strengthening health systems through public-private partnerships

theory, evidence and lessons for developing countries

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public-private (integrated) partnerships

- operator commits to design and build facilities, and deliver a set of clinical services within them
- operator assumes financial & operational risks, and receives a financial return via a unitary fee
- payment made as, when, and to the extent that outputs specified in the contract are delivered
- payments may be subject to limited deductions if services fail to not meet contracted standards

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Public-Private Integrated Partnerships Demonstrate The Potential To Improve Health Care Access, Quality, And Efficiency

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ABSTRACT Around the world, publicly owned and run health services face challenges. In poor countries in particular, health services are characterized by such problems as inadequate infrastructure and equipment, frequent shortages of medicines and supplies, and low quality of care. Increasingly, both developed- and developing-country governments are embracing public-private partnerships to harness private financing and expertise to achieve public policy goals. An innovative form of these partnerships is the public-private integrated partnership, which goes a step further than more common hospital building and maintenance arrangements, by combining infrastructure renewal with delivery of clinical services. We describe the benefits and risks inherent in such integrated partnerships and present three case studies that demonstrate innovative design. We conclude that these partnerships have the potential to improve access, quality, and efficiency in health care.

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handshake

IFC's quarterly journal on public-private partnerships

In this issue

integrated health systems: Lesotho's pioneering model
access to healthcare for the poor: Lessons from Ghana, India, and Mexico
cost efficiency: Singapore's secret to healthcare

economic features

Social welfare gains may arise from three features:

1. ownership - operator owns right to revenues and can dispose of this to innovate and invest
2. bundling together the various production and provision phases internalises costs & benefits
3. allocation of risk is to the party best able to manage it, thus minimising its economic cost

cost of capital (equity)

- Finance theory predicts low cost of equity: determined by covariance with the market:

$$\overline{r}_i = r_f + \beta_i (r_M - r_f)$$

- In practice, corporate hurdle rates are set and include premium for specific (& country) risk

- Markets concentrated/ bidding contests ltd.

cost of capital (debt)

- Key determinant of cost: credit risk (i.e. probability of default and recovery rate)
- Post-Lehman, banks are capital-constrained; alternative lenders lack specialist HR capacity
- Capital markets in developing countries are shallow, and lending is short term and costly
- Development finance a necessary condition?

fiscal policy and incentives

- IMF performance criteria provide strong incentives for off-balance sheet financing (Irwin)
- Unusual characteristics of partnerships payment profile may create decision-making distortions
- In many cases, there has been indexation of full unitary charge – a tax on future generations?
- In LICs, discretionary portion of budget small: manipulation in projections harmful in outturn

an African case

- $120m tertiary hospital + plus gateway clinics
- 15-year contract for primary and tertiary clinical services (exc. cancer/ renal services)
- contract specifies upper demand parameter; otherwise unitary fee fixed and index-linked
- all services provided for MoH-set user fee

observations

- Contestability

In effect, one bidder – so bilateral (and exclusive) negotiation

- Contract design

Based on Europe standard – but much more ambitious scope

- Performance

High spec building to time and budget; improved clinical outcomes

- Cost of capital

Rose by 2.5% from expected to outturn; cost about 80% higher

- Contract monitoring

Outsourced to regional; no internal capacity to do monitoring

- Affordability

Missed payments; little understanding of cost dynamics

conclusions

- Where it is easy to specify, measure, and monitor services, partnerships are beneficial. But in health care this is hard
- Contracts are incomplete = service quality is at risk. Only where base provision is poor is economic case convincing
- Value for money depends on broad range of exogenous variables – e.g. market concentration/ capital constraints
- Assessing and managing fiscal risks is complex, and there may not be knowledge or incentives to do this accurately
- Technical assistance necessary, not sufficient in some LICs