



Public Private Partnerships for Health: *PPPs are Here and Growing*

MOTIVATIONS FOR HEALTH PPPS

Governments everywhere are grappling with rising healthcare costs and increased demand for healthcare services in the face of ongoing budget constraints. As governments struggle to stretch their healthcare funding and produce better results, many are increasingly turning to PPPs with the private sector. There are four key factors driving governments worldwide to use the PPP model for health sector improvements:

- Desire to improve operation of public health services and facilities and to expand access to higher quality services
- Opportunity to leverage private investment for the benefit of public services
- Desire to formalize arrangements with non-profit partners who deliver an important share of public services
- More potential partners for governments as private healthcare sector matures

The potential benefits of public funding and private delivery of health facilities and services are well-known, but the path from publicly-run hospitals to publicly-funded and privately-provided hospital services is not so well-known and can be challenging.

KEY MESSAGES

- Health PPPs are becoming more popular globally, but are not a new or just a passing fashion. Health services and facilities have been delivered under public-private collaborative arrangements in many well-performing health systems around the world for many years.
- The term PPP is widespread but often misunderstood, leading to misunderstandings amongst government, the general public and potential partners.
- This note provides a snapshot of PPPs for health, together with definitions, examples and brief case summaries selected to stimulate thought and discussion on the use of health PPPs in Africa.

DEFINING PUBLIC PRIVATE PARTNERSHIPS

The terms used to describe these PPP arrangements can vary across countries, legal systems, and disciplines – PPPs may be called “administrative concessions” in Spain, “hospital conversions” in Australia, “social organization” in Brazil and “social mobilization” in Vietnam. In Africa, there are projects for “co-location”, “public private partnerships” and “PPPs”.

What PPPs are... Initiatives that establish a contract between a public agency and a private entity (for-profit or not-for-profit) for the provision of services, facilities and/or equipment. A PPP exists when members of the public sector, such as federal, state, and/or local officials and agencies, join with

members of the private sector, for example: service providers, employers, philanthropies, media, civic groups, families and other service providers, in pursuit of a common vision and goals. In equal partnerships, all of the partners bring resources to the table, contribute to the development and implementation of the project, and benefit from its results.

What PPPs are not... PPPs do not involve divestiture or getting the public sector out of providing services. PPPs are not privatization! For example, when the Republic of Georgia decided it had too many hospitals for its needs, the master plan called for one third to remain “as is” (public infrastructure and government service provision), one third to be privatized (sold to private sector, no agreement for funding or to continue hospital

services, may be converted or knocked down); and one third PPP (contracted to private operators for delivery of hospital services

with funding from the social health insurer). Only a third of the services could therefore be considered public private partnerships.

The following table provides clear references for the types of public private partnerships seen in the health sector.

Defining Categories of Public Private Partnerships

Category	Private sector responsibility	Public sector responsibility	Examples
Public Health Services PPP	<ul style="list-style-type: none"> Manages services under contract with government or public insurance fund May provide clinical and nonclinical services May provide commodities, especially pharmaceuticals, at concessionary rates May employ staff and/or also be responsible for new capital investment, depending on contract 	<ul style="list-style-type: none"> Contracts or otherwise forms a partnership with a private sector entity for the provision of public services Pays private operator for services provided, and monitors and regulates services and contract compliance Partnership may include development partners 	<p>African Programme for Onchocerciasis Control (“Riverblindness”)</p> <p>Performance-Based Financing (PBF)</p> <p>Riders for Health (Transport)</p> <p>Food Fortification (Salt Iodization)</p>
Hospital Services PPP	<ul style="list-style-type: none"> Manages public hospital under contract with government or public insurance fund Provides clinical and nonclinical services May employ all staff and/or be responsible for new capital investment, depending on contract 	<ul style="list-style-type: none"> Contracts with private firm for provision of public hospital services Pays private operator for services provided, and monitors and regulates services and contract compliance Partnership may include development partners 	<p>Brazil: Sao Paulo Hospitals</p>
Facilities-finance PPP	<ul style="list-style-type: none"> Finances, constructs, and owns new public hospital and leases it back to government 	<ul style="list-style-type: none"> Manages hospital and makes phased lease payments to private developer 	<p>United Kingdom: Private Finance Initiative</p>
Combined Facilities and Services PPP	<ul style="list-style-type: none"> Finances, constructs, and operates new public hospital and provides nonclinical or clinical services, or both 	<ul style="list-style-type: none"> Reimburses operator for capital and recurrent costs for services provided; provides relevant public premises (e.g. land; building) 	<p>Lesotho: Queen/Mamohato Memorial Hospital and Clinics</p>
Co-location PPP	<ul style="list-style-type: none"> Operates private wing or department Fulfills agreed payment and service access conditions; appropriately maintains public land or building used 	<ul style="list-style-type: none"> Manages public hospital for public patients Manages relationship with private unit (e.g. sharing joint costs, staff, and equipment) Supervises fulfillment of patient access and other conditions 	<p>South Africa: Pelonomi & Universitas Hospitals</p>

CASES

The following two cases illustrate models of health systems strengthening through local workforce development and research. One represents an established non-governmental program with a history of growth and change, while the other presents the plan of a recently launched public-sector program with great promise for national transformation.

CASE 1: African Programme for Onchocerciasis Control (APOC: the “Riverblindness Programme”)

- 28 countries form a partnership with a pharmaceutical company (Merck) and 30+ development partners.
- Merck provides treatment free (“as much as necessary for as long as necessary”) and funds the system for delivering treatment to the countries.
- Countries allocate resources for free delivery to the population at risk, using national health systems, with additional financial support from development partners.
- People at risk receive treatment free at the point of delivery through the public community health system, and public good

accrues because areas which were previously infectious become safe for public access.

RESULTS: 95 million people a year in 28 countries receive treatment, and 25M hectares of arable land are brought back into use, enough to feed 17 million people.

CASE 2: Performance Based Financing (PBF) to Improve Health Sector Results

- PBF programs, being tested now in South Asia and Sub-Saharan Africa, provide for direct payments to health facilities contracting with government based on the quantity and quality of services delivered.
- Quality and quantity of services is generally monitored, with strict verifications procedures established.
- Participating facilities may include faith-based mission hospitals and clinics, NGOs and fully private entities.
- PBFs may include performance bonuses for reaching or surpassing specific goals, but often do not cover the full cost of services, requiring governments to assume provision of many inputs (e.g. salaries, equipment and some drugs).

RESULTS: PBF programs can deliver big improvements - in Haiti immunization rates rose from 34% (2000) to 100% (2005). In Afghanistan, contracted facilities demonstrated an 18% rise in both the quality and quantity of care in the two years under study.

CASE 3: Riders for Health (The Gambia)

- Reliable transport is one critical success factor to health care delivery, affecting many key inputs including health workers, ambulances, supply stock outs and lab services.
- The Gambia partnered with Riders for Health, a not-for-profit, to provide transport management and, eventually, full fleet management for all trucks, cars, motorcycles and ambulances.
- The contract is based on an agreed cost per kilometer, covers “last mile” space, and includes provisions for preventative maintenance and training for the 100% local staff. Contracts may also include vehicle leasing for renewal.
- Capital funding, when required, was provided through local and regional banks.

RESULTS: In the Gambia, the Ministry of Health’s partnership with Riders produced a highly reliable and cost effective national health transport network. To date, the fleet has experienced only two negligent breakdowns in over 7 million kilometers travelled. Similar pilot projects are underway in Nigeria, DRC, Zimbabwe, Lesotho, and Zambia.

CASE 4: Food Fortification (Salt Iodization)

- Food fortification can reduce potentially damaging micronutrient deficiencies. Salt iodization prevents iodine deficiency, which causes large IQ deficits among children, mental retardation, still-births and other effects.
- Successful food fortification programs depend on PPPs. Between 1993 and 2005 China increased iodized salt production from 3.3 million tons to 8 million tons per year, and today over 96% of the salt is iodized.
- Introduction of legislation in 1993, high level government commitment, and a strong partnership with the salt industry led to these dramatic results.
- Globally, over 70% of the salt is iodized and 84 million young brains are protected; but, nearly 38 million children are still born unprotected from Iodine Deficiency Disorders (IDDs), one third of them in Africa. There is also re-emergence of IDD in industrialized nations.

RESULTS: PPPs for food fortification can be a highly cost effective intervention, widely accepted by the public, private industry and civil society. Successful results, however, require an integrated, sustained program of shared responsibility that includes policies, standards and monitoring to produce effective results. Many countries in Africa like Burundi, Kenya, Lesotho, Rwanda, Swaziland and Zimbabwe have also achieved universal salt iodization using similar strategies.

CASE 5: Sao Paulo (Brazil) hospitals

- Sao Paulo State Government financed, built and equipped 16 new hospitals under traditional public works contracts.
- The state was not able to complete and operate all the hospitals, so contracted with not-for-profit hospital operators to manage the hospitals (including all clinical and non-clinical services).
- The contract obliges the operator to treat all local residents.
- The hospital operator receives global fixed budget from the Sao Paulo State Government, provided specified patient volume and quality parameters are achieved.
- Government also provides capital expenditure reimbursement, within set parameters.

RESULTS: To date, it appears that through these contracts, Government provides higher quality services for the same cost as public provision.

CASE 6: Queen 'Mamohato Memorial Hospital and Clinics PPP (Lesotho)

- The Government of Lesotho had steadily increased spending for its aging national referral hospital, Queen Elizabeth II, yet services, facilities and equipment continued to decline.
- In 2009, Government tendered for a PPP health network, fully replacing the hospital and refurbishing and expanding a network of primary care clinics to improve services to the capital city of Maseru.
- The winning bidder, Tsepong, designed and built the hospital and provides all clinical and non-clinical services. Tsepong is a consortium comprising local and regional Basotho doctors, investors and service providers, led by Netcare, a healthcare provider based in South Africa.
- The PPP agreement is very detailed, with a pre-agreed set of payments based on services and performance, including performance measures, monitoring and accreditation requirements.

RESULTS: The clinics opened in 2010 and the new Queen 'Mamohato Memorial Hospital in 2011. Facilities and service quality have dramatically improved, with neonatal mortality cut in half.

QUESTIONS TO AFRICAN MINISTERS

- What could development partners do differently to assist you in developing PPPs?
- What do you need in terms of capacity building assistance to increase your activity in health PPPs?

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