as Australia, Spain, and the United Kingdom he points out that new facilities have, in general, been more expensive than they would have been if procured by using traditional methods. Although it is true that compared with the conventional system, new facilities are more likely to be built on time and within budget, this often seems to entail compromises on quality. The need to minimise the risk to the parties means that it is very difficult to "future-proof" facilities in a rapidly changing world. Finally, such projects are extremely, and in some cases prohibitively, complex. In McKee's opinion, while it is premature to say whether the problems

experienced relate to the underlying model or to their implementation, it does seem that a public–private partnership further complicates the already difficult task of building and operating a hospital.

Form a budgetary standpoint, financial problems posed by the financing of new assets in National Health Service's centres via PPP are exactly the same as those relating to the introduction of new health technologies. Because the cost-effectiveness analyses conducted on the emergence of new health technologies often demonstrate favourable cost-effectiveness, the introduction of the technologies into regular clinical practice is usually recommended. However, although new treatments and technologies are more cost-effective, they have an incremental budgetary impact, so decisions regarding their introduction into the portfolio of services should also be supported by studies of budgetary impact and financial sustainability.

Ultimately, the controversy that arises over the financing of new assets associated with the delivery of health services is none other than the traditional dispute between quality and quantity in providing public health services. The PPP strategy favours a volume of investments in the health sector that, from a budgetary point of view, would not be able to be sustained in the traditional model of public procurement. The financial burden that these investments are imposing on the budgets of current expenditure in the coming years will force a decrease in the quantity or variety of benefits, except in the unlikely case that an increase in the volume of health financing might happen.

From the standpoint of managers and regional authorities it is logical to expect an increasing trend in improving and modernising health facilities and services. However, from the perspective of financial authorities it would be desirable to have greater concern about the affordability and financial sustainability of projects underway.

So far the majority of regulations concerning the new PPP procedures have focused on the need to ensure efficiency improvement, namely so-called "value for money". Typically, as many studies testify, the PPP procedure offers notable improvements in efficiency and effectiveness when we use the traditional procurement as a reference ("public sector comparator"). However, the increased efficiency of individual projects does not mean that at the aggregate level the financial burden of such projects is bearable by the public purse.

Therefore, in order to prevent the PPP strategy from becoming a source of public deficit that would be unacceptable by budgetary limits, it is imperative that practice guidelines and national regulations on PPP procedure incorporate the overall budget restriction as a prerequisite over the efficiency of individual projects, to be regarded as a necessary but not sufficient condition.

Although sometimes PPP is only seen as a way to privatise public services, PPP implementation could deter excessive pressure from building up within public systems to move towards privatisation. We should not forget that PPP is a type of public procurement in the sense that it makes it possible to combine market efficiency and public interest in satisfying needs of the population. That combination implies private production along with guarantees of public rules and institutions.

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