PUBLIC-PRIVATE INVESTMENT PARTNERSHIPS
An innovative approach for improving access, quality, and equity in healthcare in developing countries

The Global Health Group
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Partnerships for Access, Quality, and Equity

Public-Private Investment Partnerships (PPIPs) are an innovative approach for improving healthcare services and infrastructure in developing countries. PPIPs are a special form of public-private partnership (PPP) that comprise long-term, highly structured relationships between the public and private sectors designed to achieve significant and sustainable improvements to healthcare systems at national or sub-national levels.

PPIPs position a private entity, or consortium of private partners, in a long-term relationship with a government to co-finance, design, build, and operate healthcare facilities, and to deliver both clinical and non-clinical services at those facilities over a decade or more.

PPIPs enable national governments to prudently leverage private sector expertise and investment to serve public policy goals—specifically the provision of high quality, affordable preventive and curative care to all citizens. PPIPs aim to be “cost neutral” to patients, who incur the same out-of-pocket payments, usually zero or minimal, as they did in the previous dilapidated and poorly run public facilities.

The Global Health Group (GHG) at the University of California, San Francisco is serving as a clearinghouse for information on PPIPs worldwide. The GHG will evaluate PPIPs, determine promising practices that might inform governments embarking on PPIPs, disseminate lessons learned, and promote South-South learning exchanges on PPIPs.
Why Consider a Public-Private Investment Partnership (PPIP)?

Background

Government-run health systems across the developing world are in disrepair, with poor quality services provided in dilapidated facilities. For example, a typical district hospital is rundown, lacking reliable water, sanitation, or electricity, with absent or broken equipment, inadequate supply chains for essential commodities, chronic staff shortages, low service quality, and poor clinical outcomes. Such secondary hospitals, and the rest of the health system of which they form a part, suffer from poor management and a lack of sustainable and sufficient finance.

The inadequate health infrastructure in developing countries is of serious concern

- Developing countries face a growing burden of chronic diseases in addition to their ongoing struggle against AIDS, TB, malaria, diarrhea, and other infectious diseases;
- Governments lack the resources to maintain and expand infrastructure commensurate with need;
- The skills required to deliver health services efficiently exist in most countries, but often are concentrated in the private sector and underutilized by governments;
- Governments lack the experience and technical knowledge to effectively leverage existing private providers.

What PPIPs Offer

PPIPs are a novel way for resource-constrained governments in developing countries to simultaneously improve health infrastructure and healthcare service provision, while creating a platform for addressing other system-wide inefficiencies. The PPIP model delivers a “complete bundle” of services, while simultaneously providing a vehicle for local economic empowerment.
Defining PPIPs

**PPIPs Are**

A Design, Build, Operate, and Deliver (DBOD) Model
The private partners design, co-finance, build, and operate one or more health facilities, often including a tertiary hospital and surrounding primary and secondary clinics. Unlike other PPPs, PPIPs go beyond private investment in buildings and maintenance. The private partners are also responsible for delivering all clinical and non-clinical services at the facilities, from surgery to immunization to ambulances.

**Government Ownership of Assets**
The healthcare facility is owned by the government during all phases of the contract. PPIPs are carefully designed vehicles for achieving public healthcare policy goals and do not relinquish control or ownership to the private sector.

**Long-Term, Shared Investment**
A PPIP is a long-term commitment by both the government and the private partners to provide health services for a defined population. Both partners invest significant resources into the project, ensuring long-term dedication and a common interest in successful outcomes.

**Risk Transfer**
Under the DBOD model, the private partners, not the government, are responsible for meeting stringent service quality benchmarks. In addition, the private partners assume risk for delays and cost overruns in the construction phase, for human resource issues, and for failure to achieve efficiency in service delivery.

**PPIPs Are Not**

Private Finance Initiatives (PFIs)
Inclusion of clinical service provision is central to the PPIP model. PFIs are limited to construction and/or maintenance of facilities and therefore do not meet this criterion.

Privatization
Ownership of all the facilities within a PPIP remains with the government.

Contracting Out
As co-investors with an equity stake in the success of the PPIP, the private partners are not merely contractors providing outsourced services.
PPIPs Seek to Achieve

**Cost Neutrality**
By design, patients utilizing a new PPIP healthcare facility experience no change in out-of-pocket payments at the point of care. In some cases, the PPIP may also be cost neutral to the government, ensuring its annual expenditure for the new PPIP facilities and services is equal to historical expenditures. These instances can be referred to as “cost neutrality squared,” or “(cost neutrality)^2.”

**Equity of Access**
New PPIP facilities are open to all, regardless of a patient’s income or social status. Equity of access is especially critical for poor or disenfranchised populations who may not have had access to quality healthcare services prior to the PPIP.

**Quality of Care**
The purpose of PPIPs is to serve the government’s public policy goals, both for better access, and for improved quality of care for everyone, including the poorest and the most marginalized.

**Predictable Government Health Expenditures**
Fixed payments and capped overall project costs add predictability for government budgeting. Inclusion of facilities maintenance, equipment replacement, and staffing and technology forecasting in program contracts, promotes stability in national health expenditures.

**System-Wide Efficiency Gains**
New PPIP facilities are designed to operate within, and improve, existing systems. Due to the use of stringent performance indicators and performance monitoring schemes, PPIPs strive to set high and transparent standards for service delivery and outcomes, thus raising the bar for the entire national healthcare system.
Critical Success Factors

Political Will
In a PPIP, the government takes on the role of business partner, contract manager, and informed purchaser, while remaining responsible for leadership, regulation, and monitoring. Governments must have or commit to acquiring these skills. Governments must also ensure the support of the community being served. Leadership is critical.

Commitment from the Private Sector
Though a profit incentive exists for the private sector, commitment to serving its clients, both government and patients, must be of foremost importance.

Ensuring Trust Between Sectors
Long-standing ideologies often hinder collaborations between the public and private sectors. PPIPs can draw on mechanisms to overcome challenges to effective collaboration including: an open tender process, third-party facilitators, continuous open dialogue, and increased transparency by all parties.

Long-Term Investment
A successful PPIP must exist for a decade or more to give both partners sufficient time to develop sustainable system-wide processes and infrastructure. Long-term contracts also allow for more informed strategic planning, and improved feedback loops.

Independent Monitoring and Evaluation
An independent private or public agency, responsible to the government but commanding the respect and trust of both public and private partners, must be established to collect and validate performance data, ensure all contractual obligations are met, and administer or arbitrate financial rewards and penalties. This agency can also play an important role in maintaining public confidence in the new PPIP arrangements and in ensuring appropriate learning and course corrections as the partnership evolves.
The PPIP Model

A Promising Model

Under the PPIP model, the private sector finances and constructs healthcare infrastructure, and manages and maintains that infrastructure throughout a specified, renewable contract period. In addition, the private sector is responsible for the delivery of all health services—curative, preventive, and diagnostic—that take place in the newly built or renovated facilities, as well as non-clinical support services—such as medical transport, human resources, and facilities management. The private partner often forms a consortium and may sub-contract some of these services.

Capital costs are repaid by the government to the private consortium with interest over a predefined period. Ongoing service delivery costs are paid by the government to the private providers either on an agreed yearly capitated rate per covered citizen, or as a negotiated sum for contracted services for a pre-determined number of patients. Payment for service provision can also be transferred to a mandatory social health insurance entity, if one has been created.

PPIPs represent a Design, Build, Operate, and Deliver (DBOD) model, not a traditional Build, Operate, and Transfer model. Throughout the contract period, the ownership of the assets remains with the government, and at no point does the private sector own the healthcare facilities. The PPIP model allows governments to construct new, state-of-the-art healthcare facilities by spreading the costs of construction over time, while concurrently increasing access to high quality health services for all citizens, and ensuring that the improved services are cost neutral for patients.

A number of PPIPs employ national or foreign hospital accreditation agencies to undertake periodic comprehensive reviews, and ensure that international quality benchmarks are achieved.
Global Scope

The PPIP model is gaining acceptance and popularity. PPIPs currently exist, or are being established, in Australia, Canada, Lesotho, Portugal, South Africa, Spain, and the Turks and Caicos Islands. There is a growing demand for improved learning, experience sharing, and evaluation in the PPIP domain, and a number of governments are seeking technical assistance to establish PPIPs.

Three Flagship Examples

The following PPIPs show the range of possibilities for this model. The GHG has identified three flagship PPIPs, one in a low-income country: Lesotho; one in a middle-income country: Turks and Caicos Islands; and one in a high-income country: Spain.
For the first time in a developing country, a private consortium, Tšepong (Pty) Limited, led by the South African healthcare group Netcare, will co-finance, build, and operate multiple public health facilities, and will deliver all clinical and non-clinical services. In October 2008, the Lesotho Ministry of Finance and Development Planning awarded Tšepong the contract to replace Lesotho’s National Referral Hospital and only tertiary facility—the Queen Elizabeth II Hospital, now 100 years old and in poor repair. Tšepong is contracted to:

- Design, build, and operate a new 425-bed public hospital and adjacent gateway clinic;
- Renovate three strategically located urban filter clinics;
- Deliver all clinical and non-clinical services in these facilities for 18 years.

The carefully conceived PPIP arrangement has far-reaching implications for Lesotho’s entire health system. The Tšepong consortium includes small, local, and women-owned businesses as major stakeholders. Tšepong has agreed to provide a comprehensive benefit package to 310,000 out-patients and 20,000 inpatients per year for a negotiated price to the Government. The PPIP design includes a cap on the private consortium’s profit and provisions to:

- Implement penalty deductions based on an extensive performance monitoring scheme;
- In an agreement with the National Health Training College, utilize the new hospital as a training resource for all health sector employees nationwide;
- Strengthen the existing national drug-supply system to better support all facilities nationwide.

The project’s capital costs, which include the design, construction, and equipping of the new hospital, are estimated at $120 million. The Government’s capital contribution will represent approximately 36% of the total costs; the other 64% will be privately financed by the Development Bank of Southern Africa and Tšepong. Following construction, the Government’s ongoing payment for service delivery and operation of the new facilities is fixed at an amount equal to the current operating costs of the same facilities. Similarly, patients themselves will face the same minimal out-of-pocket payments at the new facilities that they currently face at the dilapidated existing ones. Thus, (cost neutrality)$^2$ is expected to be achieved.

An independent certifier, PD Naidoo and Associates, appointed by the Government and Tšepong, will conduct regular reviews during the 24-month construction phase and will perform a final certification inspection to ensure that the construction and equipment comply with standards. Oversight of service quality is provided by Turner and Townsend, a Government-appointed independent monitor, who will also administer the financial penalties resulting from any failure to meet the predefined performance standards. In addition, the Council for Health Service Accreditation of Southern Africa will provide periodic comprehensive accreditation reviews. Loss of accreditation will provide grounds for termination of the contract between the Lesotho Government and Tšepong.
In 2005, the Government of the Turks and Caicos Islands (TCI) realized that referrals outside of the Islands for medical care were contributing an additional 40% to the country’s health budget and, with an annual growth rate of over 20%, could eventually bankrupt the small but growing economy. A major reform of the entire health system was needed, starting with new infrastructure and health services that could meet the demands of the growing population; and a new financing mechanism to ensure long-term financial sustainability. The Government decided to completely revamp its health services through a PPIP arrangement that would bring state-of-the-art facilities to the Islands, and provide healthcare at international standards.

In 2008, the TCI Government finalized a 25-year contract with Interhealth Canada Ltd. (ICL) to build two new hospitals in TCI and deliver healthcare services that will be accredited by Accreditation Canada. The PPIP serves as the foundation for a major restructuring of TCI’s health system, providing:

- An integrated delivery system on the Islands that can manage the growing burden of chronic disease in the population. The clinical payment to ICL is through a full capitation that provides incentives to keep people healthy and out of the hospitals;
- A national health insurance plan, modeled on social insurance principles, that allows equal access for all residents to the new health facilities and reduces out-of-pocket costs;
- The establishment of a Health Regulatory Authority to monitor and regulate quality and access for the health sector.

The project creates two subsidiaries of ICL: Interhealth Canada Infrastructure Ltd. and Interhealth Canada Clinical Services Ltd. The former will design, build, equip, and manage two new medical facilities. These are:

- A 40-bed facility on Providenciales;
- A 20-bed facility on Grand Turk.

Interhealth Canada Clinical Services Ltd. will be responsible for the delivery all health services at these facilities, including comprehensive primary, secondary, lower tertiary, and emergency care. The clinical services specifications include a comprehensive list of key performance indicators based on international standards, with payment subject to deductions for non-compliance. It further requires that maintaining accreditation by Accreditation Canada is a prerequisite for payment, and loss of accreditation would allow the TCI Government to terminate the agreement.

The capital costs for the hospital, which include procurement, financing, design, and construction costs, are estimated at $124 million. ICL is responsible for financing the complete project costs and bears risk for all financial outlays throughout the design and build phases. The Government’s payments for the Design-Build-Operate portion of the contract start only when the hospitals are completed in early 2010. For clinical services, the payments start only when the hospitals begin delivering services in spring 2010.

Because of TCI’s large and rising overseas treatment costs, which will greatly decrease as services are provided on the islands, the new health system is expected to reduce Government health expenditures. All those who live and work in TCI will receive better access to higher quality services, with lower out-of-pocket payments. Thus, in TCI, (cost neutrality) is expected to be exceeded.
Footnotes:

- Interhealth Canada Clinical Services (TCI) Ltd. – Interhealth Canada Ltd. subsidiary responsible for providing clinical services, maintaining equipment, and supplying information technology and management.
- Interhealth Canada Infrastructure (TCI) Ltd. – Interhealth Canada Ltd. subsidiary responsible for designing and building hospitals, initial equipment purchase, and facilities management.
In 1997, the Regional Government of Valencia selected the Alzira Health District for the first PPIP in Spain. The PPIP arrangement, also called the “Alzira model,” is based on a strategic partnership between the Government of Valencia and Union of Temporary Businesses (UTE) Ribera, a private consortium comprising Adeslas (a private health insurance company), Ribera Health (a conglomeration of Bancaja and CAM banks), and Dragados and Lubasa (construction companies). The Government of Valencia granted UTE Ribera a 15-year (extendable to 20 years) “management concession” to provide a health system for Alzira integrated with the existing National Health System. UTE Ribera is contracted to:

- **Design and Build** a technologically advanced 300-bed University Hospital—Hospital de La Ribera—and **operate** the district health network consisting of Hospital de La Ribera, 4 integrated health centers and 46 primary health centers;
- **Deliver** clinical and non-clinical services for the 250,000 residents of Alzira district and for any out-of-district patients.

Under the contract, the Government of Valencia pays UTE Ribera an **annual capitated rate** for each Alzira resident. The rate is adjusted yearly based on the Consumer Price Index and the Valencia Health Ministry’s budget.

The Alzira model also pioneered cross billing between the Valencia Health Ministry and UTE Ribera. This arrangement, in which “money follows the patient,” requires UTE Ribera to pay the Valencia Health Ministry 100% of the costs of the treatment of Alzira residents in other districts. The Valencia Health Ministry pays UTE Ribera 85% of the costs of the treatment of non-Alzira residents in the Alzira district. This arrangement ensures that: patients have the freedom to choose providers; the provider rendering the health services is appropriately compensated; there is genuine competition between the private provider in Alzira and public providers in neighboring districts; and a strong financial incentive exists for UTE Ribera to provide such high quality services that Alzira residents will not seek care elsewhere.

Hospital de La Ribera has now been in operation for a decade and has improved accessibility and quality of care, while remaining cost neutral for patients and the Government. For patients, **health services are free** as they previously were, and for the Government, healthcare costs per capita are at least 25% lower than in other areas. Thus, **(cost neutrality)** is exceeded. The hospital has fulfilled the patients’ need for quality healthcare by achieving an 87% satisfaction rate, and by consistently falling among Spain’s top 20 hospitals. Waiting times are greatly reduced and performance indicators surpassed. Staff are better compensated than previously.

The carefully designed PPIP includes numerous provisions such as:

- **A 7.5% cap on UTE Ribera’s profits**;
- **A pharmacy incentive** under which, if UTE Ribera’s outpatient pharmacy costs are lower than the Valencia average, the savings are shared between the Government of Valencia (70%) and UTE Ribera (30%);
- **Frequent audits** by the Government and external auditors;
- **Strict oversight and monitoring** by the Government Commissioner stationed at Hospital de La Ribera.

The positive experience at Alzira has led to the establishment of new PPIPs in four other health districts in Valencia. Additionally, the Regional Government of Madrid is now embarking on a similar model.
Valencia Government

Capitated Payment
PPIP Agreement

Govt. Commissioner
Monitor and Auditor

Oversight
Reporting

UTE Ribera
Investor / Holding Company

- Adeslas – 51%
- Ribera Health (Bancaja, CAM) – 45%
- Dragados – 2%
- Lubasa – 2%

UTE Ribera
Facilities Manager, Service Provider

Payment

1 University Hospital

Facilities Mgmt & Clinical Services

4 Integrated Health Centers

46 Primary Health Centers

Clinical Services

Patients

Dragados, Lubasa
Construction Contractor

Payment

Construction

Footnotes:
- Adeslas – Spanish insurance company (Group Agbar);
- Ribera Health – Bancaja and CAM banks are equal partners in this investment company;
- Dragados – construction company;
- Lubasa – construction company.
The Role of the Global Health Group

The GHG as PPIP Evaluator

PPIPs are at a “tipping point” and, if successful, have the ability to bring transformational improvement to health systems in a variety of settings worldwide. Given their potential and inherent complexity, the GHG holds that studying PPIPs at this early stage is vital. The GHG is therefore working as an independent evaluator to better understand the model and more effectively inform future replications.

The GHG is gathering information on past, present, and future PPIPs to identify promising practices and critical challenges, and ultimately to determine a system of metrics against which PPIPs can be evaluated. The GHG will facilitate the dissemination of the evidence and information on PPIPs through publications, the GHG website, and learning conferences.

Ensuring Evidence-Based Decision Making

Establishing a Knowledge Base: The GHG is the first objective entity to collect quantitative and qualitative data on PPIPs around the world.

Determining Evaluation Metrics: The GHG is developing metrics to allow for objective judgements on the success of PPIPs and standardized comparisons among PPIPs.

Designing for Success: The GHG is seeking to understand the critical success factors in PPIP design and operation.

Documenting Case Studies: At the request of many Ministries of Health and Finance, the GHG is producing a standardized atlas of PPIP case studies for health leaders and policy makers.

Catalyzing PPIPs

South-South Exchanges

The GHG supports regional efforts that bring together leaders from the private and public sectors to support the development of future PPIPs in developing countries.

Technical Assistance

The GHG is being asked to share findings with Ministries of Health and Finance around the world, including lessons learned from the design, implementation, and post-implementation phases of PPIPs.
The GHG PPIP Leadership Activities

Learning Conferences

Public-Private Investment Partnerships in Health Systems Strengthening; Wilton Park, UK, April 2008
This landmark conference convened 60 representatives from developing country governments, the private healthcare and finance sectors, academia, and international agencies to discuss the role of PPIPs in strengthening health infrastructure and service provision in developing countries.

The GHG co-hosted this learning conference with the Zambian Ministry of Health and Standard Chartered Bank, to stimulate significant cross-sector dialogue amongst key stakeholders representing the lead public and private institutions for health in Zambia.

Opportunities to Strengthen Healthcare Services in South Africa; Johannesburg, South Africa, October 2008
The GHG initiated and participated in this workshop, convened by the South African National Treasury and Ministry of Health, to encourage district health leaders to share examples of existing PPIPs with one another, and with the National Ministry of Health. This conference has lead to the documentation of previously isolated, unreported South African experiences.

Enhancing Health Systems through Public-Private Investment Partnerships: Lessons Learned from Lesotho; Maseru, Lesotho, March 2009
The GHG joined the Lesotho Ministry of Finance and Development Planning, and the Lesotho Ministry of Health and Social Welfare, to co-host this regional meeting to share Lesotho’s pioneering experience with Ministers of Health and Finance from seven neighboring countries.

Participants at Lesotho PPIP meeting, March 2009
The Global Health Group Acknowledges the Following Information Sources

In Lesotho
The Government of Lesotho
Netcare Group
International Finance Corporation

In Turks and Caicos Islands
The Healthcare Redesign Group (http://www.hcredesign.com)
PricewaterhouseCoopers
Interhealth Canada

In Spain
Agencia Valenciana de Salut
Generalitat Valenciana
Hospital de La Ribera (http://www.hospital-ribera.com)

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Page 19 architectural drawing: National Hospital, the Turks and Caicos Islands, Courtesy of PM Group
Page 19 photo: Hospital de La Ribera, Valenica, Spain, Daniel G., Courtesy of Wikimedia Commons
Forthcoming Publications

PPIP Atlas: The GHG is documenting existing PPIPs worldwide to inform policy makers and the global health community about the promising practices and potential challenges of the PPIP model.

About the Global Health Group

The Global Health Group (GHG) is an “action tank” based at the University of California San Francisco Global Health Sciences, founded by Sir Richard Feachem in 2007. As part of its Health Systems Initiative, the GHG provides intellectual and practical leadership and guidance, for leaders in both the public and private sectors, concerning improved and expanded roles for the private sector in health systems strengthening in developing countries.

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