

# Public–private partnerships for health care infrastructure and services: policy considerations for middle-income countries in Europe



## WHO Barcelona Office for Health Systems Financing

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# Public–private partnerships for health care infrastructure and services: policy considerations for middle-income countries in Europe

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## Abstract

There is increasing interest in using public–private partnerships (PPPs) to mobilize funds for and enable reforms of health systems. This report provides a review of PPP models currently being used or considered in the WHO European Region. It finds that, in comparison with other models of engagement with the private sector, PPPs have led to good outcomes in terms of post-contractual cost-certainty, but also higher transaction and financing costs. Securing value for money means selecting the right projects, reflecting their degree of priority for the health system as a whole (allocative efficiency) and implementing these effectively (technical efficiency). PPPs should be used only when they represent the most cost-effective solution compared to other procurement options and where the capacities needed to plan, design, negotiate and monitor long-term and complex transactions are readily available. To minimize fiscal risks, ensure the integrity of procurement processes and safeguard the public interest, robust institutional checks and balances need to be in place.

## Keywords

PUBLIC PRIVATE PARTNERSHIPS  
PRIVATE SECTOR  
HEALTH FINANCING  
CAPITAL INVESTMENTS  
MIDDLE-INCOME COUNTRIES



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# Abbreviations

EBRD	European Bank for Reconstruction and Development
EIB	European Investment Bank
IFC	International Finance Corporation
IMF	International Monetary Fund
MES	managed equipment service
MICs	middle-income countries
PPPs	public-private partnerships

# Executive summary

Middle-income countries (MICs) in the WHO European Region face a number of common policy challenges that reduce their capacity to improve population health. Prominent among these are legacy issues that drive inefficiencies in health expenditure, including lack of capacity at primary care level, an excess of hospital and mono-profile specialist facilities, obsolescence of infrastructure, and high and rising out-of-pocket payments. Sustained investment and structural reform are required to address these challenges.

In many countries, there is a perception that public–private partnerships (PPPs) can play an important role in this regard, partly because they can create a (superficial) relaxation of the public capital budget constraint by leveraging private financing. This report aims to examine the empirical experience of PPPs in the MICs of the Region to provide governments and other health system stakeholders with evidence on which to base their policy frameworks in relation to PPPs and their role in capital investment strategies. In particular, the report is focused on three key questions.

1. What PPP models are being used or actively considered by MICs in the Region?
2. What are the costs, risks and benefits of these models?
3. What actions can governments in the Region take to optimize the use of PPPs?

In most countries of the Region, the PPP agenda is highly centralized, with policy formulation led by ministries of finance, and then – in effect – transplanted into the ministry of health, and from there to individual regional or local authorities. In many cases, this leads to a prioritization of form over function, as policy analysis begins with the assumption that PPPs will be used and proceeds to identify service areas/localities that may provide viable opportunities for them. Instead, investment decisions should come first and procurement decisions second. However, capital projects should be prioritized according to a plan for reconfiguration of the health estate by, for example, responding to a lack of capacity at primary care level and addressing excess capacity and/or fragmentation at secondary and tertiary levels.

Once a prioritization plan is in place, decisions about the mode of procurement/financing should be informed according to a clear assessment of the costs, benefits and risks associated with alternative options. As noted, PPPs are often seen as a means of mobilizing

additional capital; by utilizing private finance, they allow for the deferral of the budgetary recognition of capital expenditures, whereas, with conventional procurement (in which the construction/equipping project is tendered independently of facilities management/maintenance, services continue to be provided by the public sector, and funding for capital is provided by government through, for instance, grants or loans to public authorities involved), the up-front capital expenditures are recognized as they are incurred.

However, PPP contracts signed today will still place a significant call on public budgets tomorrow (once the associated facilities, equipment and services are established, and the bill must be paid). Consequently, their use should be informed by a clear strategic plan for the reconfiguration and modernization of the health estate (the investment decision – whether to invest or not in a given project) and identification of how to deliver this in a way that maximizes value for money and safeguards the future financial sustainability of the health system (the procurement decision – whether to use a PPP or conventional procurement, as defined above).

To address the latter question, a large evidence base exists on the use of health sector PPPs in high-income countries (notably for Australia, Canada, Italy, Portugal, Spain, the United Kingdom and the United States of America). This evidence demonstrates that:

- post-contractual cost overruns tend to be lower under the PPP route than under alternative procurement routes;
- standards of maintenance tend to be higher in PPPs, as private operators are incentivized to ensure that physical assets (buildings and equipment) are fully available and at the level of quality outlined in the contract (whereas maintenance of purely public assets tends to be neglected, especially, but not only, in periods when budget constraints are strict);
- transaction and financing costs tend to be higher – for example, the private operator's weighted average cost of capital will normally be a multiple of the interest rate on the government's debt, indicating that in financial terms, deficit financing is a lower-cost option for governments; and
- the obligations created by PPPs for the public sector and other health system stakeholders are debt-like in that they cannot legally be avoided or adjusted and can undermine the financial sustainability of health systems.

## **What PPP models are being used or are being actively considered in the MICs of the Region?**

In the health sector, PPPs involve a long-term contract between a private sector entity and a government entity for the provision of health facilities, equipment and services. In general, the contract is designed to ensure that the private entity bears significant risk and managerial responsibility, and that its remuneration is tied to its performance. These features are designed to ensure limited variation in the prices paid by public authorities and/or service users once contracts have been signed. In addition, a central characteristic of PPPs is that they bundle together a range of project functions (such as facility design, build, finance, maintenance and operation). This creates the potential for economies of scope to be realized by the private operator – assuming the original procurement process was competitive, this may reduce the prices paid by authorities and/or service users. There are different models of PPP, however, incorporating different assets, project functions and payment mechanisms, and featuring different combinations of costs, risks and benefits. This report focuses on three such models:

- **Model 1**, specialized clinical/diagnostic services PPPs, in which a public entity contracts with a private operator for delivery of specialist equipment and clinical services (such as dialysis, radiotherapy and day surgery) or diagnostic services (like laboratory services, imaging and nuclear medicine);
- **Model 2**, health facility PPPs, in which a private operator manages the design, build, financing and operation of health care facilities (such as hospitals, ambulatory care facilities, polyclinics, primary care centres and maternal and paediatric clinics) while management responsibility for clinical services remains in the public sector; and
- **Model 3**, so-called integrated PPPs, in which a private operator manages the design, build, financing and operation of health facilities (such as hospitals, ambulatory care facilities, polyclinics, primary care centres and maternal and paediatric clinics) alongside a defined range of associated clinical services.

## **What are the costs, risks and benefits of these models?**

Experience in the Region demonstrates that the three models present different combinations of costs, risks and benefits.

Model 1 can in principle enhance the scope and quality of specialist medical infrastructure, equipment and services that are available to the general population when, for instance, relevant capacity is lacking in the public sector, and cannot easily be established in the required timeframe. Safeguarding allocative efficiency, however, requires detailed assessment of the net benefits of allocating additional public funds to the service areas to be targeted, compared to alternatives. There is a danger that additional spending on relatively low-value, high-tech services will erode fiscal space for additional low-tech, high-value services (such as those relating to chronic conditions such as asthma, diabetes and hypertension) at the expense of allocative efficiency.

In terms of cost–efficiency, the opportunity costs of procurement through Model 1 PPPs should be compared to alternative procurement routes (such as direct public sector investment and service provision, or more routinized contracting arrangements administered by a social/national health insurance agency or governmental purchaser). While quantitative data are absent, interviews completed for this report suggest that Model 1 PPPs are associated with higher transaction costs and/or per capita/per session prices than these alternative forms of provisioning.

Use of Model 2 is largely driven by the superficial benefits of private financing – its apparent ability to defer and smooth out the budgetary recognition of capital costs. From a public interest point of view, however, this feature of Model 2 is undesirable: it can, for example, create perverse incentives within the public sector, in particular a willingness to overcommit future government revenues by, for instance, entering into contracts that will in the long term prove to be unaffordable for the public sector and other health system stakeholders. This may be driven by a combination of technical errors (related to the inherent difficulty of predicting the future), optimism bias (a non-deliberate tendency to underestimate costs/overestimate capacity to bear costs) or strategic misrepresentation (a deliberate effort to underestimate costs/overestimate capacity to bear costs).

Whatever the cause, the international evidence shows that the resulting underestimation of future costs or overestimation of the health authority's ability to service them has real, and sometimes severe, consequences for health systems. Yet in the absence of such behaviour by public authorities, this model can generate cost–efficiencies if the public authority:

- is able to generate strong competition in procurement;
- specifies its requirements in a clear and operationally relevant manner in the contract; and
- verifies (through monitoring of performance against the contractual provisions) that the operator is meeting these requirements in practice.

Where these things are not possible, or are not achieved, the risk transfer on which value for money depends will be undermined.

Compared to conventional public procurement, and to the standard forms of Models 1 and 2 as outlined above, PPPs of Model 3 can mobilize additional private financing for recurrent expenditures while enhancing the availability of medical equipment and clinical services to persons in the targeted populations. The costs to government (and service users) can be high, however, and both forecasting of, and budgeting for, these can be extremely challenging. As with the other PPP models, risks to affordability and value for money can be severe and difficult to mitigate via contract design. In this case, however, the risks are greater in magnitude and the potential impacts more severe due to the inherent difficulty of specifying long-term requirements for complex clinical services (and monitoring them adequately). In addition, equity of access and financial protection can be compromised when – as is being considered in some health system contexts – user fees are to be introduced as a major source of private operator revenues.

## **What actions can governments take to make the most effective use of PPPs?**

While each of the three models presents a different combination of costs, risks and benefits, certain principles of good practice apply equally to all. Specific recommendations for Member States include the following.

1. Ensure that the investment decision is separated from the procurement route decision and that these decisions are made in the right order. The investment decision comes first. It is concerned with questions such as what is needed to deliver the right combination of services (those covered in a State Guaranteed Benefit Package or similar, for instance) in the right kind of facilities (primary, secondary, or tertiary facilities)? Only once such questions are addressed can a decision be taken about the relative value for money of alternative procurement routes. The latter decision is concerned with the question: what procurement route will deliver the intended outputs with the most advantageous combination of costs, risks and benefits?
2. Incorporate in the procurement route decision an objective recognition of long-term financial costs and risks to the public sector, health systems and (where user fees are to be introduced/expanded in the post-contract arrangements) household budgets. Financial risks relate to uncertainties around what the future costs will be in real terms and the ability of the ultimate payers to afford them without detriment to their own financial position. Experience to date has demonstrated a willingness to use PPPs even in cases where the model is unlikely to deliver best value for money, and a propensity to overcommit future revenues by, for example, entering into contracts that are too costly for the public authorities and/or service users that ultimately will pay the bill. Given the tendency of public authorities to engage in forms of strategic behaviour, it is crucial that regulations governing the conduct of financial appraisals are robust and subject to independent scrutiny. For larger schemes, scrutiny should be undertaken by well resourced independent agencies, such as the supreme audit institution of the country.
3. Invest in the capacity required to define a strategic plan for the health estate in which all investment decisions are embedded. In view of the importance of recommendations 1 and 2, achieving success in capital investment programmes – including those in which PPP is implicated – requires strong capacity within government to undertake rigorous needs-based capital planning to define a strategic plan for the health estate in which all investment decisions should be embedded. These functions should not be outsourced to external agencies – they are core functions of government and are essential to the long-term technical efficiency of the health system. Nor are they well suited to so-called PPP units, which require more specialist skills, as outlined below.
4. Invest in the capacity required to deliver the strategic plan. Finally, there needs to be strong contracting capacity in government, ideally in the form of a specialist procurement unit, to support local health authorities in running competitive procurements, designing effective contracts and establishing structures to ensure assiduous monitoring of performance. Without such capacities in place, PPPs will not deliver benefits in respect of risk transfer that are sufficient to offset this

procurement model's higher transaction costs and financial costs. Such capacities should be complemented by robust institutional checks and balances to ensure transparency in decision-making, minimize fiscal risks and maintain the competitive integrity of procurement processes.





# 1. Introduction



Middle-income countries (MICs) in the WHO European Region face a number of common health system challenges. Prominent among these are infrastructure-related challenges that undermine organizational efficiency at system level, including:

- an oversupply of hospital capacity;
- an undersupply of primary care and diagnostics capacity;
- outdated facilities, technologies and ICT;
- lack of integration between primary, specialized and hospital care; and
- inefficient use of energy and inadequate waste management.

A sustained programme of capital investment is required to address these challenges. In many countries, there is a perception that public–private partnerships (PPPs) can play an important role in this regard, partly because they can create a (superficial) relaxation of the public capital budget constraint by engaging private financing. This interest is illustrated in recent legislative changes in Ukraine (Parliament of Ukraine, 2021) and Uzbekistan (Parliament of Uzbekistan, 2019) designed to enable the systematic deployment of PPPs in the health sector.

This report focuses on transaction-specific PPPs, which are distinct from other forms of public–private engagement such as those described in Box 1, and also more routinized forms of contracting (see section 3). A transaction-specific PPP involves a long-term contract between a public authority and a group of private investors, normally constituted as a special purpose vehicle. The contract sets out the terms under which the consortium will ensure the availability of health care facilities, equipment and services (clinical and/or non-clinical) to the public authority. The consortium manages the design, construction and financing of the required facilities and equipment and subsequently manages a range of services over the contractual period. In return, it receives a stream of payments from the authority, in some cases supplemented by user fees. The payment amounts are determined through:

- a competitive bidding process during the earlier phases of procurement; and
- a bilateral negotiation process during the later phases of procurement.

These payments are drawn on by the consortium to pay its costs (capital and operational costs, including profit margins), make scheduled payments of principal and interest to its lenders, and a supply a return on equity to its shareholders.

While PPPs mobilize additional (private) funds for capital investment, they therefore require a commitment of the public sector revenue budget over a long period.

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### Box 1. Placing PPPs in the broader context of private sector engagement

This report focuses on a specific form of public–private sector engagement – the transaction-specific PPP, of which there are three main models. It does not seek to cover the many other ways in which governments seek to engage private sector entities to influence their incentives and behaviours by, for instance, safeguarding/promoting population health objectives.

It is recognized by WHO that governments need to have a strong public policy framework in place to address the challenges the private sector can create and to harness the opportunities it can present. Such a framework may include:

- regulations that require private sector entities to report into the routine health information system;
- licencing to define and enforce the conditions of market entry and to ensure ongoing oversight of, and accountability for, performance; and
- strategic purchasing of private sector entities' capacities to, for example, enable specific populations to access health services outside of the public sector on a free or low-cost basis.

This report makes a number of observations about the costs, benefits and risks of transaction-specific PPPs. By no means are these observations generalizable across the other modalities of engagement. In addition, it should be noted that the specialist skills required for a government to manage the costs, benefits and risks of PPPs are different to those required for effective implementation of other market interventions, so it will rarely be the case that the PPP unit within a ministry of health or other relevant state agency is best placed entity to define/manage the wider policy framework for private sector engagement.

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As PPP contracts signed today will place a significant call on public budgets tomorrow (once related facilities, equipment and services are operational), their use should be informed by a clear strategic plan for the reconfiguration and modernization of the health estate (the investment decision – whether to invest or not in a given project) and identification of how to deliver on this in a way that maximizes value for money and safeguards the future financial sustainability of health systems (the procurement decision – whether to use a PPP or conventional procurement in which construction/equipping is tendered independently of facilities management/maintenance, services continue to be provided by the public sector and funding for capital is provided by government through, for instance, grants or loans to public authorities involved). To address this latter question, a large evidence base exists on the use of health sector PPPs in high-income countries (notably for Australia, Canada, Italy, Portugal, Spain, the United Kingdom and the United States of America) (Roehrich et al., 2014).

This evidence demonstrates that:

- post-contractual cost overruns tend to be lower under the PPP route than under alternative procurement routes;<sup>1</sup>
- standards of maintenance tend to be higher in PPPs, as private operators are incentivized to ensure that physical assets (buildings and equipment) are fully available and at the level of quality outlined in the contract (whereas maintenance of purely public assets tends to be neglected, especially, but not only, in periods when budget constraints are strict);
- transaction and financing costs tend to be higher and tend to result in considerable excess profits for private sector technical advisors and investors, meaning that in purely financial terms, deficit financing will often be a lower-cost option for governments than the cost of PPP financing (Hellowell, 2016); and
- the obligations created by PPPs for the public sector and other health system stakeholders are debt-like in that they cannot legally be avoided or adjusted and can undermine the financial sustainability of health systems.

In addition, the evidence shows how the financial sustainability of health systems can be threatened if the opportunity to mobilize private capital leads to poor investment decision-making (that is, investment of the wrong scale and/or on the wrong assets) by health authorities (Hellowell & Vecchi, 2015).

Experiences in MICs, however, are less well documented. This report seeks to address this gap. It draws on: a synthesis of theoretical and empirical research on PPPs; documents published by key policy stakeholders at national and international levels (documents in the public domain and those obtained through personal communication); and key informant interviews with experts with direct experience of working on PPPs in multiple MICs (see acknowledgements section) to identify key considerations for the use of PPPs in the Region, focusing on three research questions in particular.

1. What models are being used or are being actively considered in the MICs of Europe?
2. What balance of costs, risks and benefits is presented by these models?
3. What actions can governments in the Region take to mitigate the costs and risks of PPPs?

The report is structured accordingly, and a final section provides a summary of recommendations.

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1. Supporters of PPP sometimes imply that post-contractual cost certainty can be taken as an overall arbiter of value for money. However, this is incorrect: it is evident that a project delivered on budget (meaning costs for the public sector do not exceed those outlined in the contract) can still represent poor value for money if the authority overpaid for the risk transfer mechanisms that led to that outcome.



2. What models are being used or are being actively considered in the MICs of Europe?





PPPs share a number of common features, the defining ones being:

- the use of private financing for capital (and sometimes recurrent) expenditures;
- the bundling together of outputs and activities within the scope of a single contract between a public and private sector entity; and
- the sharing of costs, risks and benefits between the contracting parties.

In the WHO European Region, as elsewhere, PPPs have been used to address a number of objectives, including:

- the harnessing of private sector resources (such as capital, human resources and/or expertise) by the commitment of a defined public sector and/or user-fee revenue stream;
- the need to overcome constraints on public sector capital budgets and thereby enable additional expenditures on health facilities, equipment and services;
- the opportunity to leverage new construction and facilities management/maintenance skills (some of which are only found in the private sector and which may be difficult to fully leverage via public procurement) to improve the quality and efficiency of health care assets/ services; and
- the opportunity to enhance the transparency and value for money of government procurement processes.

Models of PPP differ, however, varying in terms of the scale, nature and timing of the expenditures and risks involved. Table 1 provides an overview of three PPP models that the document review and interview data demonstrate have been used in the MICs of Europe. Table 1 notes their key economic features and provides a brief summary of the key opportunities and challenges that relate to each of them. More detailed commentary on each of these models is then provided in section 3 (see below).

Table 1. Types of health sector PPPs used in MICs in the WHO European Region

Note: no quantitative data exists on the number of health sector PPPs in the Region.

Source: author's analysis, based on International Finance Corporation (2021).

PPP model	Economic features	Opportunities and challenges
<b>MODEL 1</b> Specialized clinical/ diagnostic services	The public sector identifies specialist services (such as dialysis, radiotherapy and day surgery) or diagnostic services (like laboratory services, imaging and nuclear medicine) to be provided by a private operator. The private operator finances up-front capital costs. Payment to the operator is made by government on the basis of an annual per capita or per treatment model (or a combination), and in some cases users' co-payments.	<p><b>Opportunities</b></p> <p>The model can enhance the availability of medical facilities, equipment and services for the population(s) targeted, while improving the quality of clinical services and/or the efficiency of their provision.</p> <p><b>Challenges</b></p> <p>High transaction costs and/or per capita/per session prices are probable relative to other modes of delivery, including other methods of contracting with the private sector. The model may influence and perhaps distort resource allocation priorities unless projects are selected specifically to address identified gaps in the availability of prioritized services (as defined by the essential health service package, for instance).</p>
<b>MODEL 2</b> Health facility	The private sector partner manages the design, build, financing and operation of health facilities (such as hospitals, ambulatory care facilities, polyclinics, primary care centres and maternal and paediatric clinics). Management of clinical services remains in the public sector. Contracts typically last for 30+ years and may include outsourcing of so-called soft facilities management (like catering, cleaning and laundry). Payment to the private operator is made by government, usually on the basis of a performance-adjusted availability charge. Co-payments by users for some limited costs – such as parking charges – may also be in place.	<p><b>Opportunities</b></p> <p>The model can enable access to private finance for capital expenditure, circumventing public budget constraints and enabling additional investment in the health care estate and equipment. It can also enhance the efficiency of capital procurement, with an emphasis on establishing certainty of public sector costs over the lifecycle of the assets.</p> <p><b>Challenges</b></p> <p>Substantial government capacity and a competitive market environment – one that enables a competitive procurement process – are required to secure and sustain value for money over the duration of the contract. In practice, costs can be difficult to forecast and budget for ex ante, and the opportunity to defer and smooth out the costs of capital investments presented by private finance may lead to an overcommitment of future public sector funds. As a result, there are risks to affordability ex post, such that the financial sustainability of health systems can be compromised (Hellowell &amp; Vecchi, 2015).</p>
<b>MODEL 3</b> Integrated	The private operator manages the design, build, financing and operation of health facilities (such as hospitals, ambulatory care facilities, polyclinics, primary care centres and maternal and paediatric clinics) and the full range of associated clinical services on a long-term basis, typically ranging from 10–30 years. Payment to the private operator is made by government, usually on the basis of a prospective global budget that includes the operator's cost of capital, and also co-payments by users.	<p><b>Opportunities</b></p> <p>The model can mobilize private financing for both capital expenditure and recurrent expenditure (if user fees are involved), enhance the efficiency of government procurement with an emphasis on lifecycle costs, and enhance the range and quality of medical equipment and clinical services to persons in the targeted populations.</p> <p><b>Challenges</b></p> <p>Substantial government capacity alongside a market environment that enables competitive bidding are required to secure and sustain value for money over the duration of the contract. Contracting authorities must be able to specify clinical service requirements and monitor that these are delivered in practice. Failure to do so places the quantity and quality of clinical services at risk. Market prices can be high due to a lack of qualified bidders and high transaction costs – related costs are difficult to forecast and budget. The risks to affordability – and thereby to the financial sustainability of health systems – can be high in magnitude and difficult to mitigate in practice. Equity of access and financial protection will be compromised if user fees are a major component of the private operator's revenue stream.</p>

3. What balance of costs, risks and benefits do PPPs present?



## 3.1 Model 1. Specialized clinical and diagnostic services

In this model, the private operator commits to deliver:

- a specified range of clinical and/or diagnostic facilities and/or equipment; and
- a specified range of services to a defined number of patients over a multi-year period (often 4–10 years, with longer durations for more capital-intensive contracts).

Typically, private operators assume responsibility for: renovating and/or equipping facilities; maintaining and operating equipment; procuring all medical supplies; recruiting, training and managing all staff; and treating patients. Government payments to the operator can be based on prospective global budgets, capitation payments, fixed fees-for-service or case-based payment (which may be adjusted annually). There is also, in some cases, a defined schedule of user charges.

Model 1 PPPs are in some ways similar to other contracting arrangements used by governments and other public authorities, such as social/national health insurance agencies that have included private operators in the network of providers eligible to receive pre-paid/pooled funds. There nevertheless are also important differences, summarized in Table 2, such that PPPs tend to be associated with much higher transaction costs than other forms of contracting.

Table 2. Distinguishing Model 1 PPPs from other forms of private sector contracting

Function	Routine private sector contracting	Model 1 PPP contracts
How contractors are selected	Contracts are allocated to any willing provider that meets set criteria (as defined, for example, through accreditation/empanelment/certificate of need arrangements).	Contracts are entered into with winning bidders – in principle, those that have offered the best terms (price/quality) during the competitive procurement process.
Type of competition involved	Competition takes place in the market – that is, after contractual arrangements have been established.	Competition takes place for the market – that is, before contractual arrangements have been established.
How outputs (and their range and volumes) are defined	Service volumes are defined by demand among patients within the specified group (such as residents in a defined locality enrolled in a specific insurance scheme). The range of services, quality standards and fee structure/amounts to be paid to contractors are determined at health system level.	Service volumes are determined by mechanisms set out in the contract (these may be volume-based but more often are availability-based, or a combination). The range of services, quality standards and fee structure/amounts to be paid to the contractor are specific to the transaction, and determined during the procurement process. <sup>a</sup>
Basis for payment	Money follows the patient.	Patients follow the money.
Benefits	<p>The contract can be light touch (as accreditation/empanelment criteria set minimum standards for issues such as provider competencies/equipment standards), reducing transaction costs.</p> <p>Incentives to provide high-quality care flow from financial incentives to attract and maintain patient demand, assuming that market conditions enable consumer choice/provider competition.</p>	The contractor has strong financial incentives to: deliver construction on time and in line with defined standards; and after completion/provision of the capital assets, operate them at the level of quality defined in the contract (as failure in either case may lead to delayed/reduced payments and associated financial losses).
Costs and risks	<p>A lack of detailed performance criteria and enforcement mechanisms may lead to gaps or weaknesses in the quality/quantity of service delivery.</p> <p>Performance relies on the conditions of entry and the market environment, including the robustness of the regulatory apparatus and the appropriateness of payment mechanisms and prices – where these are inadequate or ineffective, performance pressure on provider(s) is limited/inadequate, at the expense of patient care and value for money.</p>	<p>Contracts need to be lengthy and detailed, and monitoring arrangements extensive. For both reasons, transaction costs will tend to be very high. This may result in risks to value for money and affordability of contracts because of the direct burden of transaction costs and the downward pressure such costs can exert on the level of competition during the procurement process.</p> <p>Establishing comprehensive contracts is challenging. Any major gaps or limitations in contracts may compromise the contractor's incentive to perform well, at the expense of value for money for the public sector.</p>

a. Where a government or health agency has – or plans to have – a substantial programme of such contracts in place, it may attempt to reduce the transaction costs of individual contracts by standardizing such variables.

In principle, Model 1 PPPs have the potential to:

- enhance the availability of high-quality specialist medical infrastructure, equipment and services for the general population;
- improve health authorities' procurement of equipment, with an emphasis on reliability of operations, and strengthen the predictability of costs to government over the lifecycle of the assets;
- enable the development of new models of care through, for instance, hub and spoke models that improve organizational efficiency;
- allow the public sector to benefit from the skills of specialist international players, of whom there are many in key areas such as dialysis, radiotherapy and day surgery; and

- enable health authorities to attain experience and knowledge in procuring, designing and monitoring contracts for complex health services – building capacity for more institutionalized approaches to contracting and/or more complex forms of PPP contracting.

Model 1 has been used in a number of MICs over the course of the last two decades, most commonly for haemodialysis. There is good evidence from recent experiences in Kyrgyzstan, the Republic of Moldova and Romania that the model can be used to expand the availability and distribution of modern medical equipment and improve access to high-quality services for targeted populations. PPPs can also stimulate the development of a market in the private provision of clinical services that can (in the longer term) enable more service provision to occur outside of hospitals. This has been the case for haemodialysis in Romania, in which an initial programme of PPPs led to multiple short-term, and more flexible, contracts with dialysis providers that were entered into directly by the insurance fund – an experience that also seems to have been replicated in the Republic of Moldova and, most recently, in Kyrgyzstan (see Box 2).

However, evidence on value for money from a contract-specific perspective (asking whether government costs may have been lower or the quantity/quality of facilities and services higher by using other modalities) is limited and is constrained by the absence of a clear counterfactual, or clear cost benchmarking. It nonetheless is apparent that transaction costs tend to be high relative to other forms of delivery, including other types of delivery under contracts such as direct contracting of private sector dialysis providers by insurance funds or state purchasers and/or managed equipment service (MES) leases undertaken by autonomous health care providers. Indeed, in some countries, the resulting costs may be affordable only if governments are able to access external support through, for example, development partners. The transaction costs faced by private sector bidders also tend to be high, increasing bid prices and limiting the number of bids, contributing to higher contract prices and/or service fees.

In analysis of value for money, such costs need to be considered alongside any operational efficiencies that the PPP model is expected to generate.

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## Box 2. Haemodialysis PPPs in Kyrgyzstan

Legislation to regulate the use of PPPs in the health sector was enacted in Kyrgyzstan in 2013. From that year, the Ministry of Health worked with development partners to prepare feasibility studies for a project to deliver haemodialysis capacity in the country. Initially, the level of interest from international market players was considerable, with expressions of interest from companies headquartered in 12 different countries, but several companies withdrew over the course of the procurement process, reducing the degree of competitive pressure. The Government eventually prequalified two bidders, both of which submitted a bid. The project was awarded to Fresenius, a German company. Fresenius signed a 10-year contract to finance, lease and operate four haemodialysis centres offering a minimum of 75 000 dialysis sessions, train health professionals from several public centres and develop home-based peritoneal dialysis services. As of April 2022, this contract was still in place, though the price per session (approximately US\$ 100) is now viewed by the Ministry as higher than current market rates.

Reflecting on the transaction and operational costs of the PPP, policy-makers have opted to diversify their approach to private sector engagement in future, including in the form of direct contracting by the Mandatory Health Insurance Fund with haemodialysis providers on the basis of one-year contracts. These contracts are regarded as having a number of advantages over PPPs, including shorter procurement periods, greater flexibility in service provision and lower contract periods and costs. This experience helps to demonstrate that where a mandatory health insurance fund exists and is capable of acting as a strong strategic purchaser, alternatives to PPPs can be found. In some cases, these alternatives represent a more affordable solution or better value for money, taking into account the up-front transaction costs and the long-term costs to government.

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In addition to matters of transaction costs, finance costs and per capita/per treatment costs, it is important to consider the broader issue of allocative efficiency, which refers to whether the right services are likely to be purchased through Model 1. It is important that services are selected according to their degree of priority for the health system as a whole as reflected in, for example, the package of essential services covered by the national health insurance scheme rather than their amenability to be provided under a particular modality. It is apparent that services such as dialysis, radiotherapy and day surgery can be delivered under Model 1, but further case-specific analysis is needed to consider whether they should be. Analysis should consider the need for developing additional capacity in these areas and the net benefits of this private sector engagement modality in comparison to others (such as via subcontracting by public providers or direct contracting of private providers by a strategic purchaser). It should also be noted that the services purchased under this model are likely to represent only one input into a care pathway, and not a whole case episode.



There should be clear guidelines with referral criteria on the types of patients eligible to receive the related services, alongside robust monitoring to guard against opportunistic behaviours by providers.

Examples of projects of this type under consideration in the WHO European Region include:

- establishment of a new radiology centre at the National Cancer Institute, Kyiv, Ukraine; and
- establishment of three haemodialysis care centres in three regions of Uzbekistan – the city of Tashkent, the Republic of Karakalpakstan and the Khorezm region (in operation from April 2022).

## 3.2 Model 2. Health facility PPP

In this model, the private operator manages the design, construction, financing and operation of health facilities (such as hospitals, ambulatory care facilities, polyclinics, primary care centres and maternal and paediatric clinics). The name refers to “health facilities” because the public sector retains management of all clinical services and employment of all clinical staff. The model therefore focuses on the modernization of infrastructure and related activities, such as maintenance, rather than clinical services, although it can also have a major impact on services. Contracts typically last for 30 years or more – a period of time set to reflect the lifecycle of the contracted facilities – and may include outsourcing of some so-called soft facilities management (such as catering, cleaning and laundry), but this has been less common in recent years. Payment to the private operator is made by government, usually on the basis of availability (that is, the extent to which the specified facilities at the required standard are available for public sector use) and may be supplemented by user fees for some services (such as parking fees). Key features of this model include:

- long-term contracts – typically 30 years or more and up to 60 years in some cases;
- the sharing of risks between the public authority, private operator and investors/creditors;
- contracts based on a specified payment mechanism (the so-called availability charge), analogous to a prospective global budget, albeit one that can be adjusted according to performance;
- government ownership of the assets at the end of the contract, at which point facilities and equipment must be in reasonable condition; and
- bundling of infrastructure and non-clinical services within a single transaction.

Payment to the private operator is made in full only if the specified infrastructure and services are made available in accordance with the standards set out in the contract. The operator therefore has a

compelling incentive to deliver the specified infrastructure on time and to budget and to ensure that it is constructed and, once completed, maintained well, remaining fit for purpose throughout the long contract period. Achieving this degree of risk transfer, however, is dependent on a number of factors, including the ability of the authority to specify its needs in a legally enforceable and operationally practicable contract and to verify that the operator is meeting these needs in practice. The authority must also be able to run a competitive procurement, such that bidders are forced to ensure that bid prices approximate to their marginal costs of production, eliminating excess profits and enabling the state to capture a share of the gains from efficiencies related to risk transfer and the economies of scope engendered by the bundling of activities (design, build and maintenance, etc.).

Consequently, achieving benefits from this model requires that the authority has (or at least has access to) a high level of contracting expertise.

Even where such conditions hold, benefits may in practice be offset by the high transaction and financing costs that are, as the empirical evidence shows, generic features of the model. For example, Dudkin & Vällilä (2005) showed that a sample of social infrastructure PPPs undertaken in the United Kingdom had higher precontractual transaction costs than would have been generated under conventional public sector procurement. These amounted to about 10% of the capital expenditure value of the project on average for both state authorities and the winning private sector bidders, and up to 5% of that value for losing bidders. The authors attributed these additional costs to the long-term nature of PPPs, the complexity accruing to bundling of functions and the emphasis placed on risk transfer, all of which increase the costs of procurement across parties. In addition, transaction costs accrue to private financing itself – for example, the additional fees that equity investors must pay to their lenders and to sellers of financial derivatives that are used to hedging against inflation and interest rate risks. These fees add to the operator's costs and are then factored into the availability charge to be paid by the authority. Such transaction costs have no direct parallels in alternative forms of procurement. Finally, the rates of return on private debt and equity add to the costs of PPP projects. A private operator's weighted average cost of capital will normally be a multiple of the interest rate on the government's debt (Hellowell & Vecchi, 2012).

Many governments are attracted to this form of PPP for economic rather than financial reasons. The model allows the budgetary recognition of capital expenditures to be:

- deferred (the government only pays once the facilities are operational); and
- smoothed out (the up-front costs are repaid across the contractual term in a manner similar to a residential mortgage).

The ongoing costs of PPPs cannot be avoided indefinitely, however. The future costs of such PPPs are, in effect, debt-like in their structure. For such reasons, international accounting rules have made it difficult for the obligations under PPPs to be accounted in so-called off-the-budget

sheets (Eurostat & European PPP Expertise Centre, 2016). Even where the current accounting rules allow for this, as appears to be the case in many MICs in Europe, it is apparent that accounting definitions are subject to periodic revision. It is also possible that the debt will transfer back to the on-budget sheet at some point in future. The opportunity to defer and smooth out costs through PPPs can create budgetary incentives in the public sector that may undermine the financial sustainability and service capacity of health systems because of:

- a willingness to use PPPs even in cases where the model is unlikely to deliver best value for money (that is, where the benefits of risk transfer and bundling are more than offset by higher transaction and financing costs, as described above); and
- a propensity to overcommit future revenues by, for example, entering into contracts that are too costly for the public authorities and/or service users that ultimately will pay the bill.

Reflecting these concerns, current advice from the International Monetary Fund (Irwin, Mazraani & Saxena, 2018) is that governments should avoid overinvestment by:

- developing and implementing clear rules for their use, including financial analysis to determine affordability over the full period of the contract;
- identifying, quantifying and disclosing all PPP-related risks to government; and
- reforming budget frameworks and government accounting procedures to capture all future costs in a comprehensive way, including actual and conditional liabilities (those that relate to changes in macroeconomic variables such as inflation, interest rates and exchange rates, all of which can have a material impact on the affordability of PPP schemes to payers) (Box 3).

In addition, when a health ministry expects to make large-scale use of health facility PPPs, it may be beneficial to establish an overall “control total”. This is a defined limit to the total value of all future PPP liabilities that can be entered into in a given period and is, in effect, an attempt to establish an overall credit limit for public authorities. While a control total does not eliminate the budgetary incentive to use PPPs over other forms of procurement (at least until the total has been reached), it may help to stimulate a shift from a medium-term to a long-term budget-planning horizon and more disciplined prioritization of investments.

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### Box 3. Health facility PPPs in Türkiye

PPP contracts have been signed for 20 so-called city hospitals in Türkiye, with a total capital expenditure value of US\$ 11 billion. Türkiye has become an important source of inspiration for the use of PPPs in Ukraine and other countries in the WHO European Region. This is part of a wider process in which a number of investors – including commercial banks and multilateral development partners such as the European Investment Bank (EIB), European Bank for Reconstruction and Development (EBRD) and the International Finance Corporation (IFC) – have been seeking to harness their experience of the PPP programme in Türkiye and apply it to other emerging markets.

According to recent media reports, however, the Ministry of Health has announced that there will be no further PPPs in the country and that all future hospital construction projects will be financed from government sources alone. The decision was taken after it emerged that payments for just 10 operational hospital PPPs accounted for some 27.8% of the Ministry of Health budget.

Key elements of the budgetary pressures created by the PPP programme in Türkiye include:

- the large scale of the projects and the public revenue commitments they involve; and
- exchange rate volatility aggravating the budgetary challenge, as public revenue commitments were tied to the value of the US dollar, meaning that as the Turkish lira depreciated against the US dollar, the proportion of the Ministry of Health budget (denominated in lira) allocated to PPP payments had to be increased.

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Examples of projects of this type under consideration in the WHO European Region include:

- construction of a modern general hospital (based at the Emergency Hospital in Lviv, Ukraine), which is currently at the pre-feasibility stage;
- construction of an emergency wing for the Poltava Regional Clinical Hospital in Ukraine; and
- initiation of procurement processes for four Model 2 PPPs for multidisciplinary hospitals in the cities of Aktobe, Atyrau, Karaganda and Taraz in Kazakhstan.

### 3.3 Model 3. Integrated PPPs

In addition to the models described above, a third PPP model is being considered in some MICs (such as Ukraine) and is, in general, one of a menu of PPP options presented by development partners such as IFC, EBRD and the Asian Development Bank to country partners. Under this model, a private operator is tasked with building and maintaining new or rehabilitated facilities and managing the full range of clinical and non-clinical services in them, usually for periods of 10–30 years. Because this model combines infrastructure-related and clinical services, it is sometimes referred to as the integrated model.

As clinical services are delivered by the private operator, this model can accommodate user fees either as a minor or major component of operators' revenue stream. In such cases, public funding may be used for specific purposes (such as purchasing a certain volume of essential services and/or co-financing capital expenditures to address a so-called commercial viability gap). In either case, the model provides an opportunity for governments to increase private financing for recurrent expenditures (alongside capital expenditures) and, for the same reason, raises concerns in terms of equity of access and financial protection for patients.



4. What actions  
can governments take  
to make effective use  
of PPPs?





A number of conditions need to be met for PPPs – of any form – to be successfully implemented.

## 4.1 Determining the role of PPPs in shaping the provider network

As noted above, PPPs are a tool used to pursue a government’s strategic objectives. They do not constitute a strategy in themselves. Whether they impede or support the government’s strategic objectives is an open question – they might, and they might not. PPPs can only enhance the allocative efficiency of health systems if they are embedded in a strategic plan for the provider network – one that defines its future scale and configuration – and one that is informed by, and integrated into, the (often evolving) organizational, financing and purchasing strategies of the health care system as a whole.

While this may seem obvious, it is worth re-emphasizing. In most countries in the Region (as elsewhere), the PPP agenda is highly centralized, with policy formulation led by ministries of finance/economies (or equivalent). It then – in effect – is transplanted into the ministry of health (alongside departments responsible for the road, rail and energy projects that have also been prioritized under project finance/PPP programmes) and from there to individual regional or local authorities (Agency for Support of Public–Private Partnerships, 2021). This approach has been observed in multiple other countries and can lead to prioritization of form over function, with decision-making beginning with an assumption that PPPs will be used and the analysis focusing on how PPPs can be applied. In turn, this carries the risk that investment programmes become distorted away from the objectives set out at the beginning of this report, including the needed reconfiguration and modernization of the Region’s health estates. In addition, PPPs may be used for projects where they do not represent value for money, and this risk is amplified if local-level authorities or other contracting entities (often with limited capacity in PPP and contract management) are provided with subsidies or guarantees conditional on the use of PPPs specifically.

However they are financed, capital projects should be prioritized according to a plan for reconfiguration of the health estate by, for example, responding to lack of capacity at primary care level and addressing excess capacity at secondary and tertiary levels. Once a prioritization plan is in place, decisions about the mode of procurement/financing should be informed according to a clear assessment of the costs, benefits and risks associated with alternative options. As noted, PPPs are often seen as a means of mobilizing additional capital; by utilizing private finance, they enable the budgetary recognition of capital expenditures to be deferred (in comparison with conventional public financing of capital investment, for which up-front capital expenditures are recognized as they are incurred). In the long term, however, PPPs create debt-like obligations for the public sector (and, in the case of some models, also for patients). These need to be carefully and objectively considered through value-for-money analysis (which examines the opportunity costs of the PPP route

compared to alternative models) and financial analysis (which examines the impact of future fiscal obligations on the financial sustainability of the (national or local) health systems).

## 4.2 Financing the long-term costs of PPP contracts

In some countries in the Region, health facilities' capital and maintenance costs are funded through a different route to funding for services. For instance, it is common for infrastructure costs (maintenance and utilities costs) to be borne by regional or local authorities, while service costs are borne by health care payers. In such cases, it is important that local authorities' plan to pay more for the capital and maintenance costs of PPP facilities than in the rest of the health care estate. Such costs will often be higher in PPP facilities, even in cases where the contract has been implemented effectively by procurers, for two reasons:

- the capital expenditures committed by the private operator to develop the facilities will have to be re-paid, along with the required rates of return of its creditors; and
- the maintenance costs of the facilities may be higher, reflecting the incentives in PPP payment mechanisms to ensure high standards of maintenance through the lifecycle of the contract.

Public authorities will need to ensure they can afford such costs without compromising their ability to meet their other social obligations and without crowding out investment in service areas that are unlikely to be part of PPP projects, such as primary care.<sup>2</sup>

In other countries in the Region, the capital and maintenance costs of autonomous health care providers are funded through the tariffs for services, with no additional subsidy from local authorities. This adds a level of uncertainty to the budget-planning process for health care providers. For example, if the operator is paid an availability charge (which is unaffected by service volumes) while the service provider is paid a tariff per case, the provider's costs and revenues are mismatched. This complicates the affordability assessment before contracts are agreed and/or may lead to budgetary shortfalls after contracts are signed. Such a mismatch also creates risks to investors, as any shortfall in revenues of the health care provider may result in delays to payments to the operator, threatening its returns or even (in extremis) its solvency. To avoid the potential for such problems and to ensure that projects are bankable (meaning that private investors are willing to participate in them), the mismatch may have to be resolved at local, regional or even national level through, for example, guarantees that any shortfall in providers' ability to pay will be met by authorities at a higher level.

Whoever pays the bill, it is of core importance to limit the potential for overinvestment through PPPs – a risk related to the fact that private financing allows expenditure to take place now without that expenditure

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2. In principle, health facility PPPs could be used to support capital investment in primary care networks. In practice, this is relatively rare, largely because the high transaction costs of PPPs – for both government procurers and private operators – are deemed to be too heavy for the small-scale facilities required for primary care provision. There are cases of integrated PPPs (in Maseru (Lesotho) and Valencia (Spain), for example) that have incorporated managed primary and secondary care facilities and services within individual transactions, but this is extremely rare.

scoring on the public budget (generating a kind of credit card effect, with predictable effects on the quality of investment decisions). Empirically, however, analysts often underestimate the future costs of PPPs (both direct and conditional liabilities) when conducting financial analysis. This may be driven by a combination of technical errors (related to the inherent difficulty of predicting the future), optimism bias (a non-deliberate tendency to underestimate costs/overestimate capacity to bear costs) or strategic misrepresentation (a deliberate effort to underestimate costs/overestimate capacity to bear costs). Whatever the cause, the international evidence shows that the resulting underestimation of future costs or overestimation of the health authority's ability to service them has real, and sometimes severe, consequences for health systems.

Mitigating risks to affordability requires national and/or other public authorities to ensure all plans for new projects are scrutinized by a source of independent scrutiny, such as national/municipal audit institutions. Official audits are required to establish that transactions will generate benefits in excess of their opportunity costs and need to include an assessment of the potential for costs to vary over the duration of the contract. Such variation can have a number of potential causes, many of them external to the contract itself. For example, exchange rate volatility may present a serious challenge to affordability over the longevity of the contract, as public revenue commitments tend to be tied to the value of an international currency; if the value of local currency falls in relation to that currency, the costs of PPP payments increase in real terms (see Box 3 describing the experience in Türkiye). This is also likely to be a factor in the private sector's assessment of investment risk.

### 4.3. Strengthening capacity to undertake effective PPP projects and programmes

As noted above, the decision-making process for all capital investment decisions, including those that are eventually to be taken forward as PPPs, needs to begin with the question: what investments are needed to deliver the right combination of services (such as those covered in the State Guaranteed Benefit Package, or equivalent) in the right kind of facilities (primary, secondary or tertiary facilities)? Only once this critical question is conclusively addressed can decisions be taken about the specific procurement method to be deployed and what capacity is needed to be in place to deliver the method effectively. While building capacity for the effective deployment of PPPs is likely to be important in many countries, it is even more important that ministries of health and other health authorities build strong capacities to undertake needs-based assessment of service needs, plan a strategic reconfiguration of the health estate that is aligned with this, and select and take forward the investments needed to deliver that strategy.

Yet in cases where PPPs will be used, strong capacities will be needed. Across the three models, PPPs incorporate a range of complex services,

all of which need to be specified in contract documents and payment mechanisms. Because of the multifaceted and conditional nature of health care, these services also tend to be challenging (and expensive) to monitor. Achieving successful outcomes from PPPs requires investment in the specialist human resources (either in-house or external to the organization) required to do this well. Currently, such capacities are limited in most countries in the Region. While specialist PPP agencies may exist in some limited form, ministries of health and other relevant subnational authorities need to be capable of implementing PPPs sensibly. The costs of achieving this, which include training of the required professionals and sufficiently attractive salaries to preclude corruption or poaching by the private sector, need to be considered as part of the overall economic appraisal of PPP programmes.

In general, it is sensible to start small when using PPPs, piloting the model on smaller projects in areas that are relatively measurable and monitorable (such as specialist clinical/diagnostic services, as discussed under Model 1 above) and building up the capacities of government and the market over time before moving to contracting in more complex and capital-intensive service areas, such as multi-profile hospitals. Indeed, there is evidence that the deployment of Model 1 contracts can stimulate state and market capacity for the wider adoption of contracts with the private sector. In Romania, for example, a programme of eight dialysis PPPs in the early 2000s helped to stimulate development of an efficient market in dialysis provision that now operates on the basis of short-term performance-based contracts let by the National Health Insurance House (Box 4).

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#### Box 4. Dialysis Model 1 PPPs in Romania

In 2004, four private operators were selected to run eight separate contracts – each running for up to seven years – to refurbish, operate and manage dialysis centres at eight hospitals in Romania. The projects had a combined capital cost of €28.6 million. Payments to operators were based on a defined fee per haemodialysis treatment and a defined annual fee per peritoneal dialysis patient. Contracts were awarded to operators on the basis of investment levels rather than prices. The IFC, which worked as transaction adviser on the programme, estimates that between 2005 and 2008, the Government of Romania saved €2.9 million on the cost of dialysis services. Introduction of contracts based on fixed fees has resulted in a more transparent pricing system for dialysis services and enabled the adoption of stricter national quality standards that are applicable to privately and publicly managed clinics. There is now an efficient market in dialysis provision in the country (unlike in the initial wave of PPPs, now mostly conducted outside of hospital facilities) underpinned by financing from the National Health Insurance House on the basis of simple, output-based short-term contracts with international dialysis providers, in which fixed fees for treatment have been falling in real terms for a number of years.

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# 5. Conclusion and recommended actions



This report has provided: a review of three PPP models currently being used or considered in the Region; an analysis of the costs, risks and benefits of these models; and an assessment of the specific actions that governments can take to strengthen their capacity for effective policy-making and implementation. Although PPPs have often led to relatively good outcomes in terms of post-contractual cost–certainty, they lead to high transaction and financing costs that need to be recognized, planned for and where possible mitigated by policy-makers. Securing value for money means selecting the right projects, reflecting their degree of priority for the health system as a whole, taking into account the need for rationalization/reconfiguration of physical and human resources (from hospitals to other care settings) and the potential impact of new purchasing arrangements and payment mechanisms. Securing value for money also means implementing PPPs only when they represent the most cost–effective solution compared to other procurement modalities, and where the robust capacities needed to plan, design, negotiate and monitor long-term complex transactions are available in the public sector to implement them effectively. Such capacities often are not available; where this is the case, they need to be built up over time.

In the real world, PPPs are often seen as a means of mobilizing additional capital. In utilizing private finance, they enable the budgetary recognition of capital expenditures to be deferred (in comparison with conventional public financing of capital investment, for which up-front capital expenditures are recognized as they are incurred). In the long-term, however, PPPs create debt-like obligations for the public sector (and, in the case of some models, also for patients). These need to be carefully and objectively considered through value-for-money analysis (which examines the opportunity costs of the PPP route compared to alternative models) and financial analysis (which examines the impact of future fiscal obligations on the financial sustainability of the relevant health system setting).

To minimize fiscal risks and ensure the integrity of procurement processes, institutional checks and balances need to be robust. Securing allocative and productive efficiency and safeguarding the public interest requires sources of independent scrutiny and challenge, including the activation of supreme audit institutions for larger schemes that have the potential to impact on the financial sustainability of health systems. Their findings should be disseminated as widely as possible, including in parliament and through the media, and the data, evidence and recommendations they provide utilized to inform policy adaptation and learning.

While each of the three models presents a different combination of costs, risks and benefits, certain principles of good practice apply equally to all. Specific recommended actions for Member States include the following.

1. Ensure that the investment decision is separated from the procurement route decision and that these decisions are made in the right order. The investment decision comes first. It is concerned with questions such as what is needed to deliver the right combination of services (those covered in a State Guaranteed Benefit Package or similar, for instance) in the right kind of facilities (primary, secondary, or tertiary facilities)? Only once such questions are addressed can a decision be taken about the relative value for money of alternative procurement routes. The

latter decision is concerned with the question: what procurement route will deliver the intended outputs with the most advantageous combination of costs, risks and benefits?

2. Incorporate in the procurement route decision an objective recognition of long-term financial costs and risks to the public sector, health systems and (where user fees are to be introduced/expanded in the post-contract arrangements) household budgets. Financial risks relate to uncertainties around what the future costs will be in real terms and the ability of the ultimate payers to afford them without detriment to their own financial position. Experience to date has demonstrated a willingness to use PPPs even in cases where the model is unlikely to deliver best value for money, and a propensity to overcommit future revenues by, for example, entering into contracts that are too costly for the public authorities and/or service users that ultimately will pay the bill. Given the tendency of public authorities to engage in forms of strategic behaviour, it is crucial that regulations governing the conduct of financial appraisals are robust and subject to independent scrutiny. For larger schemes, scrutiny should be undertaken by well resourced independent agencies, such as the supreme audit institution of the country.
3. Invest in the capacity required to define a strategic plan for the health estate in which all investment decisions are embedded. In view of the importance of recommendations 1 and 2, achieving success in capital investment programmes – including those in which PPP is implicated – requires strong capacity within government to undertake rigorous needs-based capital planning to define a strategic plan for the health estate in which all investment decisions should be embedded. These functions should not be outsourced to external agencies – they are core functions of government and are essential to the long-term technical efficiency of the health system. Nor are they well suited to so-called PPP units, which require more specialist skills, as outlined below.
4. Invest in the capacity required to deliver the strategic plan. Finally, there needs to be strong contracting capacity in government, ideally in the form of a specialist procurement unit, to support local health authorities in running competitive procurements, designing effective contracts and establishing structures to ensure assiduous monitoring of performance. Without such capacities in place, PPPs will not deliver benefits in respect of risk transfer that are sufficient to offset this procurement model's higher transaction costs and financial costs. Such capacities should be complemented by robust institutional checks and balances to ensure transparency in decision-making, minimize fiscal risks and maintain the competitive integrity of procurement processes.



## References<sup>3</sup>

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## The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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