Public-Private Partnerships in Infrastructures Projects in Health Sector

First and Second Generation Hospitals: The Portuguese Case

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Keywords

PPP
Health Sector
Hospital
Market Access
Risk Sharing
Contract Management
Portugal

ABSTRACT

The Portuguese health sector has suffered deep modifications since the beginning of the Portuguese National Health System, with a tendency to change the Portuguese Government's role from the provider to the regulator of services. This change in the Government's role led to an increase in the private sector's protagonism in this sector. In the last few years, private sector participation has used Public-Private Partnerships (PPP) arrangements, specially regarding the construction of new hospital units. These partnerships employ two different models. One model includes, under private sphere, clinical services and in the second model these services are operated by the Government. The goal of this thesis is to analyse the contractual models used, concluding about the advantages and disadvantages of each model, and compare the contracts already celebrated with the best practices guidelines. Although no model is clearly superior, the understanding of each model's characteristics and peculiarities may help in the decision of the best partnership profile for the development of new hospitals, resulting in a more efficient contractual process.

1. Introduction

In line with most European countries, the costs of the Portuguese National Health System have reached unsustainable levels, often without the corresponding increase in quality of the services provided. Thus, with unsustainable levels of public deficit, there has been a change in Government’s role, from provider to regulator of health care services, with private sector taking on this role, supported by its recognized best management capacity [1]. Nonetheless, the State has sought innovative models of public health management, which started as “enterprise hospitals”, and resulted in PPP arrangements use as one of the key drivers of obtaining better value for money public investment [2]. In Portugal there are two models for PPP arrangements in the development of new hospitals. The differences reside whether the clinical services are under private sphere or not. This study aims to examine the difference of the two models, concluding about the advantages and disadvantages of each model and comparing them with the best practices international guidelines. It also intends to study the international PPP experience for better understanding of the use of this contractual model.
2. Portuguese Health Sector

2.1. Hospital management models evolution

In 1977 the hospitals were endowed with administrative and financial autonomy, ripping with the conventional sector of the state. Few exceptions have been allowed since then, with the Hospital of S. Sebastião in Santa Maria da Feira (DL n. 129, of 2 April) being the first experience of public health institute with enterprise profile [3]. Other experiments followed up and in the second half of the nineties a series of innovative health management experiences begun with the concession of the management of the Hospital Fernando Fonseca in 1995 [1].

In the year of 2002, a new legal framework of hospital management was approved (Law n. 27/2002, of 8 November), which aimed the “corporatization” of hospitals (SA Hospitals), implementing a new management, contracting and financing model of health care services [3]. These SA Hospitals were poorly received by the population because they were seen as the first step toward privatization of health. However, according to the Court of Auditors [4], the level of overall quality was high and did not identify any evidence of a lower equity in access.

The profile of hospital was modified in 2005, from SA Hospitals to EPE Hospitals (Public Enterprise Entity), with the objective of providing better control of hospitals activities [3] and to strengthen unequivocal public identity of State units providing health care services [1].

In recent years, new structural forms of public health agencies are being tested as a way to address some of the weaknesses of the NHS. The PPP in health arise first in the early eighties, in the United Kingdom, later spreading to other countries. This contractual model, particularly in hospital development, sprang from an idea that the hospital network of NHS could be renewed more quickly and with lower costs with private sector investment [5]. In Portugal, this contractual form also began to be used due to budgetary restrictions, as it allowed financial relief at the time of the investment. Indeed, the use of private investment through PPP arrangement introduces a budgetary flexibility with a contra flow of future payments [6].

These reforms of hospital “corporatization” were set to approach public health management procedures to private sector’s efficiency, introduce financial incentives and create a wider distance from political power [3].

3. Portuguese PPP Hospitals

3.1. Overview

The first important step in implementing the use of PPP arrangement in health sector was the constitution, in 2001, of EMPS – Estrutura de Missão Parcerias na Saúde, which aims to promote new partnerships. Later this year, the government announced a set of new hospitals in PPP, which resulted in a first (Hospitals of Cascais, Braga, Loures e Vila Franca de Xira) and in a second wave (Hospitals of Todos os Santos (Lisboa Oriental), Margem Sul do Tejo Évora, Vila Nova de Gaia and Póvoa do Varzim/Vila do Conde). In the launch procedure of PPP arrangement there are a group of entities
involved (Interdepartamental Coordination Group), from which it is highlighted the EMPS (Public Contractor) and Central and Regional Health administrations.

Currently there are only three first generation hospitals operating, which results of a tender stage with extremely significant delays. A set of circumstance that justify these delays were identified, which result mainly from the lack of know-how and preparation of Government, leading this process in a way too similar to traditional public contracting. Another fundamental aspect is related with the lack of Government’s resources, including human which lacked the means required to drive the several processes underway [7].

3.2. First generation hospitals

For these first generation hospitals, the Portuguese Government used a DBFOT model (Design, Build, Finance, Operate, Transfer) [7], with the private partner also assuming the responsibility of providing the medical care. Therefore, two contracts were celebrated, one regarding the hospital unit (building and operation e maintenance (O&M)), and the other concerning the provision of medical care. This resulted in the constitution of two separated legal entities, with different contracts length. The first entity was linked with a contract of thirty years, and the second with a contract of ten years, with the possibility of renewal up to thirty years. This renewal possibility was defined to allow a stronger relationship between both entities. The soft facilities management, such as laundry, catering, cleaning and other is responsibility of the entity that provides the medical care.

The first wave of PPP hospitals followed the standard procedure (Announcement, Public Act, Qualification, Proposals selection, Negotiation, Adjudication and contract closure). Regarding the bidders qualification, there was a careful choice of criteria selection, with a broad scope, to ensure that the private partner has the necessary skills to complete the entire life cycle of the project, with the levels intended. However the procedure used proved to be unsuitable for a PPP, with the lack of requirements quantification resulting into excessive expenditure of resources and time in the analysis of non-user friendly documents by the Government [7].

The Proposal Evaluation phase was the most problematic of all the procurement process, not only the tender of Loures Hospital was canceled due to the impossibility of comparing proposals as it was also the most time-consuming phase, contrary to the predictions of Government [7]. Figure 1 shows the evaluation criteria used.

![Figure 1 - Proposal Valuation Criteria: 1st Generation Hospitals](image)

The set of issues reported have resulted in an average delay time of 224%, which emphasises the lack of preparation and know-how of the public sector in the process development.
Risk sharing is a key element to the success of a partnership [8], where each stage of risk management should be enforced with the utmost rigor (Erro! A origem da referência não foi encontrada.).

In general, there was a satisfactory allocation of risks, as they were retained by the party in best position to control them. Typically the private partner bears the risk of execution (design, construction, operating and maintenance) and the Government’s role is to control the compliance of the management contract. In his type of contract, the evaluation of clinical services is highly complex, as there is no obvious method of its assessing (Figure 3).

The solution achieved was the application of penalties in case of non-performance of the private partner achieving the quality levels contracted. The clinical services provided above the contracted value are transferred to public responsibility, as it support the costs of transferring the patients to another public health facility.

The performance of the private partner is assessed through a monitoring system, which has to be able to allow efficient monitoring by the Government. The remuneration of private entities is linked to its performance through a mechanism that quantifies the deductions defined in the management contract.

The proposal evaluation phase was, as already mentioned, the most problematic phase, but there are other reasons that justify the huge delay in the tender process. In the figure below (Figure 4) it is presented a short summary of the main reasons responsible for these delays.
3.2. Second generation hospitals

The bailout of Portugal introduced severe restrictions on public debt by Troika [9], which led to a stand by status of the second wave PPP hospitals. Nevertheless, the model of this partnership was analysed, in the way it was initially launched.

At request of the Government, the Management School of Porto (EGP) prepared a study [10] with the objective to create a ranking of importance for the second wave of PPP hospitals. The result of this study showed that Todos os Santos Hospital was the most important of that group. In fact, the development of this hospital allows an increased efficiency of medical care in the region of Lisbon, resulting in a significant reduction of costs, reason why, at the time of this study, Troika authorized its development.

The second wave of hospitals was launched according to the alternative procedure, predicted by the existing legal framework, in which there is a pre-qualification of bidders to be selected to the Proposal Evaluation phase. This procedure was carried out in an efficient manner, with the supporting documents to be ordered in standard documents. This fact allowed the Government to focus on the evaluation of essential parameters and not spend unnecessary resources on document filtering.

In the Proposal Evaluation phase, there was an effort by the public side in the design of a proper quantified criteria (Figure 5), making the process faster and more transparent. In fact, after the
experience of the first wave, the Government focused the evaluation process in quantified criteria, resulting in a significant increase of efficiency.

Figure 5 - Proposal Valuation Criteria: 2nd Generation Hospitals

In this type of partnership, there are some risks that should be taken into special consideration. In the design phase, the final solution presented by the private partner may not fit the appropriate needs of the operational requisites of a hospital. In fact, as the clinical provider is not in the same sphere of the architectural team, there are some special features of a hospital functionality that may not be considered. Therefore, the qualification criteria included the demand of experience of the main architect in the design of, at least, one hospital. Information sessions should be promoted so that the Government may communicate all the necessary recommendations and features [11].

The Steering Committee (Comissão de Coordenação) is the element that works actively in conflict situation, regarding all the activities that take place in a hospital, public and private provided, and it comprises members of Government, private partner and Hospital Administration.

In both partnership models there was a lack of contractual definitions regarding future renegotiations, which may have significant implications in the financial re-equilibrium. If such situation occurs, the result may be too over-costly for the public sector, as a result of there being no protection on the management contract. A PPP is not, per definition, a closed contract [12], so it must try to anticipate as much conflict situations as possible.

4. PPP International Experience

4.1. Spain

Similarly to the Portuguese case, Spain used two types of PPP models, with and without clinical services provided by private companies. The Alzira model is the best know-case (applied in 1999 to a hospital in Valencia region) where non-primary clinical services were assigned to private companies. This contract established payment according to the number of patients cared for, without a maximum limit [6]. The duration stipulated for the contract was 10 years, renewable up to 15. However, in 2003 there was a breach of contract, due to the project's financial viability, in particular the inability to disaggregate the costs of primary and secondary health-care services [13]. In a controversial process, a new contract, which included primary and secondary health-care services, was awarded to the private sector [14].
After this first experiment, new developments were initiated, particularly in the autonomous region of Madrid, with the construction of eight new hospitals. In this region, as in most cases in Spain, the adopted model covers the financing, design, construction and maintenance of hospital infrastructure management services covering hard and soft facilities. Nevertheless, the public sector remains responsible for the provision of health-care services [14].

4.2. United Kingdom

In the year 2000 Partnerships UK (PUK) was created with the objective of helping the UK Government in the difficult and innovative process of PPP [17]. The most used PPF/PFI model in the United Kingdom is DBFO (Design, Build, Finance, Operate), however in the health sector two models coexist simultaneously: DBFO applied to the hospital subsector for construction / modernization of large hospital infrastructures and model LIFT (Local Improvement Finance Trust) for the sub-sector of local primary health-care sites [1] [4]. The decision between using each of the models is based on value-for-money analysis. Due to high transmission costs in DBFO model, for small dimension projects, this model is not the most viable option [16].

The DBFO model is characterized by a unique partnership with a private partner, to provide goods and services regarding physical infrastructure, equipment and related services and the possibility of services that support the delivery of clinical services. The public partner is responsible for compensating the private partner, through a single and regular payment, during the contract period in which investment in infrastructure and respective maintenance and support services are contemplated [17]. The hospital support services, provided by the private sector, are usually referred to as hard and soft facility management (HFM / SFM). Regarding clinical services, these are not the responsibility of the private sector since the position of the Ministry of Health in the UK is quite clear in stating that the provision of clinical services remains the responsibility of the National Health Service [17].

4.3. Canada

The use of PPP is not uniform across Canada with some states using this type of contract more than others. For example, the states British Columbia, Ontario, Alberta and Quebec employ PPP as a pretext to achieve better value-for-money of public investment.

In order to encourage its use, the Federal Government implemented a program of financial incentives, however it is not yet certain the level of success this initiative achieved. The first experiences of PPPs did not use a standard model, in fact differences were observed in the approach method, with particular regard to the procedure and analysis of VFM, among others. It was identified that structures less able to deal with PPP contracts require more help and intervention and that the period of negotiations dragged on when compared with other structures better equipped to cope with these processes. Therefore there was a need to adapt the type of support provided by PPP Canada [17].
4.4. Australia

In 2000 there was a change of mentality in the use of PPPs, from an almost exclusively financial doctrine, with the goal of maximum reduction of costs and risks for the public sector, to a mentality of using PPPs as a vehicle for obtaining maximum value-for-money during the entire project cycle (whole-life cost) [18]. Indeed, the state of Victoria has not only created the Partnerships Victoria in 2000 (structure responsible for the conduct of proceedings in PPP) but also introduced a number of innovative procedures that enabled increased effectiveness and efficiency, intended on protecting the public interest. These procedures include the Public Sector Comparator and the transition of the core services of medical activity, such as the provision of clinical services, to the public sector [19]. The Government of the state of Victoria also decided that the contractual model has extreme importance in the success of the project and in the decision of which process is most appropriate, whether in PPP or not [19].

5. Conclusions

Public-Private Partnerships have a negative perception by the general population, as it is seen as a non transparent way of public services being provided by the private sector, with over-costs to the Government. This thesis does not intend to examine the values of investment, but to analyse the actual contractual design used in Portuguese hospital and the considerations made.

Regarding the first wave of hospitals, several issues were detected in the tender process, which had adverse consequences for both public and private parties [7]. After this first experience, the procedure used in the second wave hospitals was design to be more quick and efficient, allowing the Public Contractor entity to focus on most important parameters. There were mechanisms of qualification and evaluation more suited to a PPP process, with effective advantages for both parties.

Optimal risk allocation seeks to minimise the risks by allocating particular risks to the party in the best position to control them. The risk allocation process was generally well interpreted by the public contractor as it respects the risk sharing principles suggested in the international best practice guidelines.

The management contracts signed were gifted with complex mechanisms, with the evaluation of the clinical services quality being the most hard to quantify. Nonetheless, the management contract is a capable instrument which provides the public contractor with capacities for an efficient control of the performance of the private partner services. Even so, it is necessary that Government has the ability to apply the fines predicted, which may not be evident, considering the actual legal process in Braga Hospital. Several fines were already applied to this unit, but the private entity refuses to be chargeable by the situations identified. At the time of this study, there are no conclusions yet, as the process is still being investigated by the national regulator of health. The evaluation of the performance of the private entity responsible for the operation and maintenance is simpler, as it is easier to quantify the quality of the service and therefore easier to control and assess.
International experience consider that better contract management improve value for money of overall services, and Government should apply more resources in this area, as they seem to be insufficient comparing to initial estimations [20].

References


