TRADE, DEVELOPMENT AND PUBLIC PRIVATE PARTNERSHIPS

AN ANALYSIS OF PPP IN HEALTH FACILITIES: A WAY OF IMPROVING TRADE IN HEALTH SERVICE?

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This report is the result of the work carried out for the Capstone Project by Master degree students of the MPA programme of Sciences Po, Paris.

A Capstone Project is a requirement for all second year MPA students. It is a client-based consultancy whose subject is a concrete policy issue and that is carried out by small groups of students (between three to five students). It is based on a series of parallel and complementary activities: secondary research, mentoring & coaching, teamwork, field study visits, and a professional outcome or "deliverable".

This project is a professional group experience that demands effective team work. Each group receives a collective grade. The learning experience of a Capstone Project consists of managing the sometimes difficult interaction within the group, as much as applying in practice the theory learnt in the courses.

A Capstone Leader supervises, advises and monitors the work of the students and their exchange with the representatives of the client organisation. Each Capstone Leader meets regularly with the students and guides them throughout the project: from the initial research, to the fieldwork, contact with the client, draft the report and final presentation.

The authors are responsible for the choice and presentation of the facts contained in this report and for the opinions expressed therein, which are not necessarily those of the MPA and do not commit the MPA Programme.

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The Capstone team

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LIST OF ABBREVIATIONS AND ACRONYMS

AHA: Aquino Health Agenda

CPAR: World Bank's Country Procurement Assessment Report

CPIA: Word Bank's Country Policy and Institutional Assessment

CSO: Civil Society Organizations

DBFO: Design, Build, Finance, and Operation

DoH: Department of Health

EU: European Union

F1: FOURmula One

FDI: Foreign Direct Investment

GATS: General Agreements on Trade in Services

GDP: Gross Domestic Product

GHIS: General Health Insurance Scheme

GNP: Gross National Product

HSRA: Health Sector Reform Agenda

IHSS: Integrated Health Service Scheme

IMF: International Monetary Fund

IPD: Institutional Profiles Database

LGU: Local Government Unit

MDG: Millennium Development Goals

MoH: Ministry of Health

NGO: Non-Governmental Organization

NHIA: National Health Insurance Act

NIE: New Institutional Economies

NPM: New Public Management

ODA: Official Development Assistance

OECD: Organization for Economic Cooperation and Development

PFI: Private Finance Initiative

PhilHealth: Philippines National Health Insurance Program

PPI: Private Participation in Infrastructure

PPP: Public Private Partnerships

PPPH: Public Private Partnerships in Health

SRO: Supranational Regulatory Organizations

SSK: Sosyal Sigortalar Kurunu

ToR: Transfer of Operational Rights

TVE: Township Village Enterprise

UK: United Kingdom

UNCTAD: United Nations Conference on Trade and Development

UNECE: United Nations Economic Commission for Europe

VFM: Value for Money

WGI: Worldwide Governance Indicators

WHO: World Health Organization

WTO: World Trade organization

Trade, Development and Public Private Partnerships

AN ANALYSIS OF PPP IN HEALTH FACILITIES: A WAY OF IMPROVING TRADE IN HEALTH SERVICE?

EXECUTIVE SUMMARY

This report, commissioned by the United Nations Economic Commission for Europe (UNECE) in collaboration with a group of graduate students from the Institut d'Etudes de Sciences Politiques in Paris, will examine Public Private Partnership in Health (PPPH), by looking into cross-country studies both in developed countries through desk research (United Kingdom, Germany, Portugal, and Canada) and field research to developing countries (Turkey and the Philippines). Direct Interviews with a Semi-structured Method were performed at the field research in order to gather information for the qualitative analysis present in this report.

The group carried out a research project on PPPH with a focus on health facility and the provision of clinical services, looking into the best practices and deriving success factors learnt from international PPP experiences, to reap the potential benefits of PPPH, while mitigating risks and reducing potential costs, especially in the context of developing countries.

The main objectives are to study successful models in developed countries, differences between developing and developed countries concerning PPPH feasibility and the (dis)advantages of PPPHs in developing countries for the purpose of improving trade in health services.

Our research is centered on two main hypotheses:

- Hypothesis 1: Regulatory setting prior to the implementation of PPPH Projects is more likely to reduce agency costs and potential errors
- Hypothesis 2: The success and sustainability of PPPH Projects will depend on the public sector's capacity to efficiently and effectively

Four themes were set out to shape the focal points of the field research, in order to diagnose the different issues, and then collect, analyze main findings and draw main conclusions:

- Institutional Design (Policy Framework): an analysis of the existing legal and institutional frameworks, how relevant actors interact with risk assessment, public procurement process, rule of law, participation, competition, transparency, multi-stakeholder dialogue and democracy, enforcement/compliance and monitoring, etc.
- Contractual Arrangements (Risk Sharing, Incentives): the theme deals with how ex-ante contracts affect the ex-post behavior of both parties when faced with institutional and political risks.

- Institutional Quality (Equity, Efficiency, and Effectiveness): this theme is focused on analyzing the credibility, accountability, anti-corruption and capacity of the government and regulatory body to handle a PPP and PPPH project.

- Institutional Environment & Trade (Political, Economic & Social Context): the theme will consider the vast differences between social, political and economic environment present in the analyzed countries, as well as international agreements (multilateral or bilateral) like GATT/GATS, and Investment Treaties.

The different stages of PPPH in each country (nascent to advanced), different motivations for engaging in this type of contracts, and different types of institutional and regulatory frameworks provided us with a rich desk research and field scenarios in which to insert our finding from the developing countries field trip, and better analyze how to improve the sustainability of PPPH projects.

The application of PPPH requires careful and salient attention and in-depth approaches compared with other sectors. Not only is PPPH influenced by the broader political, economic societal contexts, as well as sector-specific conditions, but also by regulatory and institutional quality and environment.

Furthermore, the study leads to empirical lessons about under what conditions PPPH can raise public value, what determines successful PPPH in different contexts, and to policy recommendations to reap the benefits of PPPH and reduce potential costs in the face of emerging challenges in this new type of procurement, contrary to the traditional procurement.

1. INTRODUCTION

Public-Private Partnerships (PPPs), - generally defined as cooperative institutional arrangements between public and private sector actors over a long term - have gained wide interest around the world, and are a rapidly spreading idea due to globalization. The PPP process is not just about transactions and exchanges nor a wedding ceremony. After having sought for the right partner, a PPP ends up being similar to a marriage, a long-term partnership based on relations between the public and private sectors. From a policy maker's perspective, PPP is not only a fashionable idea, but also a contested policy idea. PPPs cannot be regarded as a universal remedy to solve infrastructural deficit in times of global financial crises. Policy responses to these fiscal crises in many countries led to cuts in public expenditure, under-maintenance of infrastructure, and under-investment in new infrastructure in many sectors, including social ones. Proponents argue that PPP is a remedy for financing shortages and a way to bring private sector expertise and civil society enthusiasm into the delivery of public services. Skeptics, on the other hand, point to high transaction costs, unclear accountability structures, risk of service failure, and the potential for eroding public sector's core value and social welfare, such as equity.

The main PPPs are focusing more on developing infrastructures in transport sector (road, railroad, airport and seaports), telecommunication, energy (electricity and natural gas), and water and sewage according to the World Bank's PPI database (World Bank 2011) OECD (OECD,The World Bank). Comparatively little has been written on the performance and the necessary institutional settings of PPP in Health (PPPH) in different contexts, despite its popularity as a new form of collaborative governance and the rapid spread of this policy idea around the world. Unlike the application of PPPs into the aforementioned infrastructures, social infrastructures such as health and education are regarded as the most sensitive, concerned more with social equity than economic efficiency and effectiveness promoted by market principles. Thus, the application of PPPH requires careful and salient attention and in-depth approaches compared with other sectors. Despite its importance to meet the Millennium Development Goals (MDG), they have not been analyzed and emphasized to a greater extent. More accumulated knowledge, as well as experience by developments taking place in developed countries is necessary for developing countries to draw main lessons from past successes and failures of those leading countries.

This report will examine Public Private Partnership in Health (PPPH) by looking into cross-country studies both in developed countries (United Kingdom, Germany, Portugal, and Canada) and developing countries (Turkey and the Philippines). The report is based on an initial discussion of theoretical and conceptual approaches to analyzing PPP in the health sector, which is applied in a comparative analysis of six country case studies, with a main focus on the institutional and regulatory settings.

Not only is PPPH influenced by the broader political, economic societal contexts, as well as sector-specific conditions, but also by regulatory and institutional quality and environment. Furthermore, the study leads to empirical lessons about under what conditions PPPH can work, what determines successful PPPH in different contexts, and to policy recommendations to reap the benefits of PPPH and reduce potential costs in the face of emerging challenges in this new type of procurement, contrary to the traditional procurement.

2. STUDY OBJECTIVES

The United Nations Economic Commission for Europe (UNECE) commissioned a paper on "*Trade, Development and Public-Private Partnerships (PPPs) – An Analysis of PPP in Health Facilities: A Way of Improving Trade in Health Service?*" in collaboration with a group of graduate students from the Institut d'Etudes de Sciences Politiques in Paris (or Sciences Po Paris). The group carried out a research project on PPPs in the health sector with a focus on health facility and the provision of clinical services. This research will look into the best practices both in developed and developing countries and will derive success factors learnt from international PPP experiences to reap the potential benefits of PPPH, while mitigating risks and reducing potential costs, especially in the context of developing countries.

Main objectives are threefold:

1) Identify specific models that have been successful and which could be replicated elsewhere, adapting to countries' specificities

2) Show the differences between developing countries and developed countries as it concerns the feasibility of doing PPPs in the health sector

3) Highlight the advantages and disadvantages of PPPs applied to the development of health service delivery in developing countries, for the purpose of improving trade in services.

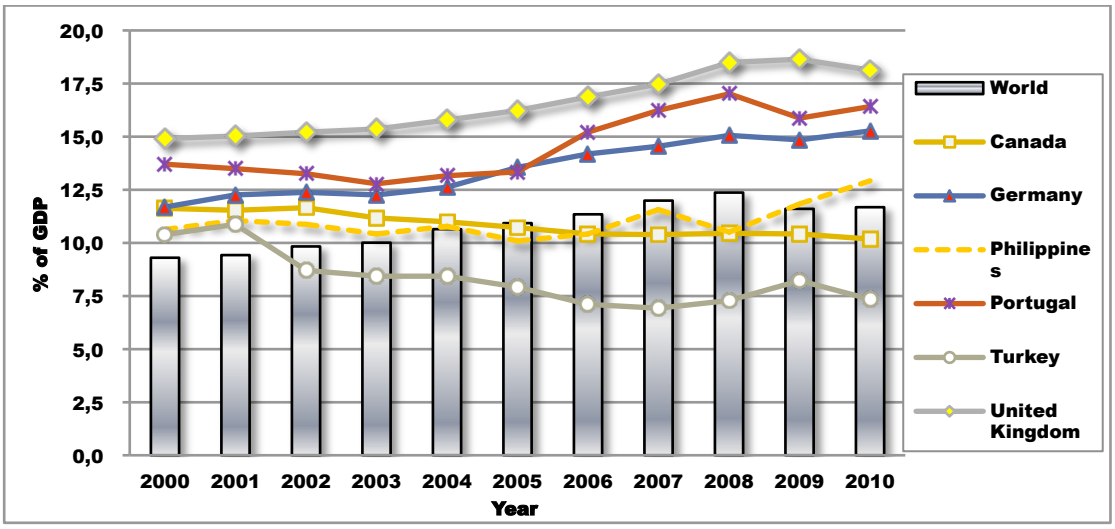
3. RELATIONSHIP BETWEEN TRADE AND PPPS

Globalization is seen as 1) *Trade*, the free mobility of goods and services, 2) *Foreign Direct Investment* (FDI), the free mobility of investment capital, 3) *Finance*, the free mobility of virtual and digital capital. Today in a globalized economy, Foreign Direct Investment (FDI) has become important as a growth engine, not only to host (developing) countries but the investing (developed) countries as well, as a way to bridge infrastructural gaps in order for them to improve not only economic competitiveness, but also social development. (UNCTAD 2008). The level of a country's economic achievement is directly correlated to the level of adequacy in the country's public services, both physical and non-physical, which can be shown by government effectiveness and institutional quality. Developed countries have established good infrastructure and are ready to further modernize them in response to the rapidly growing public service demands, but this is not the case with developing countries. They are lacking far behind developed countries and are generally still faced with great difficulty to barely suffice basic infrastructures such as health and education. As a result, public services in these countries, along with their economic performances, are relatively poor.

With globalization, developing countries are faced with an even more severe challenge, where national, regional and global demands must also be taken into account. In the health sector, medical tourism - the act of traveling to another country to seek specialized or economical medical care, well being and recuperation of acceptable quality with the help of a support system - is a rapidly growing industry, catering to patients who travel across national borders to receive medical treatment (Deloitte 2008, Deloitte 2008). The current pace of the medical tourism industry's growth and development is reflective of the pace of globalization in general, as illustrated in Figure 1 (Trade in Services). However, medical tourism growth rate is restricted by the availability of healthcare professionals within countries. Especially, an outflow of healthcare professionals due to commitments made in the country schedules of the WTO General Agreement on Trade in Services (GATS)[1] may result in limiting growth opportunities for developing countries, along with their infrastructural deficits, if they have not developed adequate strategies and policy frameworks. Also, attracting foreign professionals and patients and maintaining the quality of domestic healthcare professionals is critical to the delivery and maintenance of quality medical service. Thus, gains from globalization and regionalization depend on individual countries' strategies to regulate the private financing and provision of health services, even though GATS allow countries to make binding trade commitment in health services. GATS proponents claim that whether liberalization in health services produces a net public health gain or loss depends on the domestic regulatory structures put in place to manage its impacts (Labonté, et al. 2007).

1 The GATS distinguishes between 4 modes of supplying services:
- Mode 1 (cross-border trade) is defined to cover services flows from the territory of one Member into the territory of another Member (e.g. banking or architectural services transmitted via telecommunications or mail),
- Mode 2 (consumption abroad) refers to situations where a service consumer (e.g. tourist or patient) moves into another Member's territory to obtain a service,
- Mode 3 (commercial presence) implies that a service supplier of one Member establishes a territorial presence, including through ownership or lease of premises, in another Member's territory to provide a service (e.g. domestic subsidiaries of foreign insurance companies or hotel chains),
- Mode 4 (presence of natural persons) consists of persons of one Member entering the territory of another Member to supply a service (e.g. accountants, doctors or teachers)

Figure 1: Trade in Services (world and selected countries)

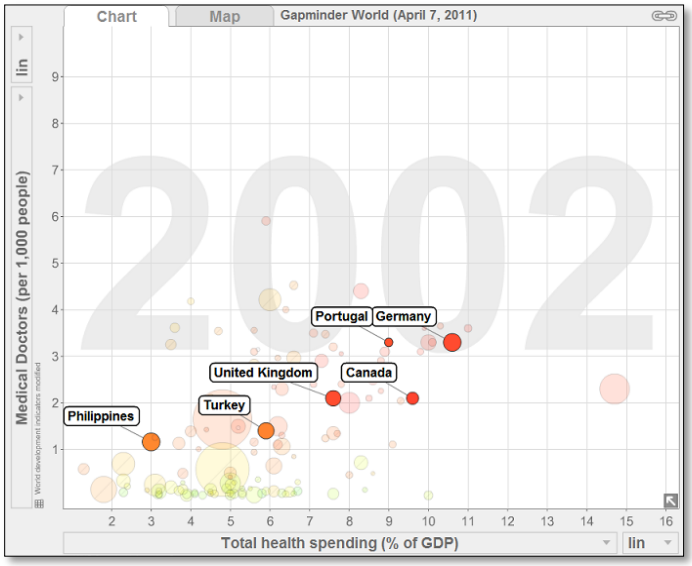


Source: (World Bank Databank) Compiled by author based on International Monetary Fund, Balance of Payments Statistics Yearbook and data files, and World Bank and OECD GDP estimate.

Note: Trade in services is the sum of service exports and imports divided by the value of GDP, all in current U.S. dollars

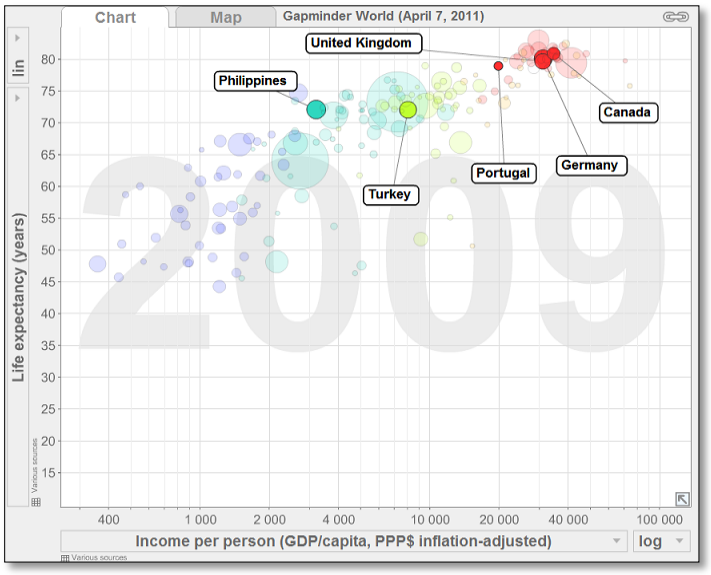
There are many factors contributing to the growth of medical tourism in recent years. First, an aging population and increased lifespan continue to strain the healthcare systems both in developed and developing countries (See figure). Second, the adoption of new technology that would provide quality care to an increasingly sophisticated population is critical to meet the public needs and improve basic healthcare, along with a convergence of standards globally and lowering costs of transportation (Deloitte 2008).

Figure 2: Medical doctors per 1000 people



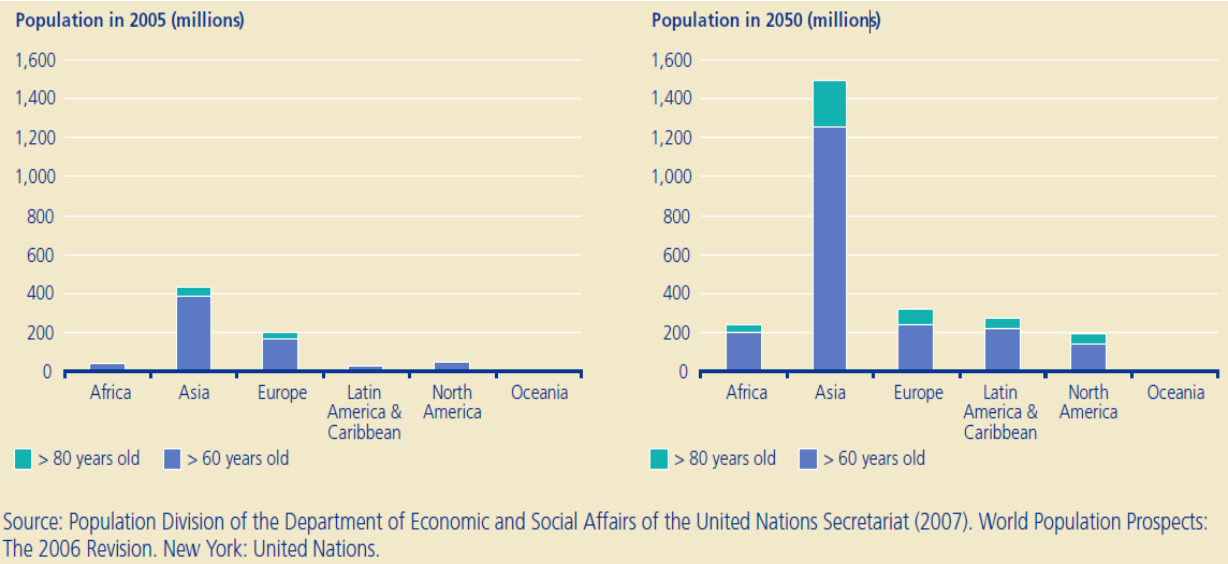
Note: the red stands for life span over 80 years. The orange stands for life expectancy below 80 years.

Figure 3: Life expectancy according to income levels



Note: The red = OECD countries. The orange = non-OECD countries. The green = upper middle income, the light blue = lower middle income, the blue = low income countries.

Figure 4: Forecast of population aged over 60 years old in 2050



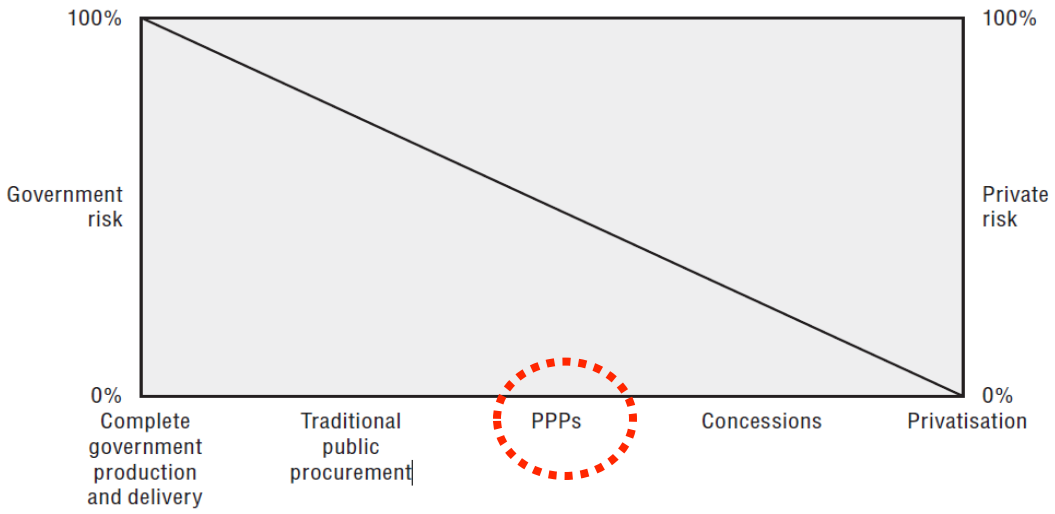
Source: (United Nations 2007)

PPP as a response to the challenge

Provision of public services is traditionally a “natural monopoly” of the state (public sector). The government takes full responsibility and accountability, and through its state owned companies

develops and runs the entire public service system in the country. However, globalization has escalated demand for public services, making it unbearable for governments alone to cope with, in terms of available resources in times of global trade and financial crises. The private sector, having accrued better resources (capital, know-how, technology, efficiency and management skills) is being therefore more deeply involved in providing these public services, effectively and efficiently, to satisfy the domestic, regional and international needs. The question now is what participation scheme and what cooperation relationship with the public authority the private sector can best fit into. PPP has been gaining wider acceptance as a response to this challenge. It is a concept that underlines collaborative governance mechanism rather than privatization, which is more oriented to supremacy of market over state with less concern over social inequity. Partnership in the context discussed here means that the government together with the private sector share the risks and responsibility in making public services available, as well accountability for the services that they render to the public to ideally achieve the same goal.

Figure 5: The Spectrum of combinations of public and private participation, classified according to risk and mode of delivery



Source: (OECD 2008)

4. PUBLIC PRIVATE PARTNERSHIPS IN HEALTH

The function of the public sector is to provide for and satisfy public needs, benefiting the community as a whole. It is the role of the government to establish goals and choose which of these collective needs will be a priority and which of them will not. But due to lack of resources, the public sector's role of provider becomes very costly, which generates a stagnation of investments and a gap in the fulfillment of public needs.

In this context, PPPs come as an alternative to overcome obstacles. The idea of PPPs is not a new one; toll roads, for instance, are a popular example of PPP. Briefly explained, a PPP is a risk-sharing contract between the public sector and a private entity, to deliver a public good or service. According to the UNECE's Guide to Good Governance, PPPs can be defined as follows:

"Innovative, long-term, contractual arrangements for developing infrastructure and providing public services by introducing private sector funds, expertise and motivation into areas that are normally the responsibility of government."

In the Health Sector, PPPs can take form in many different ways, and the functions of the private and public partners can vary according to contractual obligations, risk, rewards and main objectives of the project. Similarly to a general PPP, in a PPPH the general idea that the private sector is superior to the public sector in terms of expertise and efficiency plays a big role in influencing contracts. Ideally, the public sector benefits not only financially, but also from the private's expertise, which increases the quality of the services delivered, and the efficiency of the public operation. "The mechanics of the arrangements can take many forms and may incorporate some or all of the following features:

- The public sector entity transfers land, property or facilities controlled by it to the private sector entity (with or without payment in return) usually for the term of the arrangement.
- The private sector entity builds, extends or renovates a facility.
- The public sector entity specifies the operating services of the facility.
- Services are provided by the private sector entity using the facility for a defined period of time (usually with restrictions on operations standards and pricing); and
- The private sector entity agrees to transfer the facility to the public sector (with or without payment) at the end of the arrangement." (Grimsey and K.Lewis 2004)

In order to attract a private partner, the PPPH contract must have a clear picture of how financing and revenues work. The revenue stream is one of the most important aspects in contract negotiation, and

can influence the willingness of the private entity to participate in a PPP project or not. “In a public–private arrangement, revenues to the private firm can come from two sources, namely consumer payments, or public entity payments (or from some combination of both). The source is important because it determines (1) the incentives of a private firm to adjust the cost and quality to consumers’ willingness to pay for them, (2) the amount and timing of public expenditures, and (3) the nature of the risks to which revenues are exposed.”[2]

Typologies

There are a number of different typologies when it comes to PPP contracts, each responding to specific needs stated by the public and the private sector partners involved in the project, and it is likely that new models arise, as each contract deals with very specific needs. In the health sector, a PPP contract can be established for various reasons, such as hospital infrastructure, equipment, catering, cleaning, security, and staff. Based on these needs, and among the many PPP typologies available, the most commonly models used in PPPH are:

Build, operate, transfer (BOT): In this model, the facility is designed, financed, operated and maintained by the private partner for the period of the concession. Legal ownership of the facility may or may not rest with the private partner.

Design, build, finance and operate (DBFO): Most commonly used in PFI contracts, in this model the service provider is responsible for the design, construction, financing and operation.

Leasing: In this model, one of the parties (usually the private sector) is granted the rights of operating and maintaining an infrastructure facility and/or services. Under the leasing contract, the private and public partners share revenues from customers.

Management Contract: In a management contract, the private sector is responsible for the management of part or the whole public enterprise, while the public sector retains ownership of the equipment and the infrastructure. Through this model, the private sector can spill out expertise and know-how into the public service. These are usually short-term contracts that can be extended.

Service Contract/Outsourcing: A service contract is used when the private sector is responsible for the supply of labor, equipment, energy, water treatment, catering, security, and cleaning. Through this model, delivery of services and goods is ensured by the private sector, which decreases delays and failure in the public sector service provision, increasing efficiency.

2 Ibid.

5. CONCEPTUAL FRAMEWORKS

5.1. The Main Drivers of PPPs

5.1.1 POLITICAL RATIONALE IN THE PURSUIT OF GETTING VOTES

In the UK, PPPs were fostered in the 1980s by the Thatcher and Reagan administrations as the main strategy for urban development. That policy exemplified their neoliberal capitalist enshrinement of the supremacy of the private sector and market forces in nurturing development. To reduce government expenditures on public services and shrink its areas of responsibility, PPPs were prompted as avoiding presumed inefficiencies of the public sector, by relying on the private sector (Miraftab 2004). Furthermore, PPPs can be a language game designed to 'cloud' other strategies and purposes such as "privatization" and "contracting out" (Hodge and Greve 2010). In other words, it can serve as policy rhetoric for political gains through the encouragement of private providers to supply public services at the expense of public organizations themselves, camouflaging new interests of transaction advisors, legal advisors, and financial bankers pursuing large commissions at the expense of the public interest. "Contracting out" and "privatization" are expressions that generate opposition quickly, and expressions such as "alternative delivery systems" and now "public private partnerships" invite more people and organizations to join the debate, and enable private organizations to get a market share of public service provision. (Savas 2012) Ideologically, the Blair government in Britain put an emphasis on PPPs, including Private Finance Initiative (PFI) that the Labor party had criticized before it was in power[3]. The decision to link the use of private finance to the adoption of bundled contracts for engineering works has been a political one in the UK's PFI model. On the contrary, the majority of PPPs in Canada and the United States have been publicly funded. (Hodge and Greve 2010) Flinders suggests that PFI is simply a buy now, pay later scheme with a private sector's mega credit card (Flinders 2005). The political incentives for government have been high - voter acceptance, quicker promised delivery of infrastructure and more positive relationships with finance and construction businesses. This can create a network of new elites dominated by senior public and private sector executive managers who will benefit from new types of PPPs (Aldred 2008).

5.1.2 ECONOMIC RATIONALE IN SEARCH FOR VALUE FOR MONEY AND RISK SHARING

PPPs allow governments to leverage the expertise and skills of the private sector to improve the quality and accessibility of public health care systems, without burdening public finances. It can provide more Value for Money (VFM) compared to traditional forms of procurement and production, which does not transfer risks to the private sector. VFM is defined as the optimum combination of whole life cost and quality to meet the user's requirement. PPP policy is justified on cost-efficiency grounds. Value for money depends on appropriate risk transfer between the public and private sectors (IFC 2010). PPPs can be tailored to meet specific needs, with the private sector's role ranging from facility management

3 See the case study in Chapter 8 UK country study

and non-clinical services, to specialized clinical services, to full hospital management including all clinical services.

Financially, private financing is a way to provide infrastructure without increasing the public sector borrowing and reduce pressure on public finance constraints (World Bank 2011). The fiscal constraint argument for PPPs is driven by pressures for governments to reduce public spending to meet political, legislated and/or treaty-mandated fiscal targets (i.e. Maastricht criteria) (OECD 2011). A bad practice is that governments use private finance to disguise public expenditure and to push it 'off-budget', without any real risk transfer, innovation, or efficiency gain. The consequences of pushing commitments 'off-budget' are reduced incentives and ability to control costs, and the risk that the government will accumulate more liabilities than it can manage. A good practice is to integrate PPPs into overall fiscal accounting and risk management framework, thus 'on-balance' (World Bank & PPIAF 2007).

5.1.3 INTERNATIONAL DIFFUSION SUCH AS POLICY TRANSFER AND LESSON DRAWING

Policy transfer is understood as a process by which knowledge of policies, administrative arrangements, institutions and ideas in one political system are used in the development of similar features in another. (Dolowitz and Marsh 2000) If bureaucrats or elected politicians search for policy solutions to new or changing problems, then they are likely to look for "solutions" abroad. Therefore, states *learn* from one another, they borrow innovations perceived as successful elsewhere. PPP ideals and innovations can be conveyed along relational networks between actors, consultants employed by national or foreign governments in search for solutions to infrastructure problems, multilateral and international development agencies, and policy documents such as international agreements and implementation guidelines. Also, states *compete* with each other, they emulate policies of other states to achieve an economic advantage over other states or avoid being disadvantaged. (Berry and Berry 2007) The idea of policy transfer takes either voluntary or coercive forms. The latter distinguish between 'direct coercive transfer' and 'indirect coercive transfer". In the case of the former, one government may force another to adopt a policy, international institutions such as the World Bank or the International Monetary Fund (IMF) and aid agencies may ensure a government adopts a certain policy, for example, attaching conditions to a loan, or a transnational corporation may influence policy adoption by threatening to take investment elsewhere. In the case of indirect coercive transfer, externalities, functional interdependence, economic constraints, competition between countries and the emergence of international consensus may all influence policy adoption. (Holden 2009)

This policy change stemming from policy transfer would result in convergent or divergent change through the mechanism of '*translation'* by transnational policy entrepreneurs as well as of '*bricolage',* which refers to the creation of novel combinations of existing elements such as local beliefs and practices. Jooste, Levitt, & Scott account for divergent change in PPP by looking into Anglo-Saxon three cases on the UK, Australia, and South Africa. (Jooste, Levitt and Scott 2011) Holden argues that the PPPHs are one example of the UK's policy transfer through export strategy. (Holden 2009)

5.1.4 INSTITUTIONAL REFORM AS A WAY OF INTRODUCING NEW PUBLIC MANAGEMENT

The public sector reform movement known as New Public Management (NPM) became popular in a number of industrialized countries in the 1980s (Fussell and Beresford 2009). At the heart of this movement is a belief in the efficiency of the market and the inefficiency of the public sector. The public sector lacks any incentive to limit its own size and scope. As a result, governments can become bloated and ineffective. To solve this problem, market-based principles such as competition were applied to the public sector to create the incentives needed for more efficient government.

NPM principles, which are characterized by a set of buzzwords such as "innovation", "customer choice", "flexibility", and "competition", have been introduced to countries around the world. There were services with a high social value, and which there was general consensus that the state had an obligation to provide such as healthcare and education. However, it was believed that, by transferring responsibility for the delivery of these services to the private sector via PPPs, the public sector would be able to harness the market-based incentives the government lacked [4].

5.2 Theoretical and Analytical Underpinnings

Our analytical approach to PPPH and development of the main hypotheses are based upon a combination of the theory of incentives: the Principal-Agent model (Laffont and Martimort 2002), the Coase Theorem (R. H. Coase 1960), and the Theory of Institutions (North 1990), the Theory of Incomplete Contracts (Hart 2003, Lonsdale 2005) and Transactions Economies (Williamson 1979, Williamson 1998). This so-called "New Institutional Economics (NIE)" encompasses inter-disciplines including political sciences, sociology, management, law and economics (Brousseau and Glachant 2008, R. Coase 1998). The strength of NIE lies in its proposal to analyze governance and coordination in all sets of social arrangements. (Brousseau and Glachant 2008) Therefore, these theoretical frameworks can offer useful analytical concepts and approaches, an explanation of under what conditions partnerships between the public and private sectors can be formed, suggest insights, perspectives, and policy implications on which policy options are preferred and how to make PPPH work to reap the potential benefits while mitigating risks and reducing informational asymmetry and transaction costs, and help understand the optimal form of partnerships by reviewing their main advantages and drawbacks. We will depart from what can be learned from existing theories and experiences and proceed from there to structure an empirical approach for examining multiple country studies and analyzing main factors that affect PPPHs.

5.2.1 THE PRINCIPAL-AGENT APPROACH

The Principal-Agent model[5] suggests the positive results against moral hazard and adverse selection would be achieved in ex-ante contractual arrangements *through; a) a fully specified, enforceable*

4 Ibid
5 See appendix 1

contract between the government and the firm[6]*;* (Hart 2003) *b) stable terms of contract; c) monitoring service delivery; d) measurable output indicators* (Wildridge, et al. 2004, p.9)*; Performance-based contracts that depend on observable and verifiable output can be employed to create incentives for the agent to act in the principal's interest, e) credible punishment in case cheating is proven.*

In developing countries, the need for regulation is more vital because they are usually characterized by non-competitive structure or lack of market discipline. In such environments, too little market information is revealed and information asymmetries are vast (Pessoa 2008, 322). Moreover, the provision of genuinely impartial advice and the establishment of independent core public sector capacity in relation to PPPs would be crucial, given social and equity-oriented health policy goals (Holden 2009).

A better strategic approach would be for governments to consider i) the establishment of a regulatory agency independent from potential political pressures[7], ii) setting up safeguards and procedures to protect the interests of consumers and investors, deter (reduce) opportunism and agency costs, and increase *ex-ante* competition when feasible to avoid adverse selection. It needs to be sequenced before the implementation of PPPH projects. (Andres, Guasch and Straub 2007, Asian Development Bank, European Commission 2003, UNECE 2008, World Bank 2011) Also, both theoretically and empirically, regulatory control over behavior of for-profit providers tended to be ineffective unless complementary solutions such as incentive-based mechanisms and competitive contracts were required. (Tangcharoensathien, Limwattananon, et al., Regulation of Health Service Delivery in the Private Sector: Challenges and Opportunities 2008)

5.2.2 THE COASE THEOREM APPROACH

Drawing on the organizational theory, actors are characterized by their strategic behavior vis-à-vis other actors as well as by the fact that they pursue specific goals. Organizations are structures (i.e., institutionalized rules) that have been deliberately set up so as to enable them to achieve specific goals. However, there is never a perfect match between the set goals of the organization and the goals of the actors that compose the organization. Consequently, actors always strategize in order to shape (use, change, or avoid) the organizational rules under which they (must) behave, aiming at increasing their own discretionary power.[8]

6 According to (Hart 2003), the choice between PPPs and conventional provision depends on whether it is easier to write contracts on service provision than on building provision. Conventional provision (unbundling) is good if the quality of the building can be well specified, whereas the quality of the service cannot be. In contrast, PPP is good if the quality of the service can be well specified in the initial contract or more generally, there are good performance measures which can be used to reward or penalize the service provider, whereas the quality of the building cannot be. Prisons and schools are related with convention provision, whereas hospitals fall into PPPs, as although service quality specification might be difficult, reasonable performance measures can be devised.

7 Those institutions in charge of regulating public utilities can either take the form of an independent regulatory agency, or be set up as a specialized cell under line ministries or be a department within line ministries.

8 Discretionary power may translate into economic or political advantages, but does not necessarily have to.

According to the Coase Theorem approach[9], PPPs are constituted by an 'interactive negotiation and assessment process in which actors, prior to engaging in formal cooperation agreements, define the content of the project, investigate possibilities and risks, arrive at agreements on the distribution of costs, benefits, risks and responsibilities and decide on the arrangements that will govern their cooperation (Koppenjan 2005). A PPP contract can be optimized by the use of negotiation. The access to negotiation, co-operation and clear legal rules in relation to PPP must be ensured by the legal system (Tvarno 2010). In practice, governments commonly use the EU's 'Competitive Dialogue'. As a contracting party is not able to define the technical and commercial means or specify a new form of arrangement, it required government to work with bidders to develop solutions to overcome the inherent complexity of PPPS (UNECE 2008, p.31). Furthermore, establishing procedures for consultation can help reduce misunderstanding and even conflicts between governments and the private sector. An informal mechanism and opportunities for dialogue between the public and private sectors can smooth out cooperation problems. (UNECE 2008, 21)

5.2.3 THE INCOMPLETE CONTRACT THEORY AND TRANSACTION COST THEORY[10]

Generally, the transaction costs of PPPs that can be identified and measured may include the advisory costs for legal, financial and technical matters, costs for organizing and participating in the bidding process, costs for negotiating the concession contract, costs for monitoring. These transaction costs, which can be visible and unhidden, can be burdensome in the context of developing countries. These costs are highly interrelated with the lack of capacity to use regulatory and legal instruments efficiently and effectively for superior performance in the developing countries. When unprepared, developing country governments may request some form of ODA (Official Development Assistance) as the price for adopting the PPP model. The case of India is illustrative in Holden (2009), pointing out that the model of PFI is an export strategy of the UK health industry as well as an attempted policy transfer to influence developing countries' decision to adopt the British PPP/PFI. Although India appeared to be committed to implementing PPP on a large scale quickly, they faced several obstacles such as lack of expertise, and fragmented responsibility between government departments. The Indian government requested the UK as a sponsor of Public Private Infrastructure Advisory Facility (PPIAF)[11] to help them gain professional skills and expertise and enhance technical capacity needed to make PPP projects effective. (Holden 2009, p.324)

Under imbalanced power relations, PPP projects are subject to the hidden costs due to Principal-Principal problems, Opportunistic Renegotiation and Hold-up problems (Ho 2006, Guasch 2004).12 Therefore, an important challenge in PPP governance design is to reduce these hidden costs. In order to capture the degree of accountability of the public and private sectors and avoid disruption due to political shifts, the third party including Civil Society Organizations (CSOs), local communities and Supranational Regulatory Organizations (SROs) can help reduce potential transaction costs such as principal-principal problem, renegotiation and hold-up problem and will "pull the alarm" when agencies

9 See the appendices 1
10 See the appendices 1
11 The UK, Japan and the World Bank developed a multi-donor technical assistance facility, aimed at helping developing countries improve the quality of their infrastructure through private sector involvement.
12 See the appendices 1

stray away from preferred policy path (Raman and Bjorkman 2009, 145). The state's regulatory capacity is not likely to serve the interests of the poor or the weaker members of a partnership unless strong civil society organizations and their democratic participation prompt it to do so (Miraftab 2004). Furthermore, PPPs can be characterized by a complexity of institutional, legal and technical structures. Complexity often seems to be used as a shield behind which governments can shelter and avoid accountability. Complexity may be addressed by ensuring that improved accessibility mechanisms for citizens are created (Hodge and Greve 2010, p.16). In this regard, NGOs may be responsible for monitoring performance, setting local standards, dealing with customer complaints and addressing the needs of the poor. Inclusion of all affected stakeholders such as service users' perspective can make the difference between a project being taken seriously or not. (Wildridge, et al. 2004) The Australian empirical evidence on PPP performance of the Latrobe Regional Hospital illustrates that the arrangement failed only two years into the contract not only due to a financial failure, but also a governance failure. First, it accepted an unsustainable price bid in the first place, did not undertake any comparative analysis to benchmark public provision, and did not recognize that the government was unable to transfer the social responsibility of hospital provision such as safety and hygiene (English 2005). Importantly, she noted that crucial documentation in terms of financial arrangements was withheld from citizens and not provided through Freedom of Information request to ensure transparency and openness. Second, governance risks appear to have increased with PPPs. The failure is attributable to two-way deals between the public and private sectors without including citizens, with an emphasis on primacy of protection in favor of investors rather than the public interest, and the desire of governments to proceed with hasty project construction for political purposes, among others (G. Hodge 2005). Empirically, Flinders (2005) suggests in the light of the UK experience that the process needs more careful focus with a robust framework to ensure *openness and transparency* than ideology to appreciate the long-term consequences of PPPs.

In addition, as Supranational Regulatory Organizations (SRO), either international or regional, can play a significant role as they have more bargaining power vis-à-vis larger multinational investors and address the shortage of qualified personnel to staff regulatory agencies, especially in developing countries[13]. (World Bank 2002, p.16, Pessoa 2008, p.322-323) A great asymmetry of power between such multinational corporations and the regulators of the developing countries can have negative impact on the independence of the latter. According to (Holden 2009, 326), the Romanian case is a good example of this. The Romanian government negotiated with the World Bank to get a loan from and adopted a strategy while the strategy would be binding on the current and any successor government, which is seen as a positive feature creating opportunities for foreign investors, including building and managing hospital facilities.

5.2.4 THE INSTITUTIONAL APPROACH

5.2.4.1 The Mechanisms of Governance

13 Some of regulatory functions can be contracted out to international bodies, but core functions need to be maintained in-house.

According to NIE, institutional arrangements (modes of coordination) are efficient in achieving common goals. NIE focuses on the cost efficiency of different types of institutional arrangements among actors such as market (competition), hierarchies (vertical integration), and hybrids (neither markets nor hierarchies; networking) under specific conditions (e.g. uncertainty) (Williamson 1996). For example, at the nation-state level, hierarchies historically appeared to be the preferred way of organizing the coordination among actors. While in liberal countries markets are considered to be the most appropriate coordination mechanisms for economic activities, even markets remained subordinated to government ordering such as regulation. The third form of coordination mechanism arises due to globalization, which change the rule of games under which nation states behave. Nation-states have to coordinate with non-state actors including business and civil society actors so as to achieve their goals. Different forms of governance (institutional arrangements) have different degrees of efficiency under different circumstances and incentivize actors differently, thus leading to different strategic behaviors, which in turn will lead to coordination problems and costs.

5.2.4.2 Institutional Quality

Also, institutional quality and legal system as a source of comparative advantages are the most relevant channels for the determination of trade and investment in PPPs, suggesting that gains from trade are conditional on getting the governance structures right (Hammami, Ruhashyankiko and Yehoue 2006, Andres, Guasch and Straub 2007). Institutional quality can be defined by credible, stable and predictable rules to resist influences and pressures from the stakeholders. This matters for investors through its direct influence. Empirically, Hammami, Ruhashyankiko, & Yehoue (2006) show the importance of institutional quality in attracting PPPs - a larger number of PPP projects are found in countries with less corruption and effective rule of law. In this sense, the importance of governance is highly emphasized in order for a state to put into place the enabling institutions, procedures and process surrounding PPPs, to fully benefit from PPPs (UNECE 2008).

The move towards private participation in infrastructure does not simply substitute private sector for public sector capacity. It requires that a new form of public sector capacity be developed to overcome various challenges (Jooste, Levitt and Scott 2011). The introduction of PPP will entail institutional change at various levels. Contrary to the traditional form of public procurement, PPP does not mean less government but a different government role. Because of the stronger private positions, more skilled government participation is needed. Public administration must not 'let the private sector excessively use the public credit for private gain (Scharle 2002). Holden shows that according to HM treasury's document, in the early days of implementation in the UK, the expected benefits of PFI projects were not fully realized, partly because there were inadequate project management skills for such a complex procurement process in the public sector, and because 'public sector clients had insufficient commercial knowledge and experience, in many instances even to select suitably qualified advisors. (Holden 2009, p.322) This issue is more likely to be severe in developing countries, many of which suffer from very low administrative capacity and technical know-how. This positive example was illustrated by India's request for technical assistance through ODAs to bridge the capacity gap. Let alone the development of capacity building in the public sector, a network of public, private and non-

profit[14] needs to support the development and continued operation of PPPs for the benefit of all stakeholders concerned. (Jooste, Levitt and Scott 2011) At the same time, this requires a new form of governance in dealing with PPPs rather than the hierarchal structure of government.

Moreover, the sustainability of PPPH depends on the regulatory environment, which in turn is shaped by the quality of regulations. Weak institutions such as lack of proper contract enforcement create uncertainties about the quality of regulations and therefore increase risk. Strong institutions and effective rule of law are thus important for securing partnerships. The problem cannot be the absence of instruments for assessing and monitoring arrangements, but the lack of capacity to use those instruments efficiently and effectively for superior performance.

5.2.4.3 Institutional Environment

Also, institutional environment can provide enforcement service other than an independent third party. The institutional system needs to be built on the "rule of law". Citizens' fundamental rights are recognized, which restraints the capability of capture of the last-resort enforcer. The costs of the enforcement mechanism can be shared among the citizens (Brousseau 2008). Although the property rights approach assigns a dominant role to governments and polity as law enforcer, transaction-cost view shifts attention to the way individuals and social groups actually "play-the-game", *i.e*., a self-help mechanism which relies on repeated transactions and multilateral relational contract. For example, ethnic groups still play a crucial role in facilitating contracting and trading in the absence of market institutions. Social network such as "*Guanxi*" (Chinese for personal relations) with business partners (horizontal networking) as well as party and bureaucracy (vertical networking) is a determinant factor to mitigate risks resulting from the weak legal and dysfunctional public order. (Opper 2008) However, social networks, which are limited to local level and small-sized firm, may induce information costs and collusion between network members and reduce efficiency. At the national and global level, reliable formal institutions and effective public order is an essential element of any reform agenda. Thus, "getting the governance structures rights" is seen as the core objective in developing economies.

5.3 Summary

The NIE perspective differs from the neo-classical in the sense that perfect information is not assumed, nor transaction cost of exchange is considered as zero. Institutions such as contracts, laws, constitutions and even unwritten norms and codes of behavior can be devised to reduce information uncertainty and transaction costs. The NIE approach concerns three elements or drivers of analysis: *organization, contracts and institutions.* Under incomplete contracts[15] like PPP, contracts need to be remediable to ensure changing coordination rules and flexibility because experience and learning

14 This includes sponsoring departments, PPP units, Transaction advisors, transaction auditors, Public regulators, Non-public regulators, Advocacy associations, and Development agencies.
15 See the appendices 1

process, *i.e.*, experimentalism, allow the discovery of more efficient solutions. However, the reversibility of contracts can result in opportunism and costs. Contracts are embedded in the institutional framework to save on negotiations and enforcement. As a tool complementary to mechanisms that reduce the costs of contracting, institutional frameworks such as enforcement mechanism are less costly and more powerful than a mutually agreed upon and enforcement mechanism to control for the worst deviation of the contracts. Laws are thus complementary to contracts. The institutional framework refers not just to the legislation and regulation of PPPs themselves, but also includes other elements supportive of good public governance, and capacity within government.

In case of asymmetric information, unbalanced power relations and incomplete contracts, the potential problems such as *moral hazard, opportunistic behavior, renegotiation, and hold-up* can arise.[16] Effective state intervention for equitable, efficient PPPHs requires a strong and democratic state using institutional or legislative muscle to level the playing field for all partners by regulating unequal power relationships between partners who have uneven socio-institutional capacities. Democracy can control for special interest predomination, making institutions more inclusive by protecting individual and minority rights and fostering collective deliberation. Furthermore, this condition is more likely to be met by *stakeholder governance* that supports dynamic interaction, coordination, learning process and dialogue among various levels of government, private sector, CSOs and social networks as well as international organizations to meet the *ex-post* common goal. The latter can make sure that, in cases where the role of state is weak, *ex-ante* commitments are made. This governance structure is likely to help reduce the costs shared by multi-stakeholders. Moreover, regulatory and institutional environments are shaped by their quality and intrinsic capacity in the public sector. Equally, the institutional system needs to be built on the "rule of law" to ensure that agents have confidence in and abide by the rules of society, while their rights are well protected.

Drawing on the previous theories and international experiences on governance assessments, (OECD 2012) four themes are set out to shape the focal points of the field research, in order to diagnose the different issues, and then collect, analyze main findings and draw main conclusions with a cross-country comparative perspective.

Figure 6: Linkages between NIE and Four Focal Analytical Points

NIE Theoretical Framework	Axis of Analysis
Transaction Cost Economics Coase Theorem	**1. Institutional Design (Policy Framework):** This part will focus on the policy frameworks formulated and implemented by each country in order to reduce PPP-related costs in relation with Public-Private Partnerships. How institutional and organizational design and set-up such as how decision-making affects the outcomes of PPPH is a key focal question. This theme is devoted to analyze the existing legal, regulatory and institutional structure, how the relevant actors interact with risk assessment, public procurement process, rule of law, participation, competition, transparency, multi-stakeholder dialogue and

16 See the appendices 1

Organizational Theory	democracy, enforcement/compliance and monitoring, etc.
Principal-Agent Theory Coase Theorem Incomplete Contract Theory	**2. Contractual Arrangement (Risk Sharing, Incentives):** Contracts are ex-ante tool for coordination between the two parties. The transfer of risks between the public and private is the essence of PPPs. With a long-term risk of financing and operation, the success of PPP relies on a reasonable risk allocation, incentives and clear output-based specifications to ensure mutual gains of stakeholders and attain Value for Money. This theme will deal with how ex-ante contracts affect the ex post behavior of both parties when faced with institutional and political risks.
Theory of Institutions Transaction Cost Economics	**3. Institutional Quality (Equity, Efficiency & Effectiveness):** Institutional and regulatory quality and capacity will be addressed in this theme. The purpose of PPP in is to free up government budget constraint to core economic and social development and bring expertise and efficiency from private sector to public service. But that does not necessarily mean those projects meet such goal. The question of whether PPP in the health sector can actually improve health service delivery in terms of efficiency, equity and effectiveness depends on quality and capacity to provide sound policies and regulations. Credibility, accountability, anti-corruption and capacity of government and regulatory body will be focused on.
Theory of Institutions Transaction Cost Economics	**4. Institutional Environment & Trade (Political, Economic & Social Context):** This theme will deal with "institutional environment" and look into social, political and economic environments. Key linkages among incentives, power relations and resources, and interests pursued will be examined along with mapping out the main stakeholders involved. Historical trajectories with different country specificity will be considered. Also, it will deal with international agreements such as multilateral and bilateral arrangements such as Investment Treaties, GATT/GATS. The role of ODA (Official Development Assistance) and international organizations including donor agencies in the context of developing countries will be highlighted.

6. RESEARCH QUESTIONS

The precursors of the formulation of the Capstone hypothesis are the research problems the group found when analyzing the literature and the first interviews conducted in Geneva. A PPP project is not purely about the private sector financing the public one, as previously discussed. It greatly differs from a privatization process, because "the cost effectiveness of a PPP relative to traditional procurement is a result of upfront engineering of the design solution and the financing structure combined with downstream management of project delivery and the revenue stream. All of this is a consequence of the incentives built in to the services payment mechanism and the risk transfer in the PPP model." (Grimsey and K.Lewis 2004, p.23)

According to Grimsey and Lewis, there are some common threads in the diversity: i) *participants* – a PPP involves two or more parties, one of which is a public sector body, but all must be capable of negotiating and contracting; ii) *relationship* – the partnership must be enduring and relational, implying continuity of behavior; iii) *resourcing* – each partner must add value to the relationship, be that skills, knowledge or resources, and deliver value for money; iv) *sharing* – there must be a responsibility and risk sharing between the partners, through mutual interest and unified commitment; v) *continuity* – it is necessary to have a contract ensuring certainty and setting out the 'rules of the game', to base decision-making processes in a previously established contract, although often the contract does not and cannot specify all components and outcomes. (Grimsey and K.Lewis 2004)

But because PPPs are such a particular type of agreement, and greatly vary from country to country and from sector to sector, the existing laws and regulations usually applied to contracts with the private sector do not seem to be the most effective way to legally handle a PPP contract. Each country approaches these breaches differently, and this will be further explored in the country studies. The main point is that a PPP project raises governance questions that need to be addressed. "The fact that one of the participants in a PPP is a public body creates a need for the inclusion of mechanisms of accountability quite different from those that would exist if all the participants were private. Yet, one reason for a partnership agenda is to break away from the political and bureaucratic processes that might exist if the activities were purely public. How are these potentially conflicting demands to be balanced? Can governments transform themselves from purchasers of infrastructure assets to managers of long-term contractual relationships? What are the administrative requirements needed for them to do so?" (Grimsey and K.Lewis 2004, p.34).

Furthermore, general PPP related guidelines from international organizations and reports from PPP consulting firms suggest that there needs to be sequenced approaches to implementing necessary measures before starting PPPs (ADB 2008, European Commission 2003, OECD n.d., OECD 2011, UNECE 2008, Farquharson, et al. 2011, Deloitte 2006). However, a detailed sector-specific approach and main lessons from developed countries are not missing in order for PPP related actors to choose well-thought and adequate PPP models and necessary institutional settings, taking into country specific conditions, while reducing errors as least as possible.

To address these concerns and draw preconditions for the development of PPPH in the context of developing countries - in light of the experiences of developed countries - and allow a comparative analysis between the developed and developing countries, the main research questions are as follows:

1) Do countries that put in place regulatory and institutional frameworks, *before* establishing PPP projects in the health sector, have more sustainable PPPH projects?

2) In light of previous PPPH experiences in developed countries - such as the United Kingdom, Canada, Germany and Portugal - what factors make PPPH work in the context of developing countries, especially in the Philippines and Turkey?

3) In developing countries, what needs to be done specifically in the regulatory and institutional settings to reap the potential benefits of PPPH projects?

To formulate the hypotheses, the group considered these research questions and, through literature analysis and direct interviews in Geneva, reached the preliminary conclusion that, in order to have a successful PPPH experience, it is necessary that countries first think about their governance structures, the institutional matrix, developing and implementing institutional and regulatory frameworks that will shape the relationship between the public and the private sectors in a PPPH project.

Hypothesis 1: Regulatory setting prior to the implementation of PPPH Projects is more likely to reduce agency costs and potential errors.

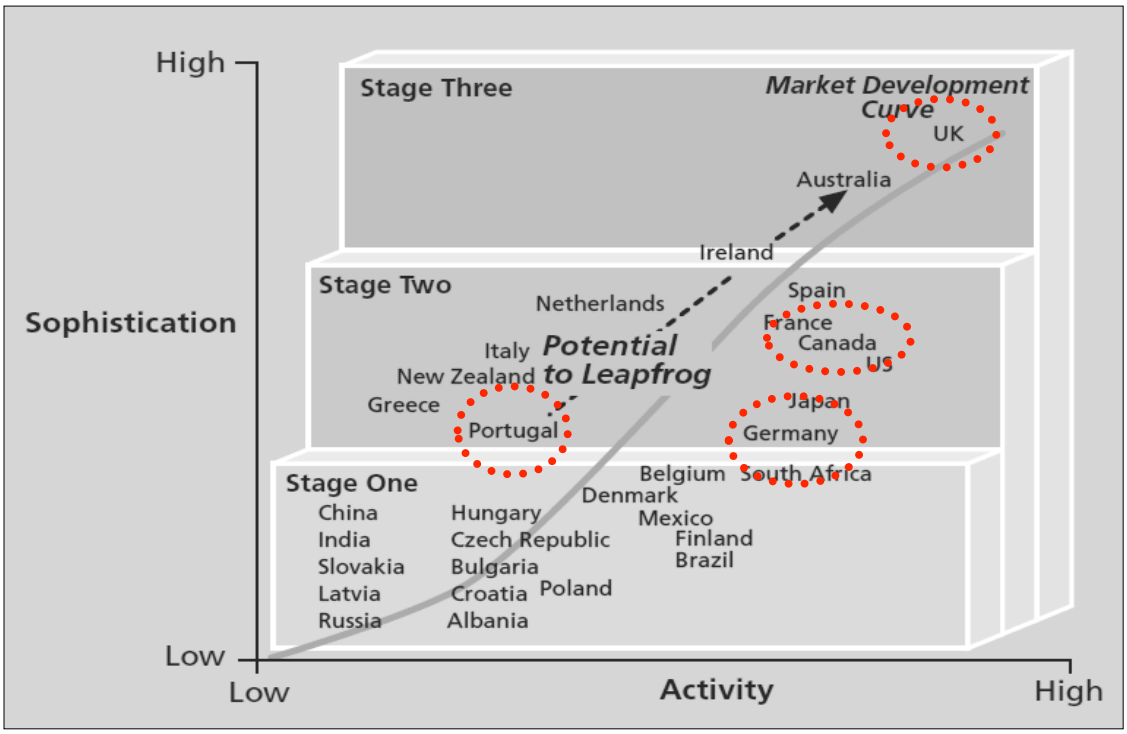
Hypothesis 2: The success and sustainability of PPPH Projects will depend on the public sector's capacity to efficiently and effectively implement regulatory and institutional frameworks aiming to safeguard the public value.

7. RESEARCH METHODOLOGY

This research used a variety of instruments in order to gather as much as representative and detailed information as possible on the theory and on the practice of PPPH, both in developed and developing countries. The following instruments were used.

Multiple Case Studies: Our research design is founded on a multiple-case study of four leading PPPH countries (the United Kingdom, Germany, Portugal, and Canada) and two emerging countries (Turkey and the Philippines). The multiple case approach is useful, as it helps us to abstract findings and lessons that may be more generalizable and reliable than those drawn from a single case study. Case studies are used to make comparisons across space by holding constant a sector (health), so the analysis can make better inferences of the role of political institutions on socio-economic outcomes (Alston 2008). The case studies in relation to PPPH were chosen to achieve a balance in terms of experience and different stages of evolution (nascent to advanced), different initial conditions and motives for PPPHs (political, economic and institutional rationales), types of institutional and regulatory models (centralized vs. decentralized decision-making, or bundling or unbundling of PPPH tasks) according to (Hodge and Greve 2007, p.553, Lonsdale 2005), and the level of success achieved (Deloitte 2006).

Figure 7: PPP Market Maturity Curve



Source: (Deloitte 2006)

According to (Lonsdale 2005), the conventional wisdom shows that bundling of tasks is more efficient and cost-effective, creating incentives and synergies between interdependent multiple tasks. However, by contrasting bundling with unbundling with different institutional structures, the question is to test whether or not PPPs in the health sector is also relevant with the conventional wisdom and to see what make difference across countries in PPPH.

Figure 8: A Typology of Public-Private Partnership in Health

		Types of Decision-Making	
		Centralized (top-down)	Decentralized (bottom-up)
Types of PPPH tasks	Bundling	Portugal (old)	-
	Unbundling	United Kingdom (old) Philippines Canada Portugal (new)	United Kingdom (new) Germany

Note 1: Depending on the organizational form, top-down approach is one pushed by the government either with centralized units or without centralized units. Bottom-up approach is based upon stakeholder participation and consultation.

Note 2: Bundling includes both clinical services and non-clinical services under one package contract. Unbundling implies that clinical services provided by doctors and nurses and ancillary services are divided in one single contract.

Source: author's own classification.

***Qualitative Analysis (Direct Interviews with a Semi-structured Method [17])*:** prior to our field trip conducted in two developing countries (Turkey and the Philippines), we complemented this initial analysis through interviews and discussions with professionals in (inter) national organizations based in Geneva, who have extensive experience in PPPH related field, in order to define key issues through the research project.

In Switzerland (Geneva), 9 visits were made with 11 interviewees. In Turkey (Istanbul), we had all together 12 interviews, with 14 people, and visited 2 hospitals. In the Philippines (Manila), we made all together 20 visits, interviewed 30 people, visited 4 hospitals including one PPPH project.

17 See appendices 1

They were interviewed with the use of a semi-structured method. This descriptive narrative draws on interview transcripts. All interview transcripts remains strictly confidential and anonymous so that interviews, which will be reflected in our analysis of PPPH.

Figure 9

Category of Interviewees	Purposes of visits	Remarks
International Organizations	General guidelines on PPPH and multilateral agreements such as GATS from WHO, UNAIDS, UNECE, WTO, UNCTAD	Preparatory interviews in Geneva before the field mission
Health related academia	Recent research and issues on PPPH	
Global PPPH	Global Public-Private entities such as GAVI Alliance, the Global Fund to fight against diseases	
Public sector	Institutional and regulatory settings, rationale behind PPPH, governance structure, current health status	Interviews during the Field mission in Turkey and the Philippines
Private sector	Reasons for partnering with the public, main concerns over PPPH, expectations from the public sector	
PPP dedicated unit	Roles and functions, corporate governance structure, bidding process, regulatory and legal frameworks in place	
Health facilities	Outsourcing and New Public Management including doctors and administrative staff	
Health and social security	National health service system. social equity over health service delivery	
Development Bank	Official Development Assistance (ODA), development policy frameworks in place, roles played by national and regional development agencies to assist PPPH	
Commercial Banks	Project financing through loans in PPPH	
Consulting firm	Transactions and legal advisors involved in PPPH, legal frameworks and investment related issues	
Academia	History of PPPH, trade and development, views toward PPPH	
Non-governmental organization	Views toward PPPH and participation in policy making	

Note: see a list of interviewees in the appendices 1

***Secondary Literature Review*:** we reviewed the theoretical and empirical literature on the PPPs with a general and sector-specific approach. The development of PPPs in the health sector is more nascent

in the developing countries than in the developed countries. Comparatively, little has been written on the performance of PPPH in different contexts, despite its popularity as a new form of collaborative governance around the world. The main PPPs are focusing more on developing infrastructures in transport sector (road, railroad, airport and seaports), telecommunication, energy (electricity and natural gas), and water and sewage according to the World Bank's PPI database. (World Bank 2011) However, social infrastructures such as health and education have not been analyzed and emphasized to a greater extent, despite its significance to meet the MDGs, to draw main lessons (see references).

***Quantitative Analysis*:** to analyze the determinants of PPPHs and assess cross-country differences and changes in country performance over time, as a complement to the qualitative analysis, Benchmark Indicators such as the World Bank Institute/Brookings Institution's Worldwide Governance Indicators (WGI) capturing core 6 dimension of governance[18], Health Expenditure Indicator from WHO, *inter alia*, as well as indicator data gathered from national sources.

Limitations

This report is intended to provide better understanding, both theoretically and empirically, of PPPH in an area as complex as PPP project development, especially where the scope of projects and the range of operating environments vary enormously across countries. However, this report has a limited list of interviewees and countries, and data availability such as the absence of international statistics on PPPH at the global level and the lack of national database, due to the recent development of PPPH especially in the developing countries compared with the developed countries. Thus, access to information concerning PPPH during the field mission both in Turkey and the Philippines is restricted.

Also, due to the time constraint (two weeks) in the field trip in Manila and Istanbul, the team faced limitations to get comprehensive answers in Turkey and the Philippines. Especially, in Turkey where commercial and political capitals are separated into Istanbul and Ankara, the geographical constraint limits in-depth interviews with government officials who are mainly based in Ankara.

Country case studies on the OECD countries to draw main lessons are based upon desk research and literature review rather than field trip. To assess the on-going development and performance in terms of institutional and regulatory settings in both developing countries, the team relies on stakeholder interviews and relevant national database and publications in order for the team to make adequate inferences and make policy recommendations. The following pages are intended to provide helpful general guides to inform the development of more detailed practices and country-specific approaches.

18 1) Voice and Accountability, 2) Political Stability and Absence of Violence/Terrorism, 3) Government effectiveness, 4) Regulatory Quality, 5) Rule of law, 6) Control of Corruption

8. PPPH IN DEVELOPED COUNTRIES: BEST PRACTICES AND LESSONS LEARNED

In order to have a complete grasp of the context and stage in which PPPHs are immersed in today, it was necessary to perform a multiple case study – an approach useful to help us abstract findings and lessons that may be more generalized and reliable than those drawn from a single case study. Prior to the field trip (Turkey and the Philippines), we conducted researches focused in four different leading PPPH developed countries: Canada, Germany, Portugal and the UK. These countries were chosen based on their experience in the health sector PPP, which makes it possible to develop a comprehensive comparison study with the developing countries.

The different stages of PPPH in each country (nascent to advanced), different motivations for engaging in this type of contracts, and different types of institutional and regulatory frameworks provided us with a rich desk research and scenario in which to insert our finding from the developing countries field trip, and better analyze how to improve the sustainability of PPPH projects.

Canada

Canada is a federation. Different levels of government plays different role in public health system. Regional level government, referred as province and territory, has its own jurisdiction of public policy setting. In the public health area, provincial level government takes the main authority while the federal government empowers to enact laws that apply to the whole country. In that sense, the public health system in Canada is different in structure and operation from province to province. Besides legal power, Canada federal government controls the health system through constitutional spending power. After evaluation, the federal government directly transfers the health care spending to provincial level government, or to individuals and groups. Holding the fiscal power, federal government reserves its influence on health care policy setting. In order to strengthen the legal framework of health system, The Canada Health Act was released and it sets a list of goals that provincial government is expected to meet as a condition of receiving federal loans. It regulates that were the goals not met, federal government can withdraw financial support to local government. All hospitals, in Canada, public or PPP type, by law must be public institutions. (Makarenko 2010)

1. CHARACTERISTICS OF CURRENT PPPS

The definition embraced by The Canadian Council for Public-Private Partnerships is:

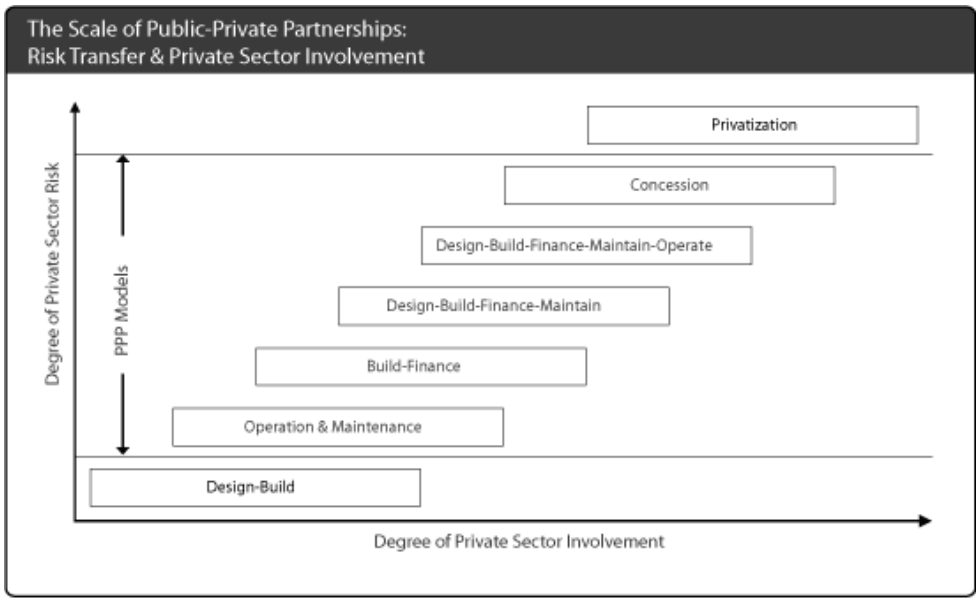
"A cooperative venture between the public and private sectors, built on the expertise of each partner, that best meets clearly defined public needs through the appropriate allocation of resources, risks and rewards."

Contrast to US, there is a major difference to the concept of "privatization" in Canada. In the country, full divestiture or turning over a specific function to private sector, even when public sector retains the regulatory right, is regarded as "privatization". And it is seen as the furthest point of PPP where most or all assets are held by private sector. (Canadian Council for Public-Private Partnerships 2011)

Defined by The Canadian Council for Public-Private Partnerships, there are common 8 typologies used in Canada: Design-Build (DB), Finance Only, Operation & Maintenance Contract (O & M), Build-Finance, Design-Build-Finance-Maintain (DBFM), Design-Build-Finance-Maintain-Operate (DBFMO), Build-Own-Operate (BOO) and Concession. DBFM is the most common typology of PPPH in Canada.

The Canadian Council for Public-Private Partnerships presents a spectrum of public-private partnership models used in Canada. It indicates the different level of risk transfer in PPP model from Design-Build to Privatization. (Canadian Council for Public-Private Partnerships 2011)

Figure 10



Hospital and healthcare is the most active sector of PPP in Canada with many big projects completed and ongoing within the country. Most commonly used model in health sector is design-build-finance-maintain (DBFM), including hard facility management and non-health care services. (Food, security etc.)

Based on database of CCPPP, until Nov 2011, 59 out of 159 PPP projects all over the country are related to hospital & healthcare. Among 59 projects, 23 of them are using DBFM model, all of them are with cooperation of provincial/territorial governments, 25 are at operation stage, 26 are under construction, 40 located in Ontario, 10 in British Columbia, 6 in Quebec.

Under PPP hospital model, private company constructs and owns the physical hospital building and lease to hospital board. Hospital board takes the responsibility of running the hospital. Based on performance, provincial government adjusts the annual budget for the hospital of next year.

Other PPP model outside hospital complement the service of tradition hospital, like seniors care is delivered by private entities. Another example comes from for-profit MRI (magnetic resonance imaging) clinic which speed up the access to MRI scan by pay for private sectors.

Figure 11

Fact Sheet of PPPH in Canada	
Total number of PPPH projects in Canada	59 (including hospital and health care)
Total number of PPP projects in Canada	159

Percentage of PPPH among all PPP Projects	37%
Most Common PPPH Mode	Design-Build-Finance-Maintain (DBFM)
Common Roles of Public and Private Sectors in PPP Hospital	- Private company constructs and owns the physical hospital building and lease to hospital board. - Hospital board takes the responsibility of running the hospital. - Based on performance, provincial government adjusts the annual budget for the hospital of next year.
Number of DBFM Mode	23 out 59 PPPH projects are DBFM mode (39%)
Public Side in PPPH	All of the PPPH in Canada are with cooperation of provincial/territorial governments. Federal government hasn't directly involved in any PPPH project
Current Condition of PPPH	25 at operation stage (42%) 26 under construction (44%) 8 others (14%)
Location of PPPH	40 in Ontario (68%) 10 in British Columbia (17%) 6 in Quebec (10%) 3 others (5%)

Source: (Canadian Council for Public-Private Partnerships 2011)

Note: Statistics of PPPH projects is based on CCPPP database, until November 2011.

2. POLICY CONTEXT

Different provinces have their policies regarding to PPPH respectively. In PPP active provinces, like Ontario, decided to construct two hospitals resemble to UK PFI in 2002. Private partner takes design, finance, build, own and maintain the hospital while MOH and hospital boards take the funding responsibility of clinical services. In British Colombia, the province decided to finance long-term care through PPP and build hospitals through PFI.

Besides most of not-for-profit health service providers, there were certain cases of PPPH contracted to for-profit organizations, on cancer treatment and laboratory services etc. However, there is a considerable debate over the engagement of for-profit sector in direct health service provision, particularly on equity issue. During 1997 and 2001, several provinces' auditors-general expressed concern about whether partnerships will have implications for international trade obligations. And in 2001, Alberta's auditor-general requested more stringent control over clinical services contracting out. A case observation over PPPH housekeepers in hospital supported such concern. After privatization of housekeeping service, employers' wage level were cut almost in half together with significantly reduced benefits, and abolished labor union protection. (Aidan R. Vining 2008)

3. INSTITUTIONAL FRAMEWORKS

The country has a comprehensive procurement law, though not specific on PPP, providing sufficient guidance and restriction on PPP. Most of the PPPH projects also follow this procurement law. In some PPP active provinces, like British Colombia or Québec, provincial level governments establish its own PPP laws. Below is a summary the PPP laws and regulations in the country, not limited to health sector.

At the federal level, Canada Strategic Infrastructure Fund Act is used to promote the partnership between public and private sector in infrastructure building by regulating Fund. (Canada Strategic Infrastructure Fund Act 2011)

At provincial level governments and PPP agencies set up legal framework and standards to seek fairness and public interest. In 2006 May, Québec government introduced Bill 17, An Act respecting contracting by public bodies, which covers the PPP contracting condition and transparency in contracting process, fair treatment and accountability. (Global Legal Group 2007) In British Colombia, Health Sector Partnerships Agreement Act [SBC 2003] Chapter 93 defines the different roles of public and private partners and sets requirement on established agreements, though missing detailed regulations. (British Columbia: Health Sector Partnerships Agreement Act 2011) Supplement to legal framework, public companies assist establishing PPP guidelines as well. Canada PPP Fund and Partnership British Colombia, both public companies, release a guideline of PPP proposal writing and a disclosure policy for PPP procurement respectively.

At the municipal level, governments need to seek for a mandate from their citizens if the public contract is longer than 5 years. But there is no legislation on the transfer of employer from public to private sector that has the potential of simulating corruption and under table deal. Since there is no specific PPP law to follow, all PPP projects should ensure that no existing general legislation is being violated. (Hong Kong Government 2006)

Contrast to decentralized institutional framework regarding PPP in Portugal and France, Canada's PPP institutional framework facilitation was recognized as the most centralized. (UNDP 2006)Despite the country's weak PPP legal framework, authorities were set up by federal and local government to promote and regulate PPP instead.

At Federal Level, there are:

I. Infrastructure Canada,

II. Industry Canada – P3 office

III. PPP Canada Fund

At the local level, frontier PPP provinces, Alberta, British Columbia, Ontario and Quebec have their ministries or government owned companies.

I. Alberta Infrastructure and Transportation

II. Partnership British Columbia

III. Infrastructure Ontario

IV. Quebec PPP (Hong Kong Government 2006)

At the provincial level agencies or companies, capital-planning process is required for all infrastructure projects, universities and hospitals. Staffs and ministers are required to do strategic planning, like condition and value of capital assets, project future capital needs etc. as a condition of receiving provincial capital support. (UNDP 2006)

Figure 12

Institutional framework in Canada	
Legal framework of PPP	- Federal level: general procurement law, Canada Strategic Infrastructure Fund Act - Provincial level: Québec, An Act respecting contracting by public bodies; British Colombia, Health Sector Partnerships Agreement Act
Centralized Institutional Framework	Authorities at Federal Level, there are: I. Infrastructure Canada, II. Industry Canada – P3 office III. PPP Canada Fund Authorities at Provincial Level, there are: I. Alberta Infrastructure and Transportation

	II. Partnership British Columbia III. Infrastructure Ontario IV. Quebec PPP

The establishment of PPP Canada Fund marks as the entry point of the country's third decade of PPP development. After the success PPP projects at provincial level, particularly in Ontario, Québec and British Columbia, central government put a national-wide PPP promotion office in its long-term economic plan in 2006. (PEI Media 2011) And in February 2009, PPP Canada was established as a Crown corporation (corporations owned by Canada Federal Government) with an independent Board of Directors reporting through the Minister of Finance to Parliament. The merit-based fund size is $1.25 billion and can support as much as 25% to each selected project's direct construction cost. It is aiming to improve PPP projects through better value, timeliness and accountability to taxpayer. It also targets at demonstrating best practice and capacity building. In June 2011, PPP Canada closed third round of fund competition, receiving 121 proposals of fund request from different provinces and territories, covering transportation, green energy, water etc. (PPP Canada Fund 2011)

In the company's three-year operation, it already made some positive influence among Canada's PPP market. Firstly, in its fund competition process, many applicants from undeveloped PPP market were provided with PPP as a procurement solution as well as support and expertise. It helped to set up momentum and visibility of PPP procurement among decision-makers. Secondly, PPP Canada leveraged provincial and territory government to disseminate information of the Fund to other levels of government and submit application on their behalf. This helped the relationship setting between PPP Canada and provincial and territory government and ultimately driving the adopting of PPP at local level. And PPP Canada put itself in a position of an enabler and a supporter of PPP project office. (PPP Canada Fund 2011)

Figure 13

Quick Facts About PPP Canada	
Mission	Manage the $ 1.256 bn PPP Canada Fund
	Screen whether applicants for other Federal funds rigorously considered PPPs as an option for projects over $ 50m
	Advise the Federal government and provinces on their PPP programmes
	Act as a centre of excellence for PPPs nationwide
Launch of PPP Canada	2009

Fund	
Location	Ottawa
Senior Management	John Mc Bride, CEO; Greg Melchin, Chariman of the Board

Source: (PEI Media 2011)

At provincial level, the effort of promoting PPP is also active. British Columbia, a company named Partnership British Colombia was set up to promote cooperation between ministries, agencies and private sector to develop PPP projects. The company is owned by the Province of British Columbia and reports to its shareholder, the Minister of Finance. The company's main clients are public sector agencies and crown corporations, providing consultation and knowledge of PPP. Below is the ambitious shifting of corporation goal of Partnership BC in 2011 due to continuous development of PPP in Canada. (Partnership British Colombia 2011)

Below are the major funding sources of PPP in Canada

i. Public funding – government borrowing, grants or contributions and capital allocation, and property development rights

ii. Public sector support – government guarantee, monetization of government receipts or payments, credit enhancement and revenue bonds

iii. Private sector financing – capital markets and bank borrowing

iv. Philanthropic donations

v. Commercial contributions e.g. payment for naming rights (Hong Kong Government 2006)

4. LESSONS LEARNT

Canada has a mature and well-regulated market, thus a PPP specific regulation doesn't seem to be necessary to the country. PPP Canada Fund greatly promotes the establishment of PPP projects by providing funding and practical guidance. Different from other developed countries, Canada has a very centralized institutional framework over PPP with both federal level and provincial level authorities. These authorities are the main risk control and feasibility evaluation bodies to specific PPP projects in the country, so as playing a crucial role to the success of the PPP projects. Financial source of Canada varies from public to private. The country has sufficient capital market and bank sourcing to support PPP.

In PPPH, particularly hospital mode, clinical service is reserved with public sector. Fiscal budget is with provincial level government based on the performance of the hospital. Private sector mainly takes the construction of the infrastructure and non-clinical service maintenance.

All PPPH projects are in cooperation with provincial level governments. And three provinces, Ontario, British Colombia, and Quebec take the lead in this area. It shows the possibility that PPPH doesn't necessarily have to be country wise at its early stage, but may start trial in some provinces cooperating with local governments.

However, PPPs in Canada also have the following potential problems and risks need to be addressed in the future.

A. Communications / misperceptions of the public

B. Opposition by unions

C. Political commitment insufficient

D. Long term nature of PPP contracts gives rise to uncertainty

E. Complexity of transactions

F. Different cultures between public and private sectors. Different views on implementing PPPs, practices differ across different jurisdictions (Hong Kong Government 2006)

Germany

Germany is a federal republic with 16 states, also called Länder. Each state has their own constitution that is consistent with the principles of the *Grundgesetz,* the national constitution. The constitutional legislative functions are divided between the *Bundestag,* Federal Assembly, and the *Bundesrat,* Federal Council. The 'Bundestag' consists of directly elected representatives that pass laws and elect the Chancellor. The 'Bundesrat' consists of state representatives that approve laws from the Bundestag (Busse and Riesberg, Health Care Systems inTransition 2004). Thus, for a bill to become a law in Germany, both legislative bodies need to approve. Since often multiple parties form the political coalition, this legislative process is defined by delays and compromises.

In principal, legislative power lies on a state level, however the federal level has been given legislative power explicitly when it concerns national matters, e.g. monetary policy and foreign affairs, uniform laws and framework legislation. (Busse and Riesberg, Health Care Systems inTransition 2004)

Germany currently has the fifth largest economy and has one of the highest GDP within the European Union. According to the CIA World Factbook (CIA 2012) in 20110, Germany is facing an aging population, low fertility rates and declining net immigration, which pressures the social welfare system and push for structural reforms in order to sustain long term growth. Reforms implemented in the period from 1998 and 2005 by then Chancellor Schroeder addressed chronically high unemployment and low average growth. The CIA World Fact book (CIA 2012) states that these reforms contributed to lower level of unemployment and strong growth in 2006 and 2007. The unemployment rate in 2011 was 6%, which can be considered low considering the financial storm the EU is experiencing. In 2009, the German economy took a hit with a contraction of 5.1%, but recovered steadily in the following years. In 2010, GDP grew by 3.6% and 2.7% in 2011. Despite the financial turmoil in the EU, the German GDP is expected to grow with 0.6% in 2012. The resilience of it economy is attributed to high quality manufacturing products and exports outside of the EU. Chancellor Angela Merkel has paid efforts to stimulate the domestic demand through stimulus packages in 2008 and 2009 and tax cuts.

Although PPP projects in Germany have played an insignificant role in the past, major developments have occurred in the last decade in road traffic and construction. In the past, legal obstacles and ideological preferences to provide social services financed by tax revenues hindered PPPs. PPPs have become a more conventional measure to implement and finance projects at state and municipality level. The public has been drawn to PPPs due to public budget constraints and potential increase in time efficiency. Now, the German government, through its legal system, actively addresses the legal obstacles. (Hausmann 2008)

PPP in Germany are still fairly non-traditional, although many projects in the education sector have materialized. Other projects in various other sectors, e.g. health and housing, vary in their usage of the PPP-model. Some have just started whereas others have a handful of ongoing projects. Public bodies have the possibility to use the PPP-model if a comparative advantage was assessed. However, public authorities in Germany are cautious, especially when sovereign power, e.g. prison, is under pressure. (Schenk and Schmachtenberg 2007) The investment share of PPPs in health care was only 8.2%, 4 projects, in 2009. However, in half of the projects, more than 50 million Euros were invested (Partnerschaften Deutschland 2009). So far, 9 projects have been contracted out and 12 projects are

currently being considered. All projects, so far, had the aim to outsource infrastructure only. In Germany, the federal government (*Bundesregierung*), regional governments (*Landesregierungen*) and regional authorities (*Landesbehörden*) are the most important procuring authorities or public contracting entities (*öffentliche Auftraggeber).* (Schenk and Schmachtenberg 2007)

1. CHARACTERISTICS OF CURRENT PPPS

Germany currently has various definitions for Public-Private Partnership (PPP). Within the legal framework no statute with a clear definition of PPP exists, however a comprehensive definition has been advised for future PPP projects. Currently, agreement exists that the definition of PPP should include at least private participation and private resources in the provision of a public good on a voluntary, formal and longer-term basis (Kühling and Schreiner 2011). Among the various PPP models, the *Ownership, Contracting* and *Renting Model* are used the most frequently. These basic German PPP contract models have been utilized particularly in the construction sector. As all PPPH projects incorporate construction, (Partnerschaften Deutschland 2009) these contract models are highly applicable.

1.1 PPP Ownership Model

Ownership Model or "*Nutzungsüberlassungsmodell*" is the most frequently used PPP model. In this specific model the public authorities is the owner of the assets from the beginning of the contract period (Hausmann 2008). The responsibility of private partner lies with delivering the infrastructure, e.g. construction, and financing. The commitments are usually for 15 to 25 years. Consequently, the private partner carries the risk bearing during the contract period. The most attractive component for the private sector to engage in these partnerships are the regular periodical payments from the government "covering all cost of construction, financing and operation as well as risks and profit, which is usually the main awarding criteria during the public tendering process" . (Alfen and Leupold 2006, p.208)

1.2 PPP Renting Model

In the PPP Renting Model the "public contractor may be granted an acquisition option or an option to extend the lease [on an asset]". (Hausmann 2008, p.121) In this model, the purchase price is assessed at market value after construction and is not fixed beforehand in the contract. The private partner in the PPP Renting Model owns the land and property and has the responsibility to construct, finance, operate and maintain the asset. The public sector has the option to buy the facility at market value at the termination of the contract. Contracts periods are between 20 and 30 years. (Alfen and Leupold 2006)

1.3 PPP Contracting Model

The Contracting Model contracts are shorter, only 5 to 15 years. This is attributable to scope of the contract, which is limited to mainly installation, maintenance and operation. The asset is transferred at the moment of installation. Therefore, the private sector takes on a large part of the risk. (Alfen and Leupold 2006) The private partner receives periodic fees to "cover all planning and manufacturing/installation costs, operating and financing costs, as well as any loan capital repayments and profit margins of the private partner". (Hausmann 2008, p.122) In this model, the private partner is incentivized to use energy saving equipment, because operating costs remain the responsibility of the private partner.

Figure 14: PPP models in Germany

Model	Brief Description (ownership, associated risks)	Contract duration
PPP Ownership Model	• Ownership: public partner • Build operate b private partner • No transfer of ownership	• 15 to 30 years sometimes • 10 to 15 years
PPP Renting Model	• Private with option to transfer ownership to the public sector at market price, however no contractual obligation exists to transfer ownership. • Standard utilization risk	• 20 to 30 years
PPP Contracting Model	• Installation/Optimization, financing, maintenance and operation of technical equipment • Ownership: public sector	• 5 to 10 years

Source: (Alfen and Leupold 2006)

Figure 15:

Fact Sheet of PPPH in Germany[19]

[19] The number of PPP projects that have been take into consideration in Germany are the projects that have the entire life cycle approach, meaning planning, construction, finance, operation and potential deconstruction

Total number of PPPH projects in Canada	21 (including hospital and health care)
Total number of PPP projects in Canada	236
Projects with a contract	179
Projects in tender	34
Projects with PPP-elements	23
Percentage of PPPH among all PPP Projects	8.9%
Most Common PPPH Mode	Ownership, Contracting and Renting Model
Common Roles of Public and Private Sectors in PPP Hospital	- Private company plans, designs, constructs, finances, operates and potentially deconstructs facilities. - Hospital board takes the responsibility of clinical services -
Public Side in PPPH	All of the PPPH in Canada can be in cooperation with several layers of governments. Federal government can take part by providing advice and amending laws to facilitate PPP implementation.
Current Condition of PPPH	Most PPPH projects are on a “local” level.
Investments	1.7 Million – 250 Million Euro

2. POLICY CONTEXT

The German health care system is based mostly on a social health care system in which citizens contribute financially through their income tax and additional premiums of the compulsory health insurance. People earning less than €48,000 are obliged to be covered by this insurance scheme, including the dependents. Over 200 public health insurance funds, also called sickness funds, are autonomous, not-for-profit, non-governmental bodies regulated by law. (Busse 2008) Citizens earning

more than €48,000 can choose to insure themselves privately or not to insure themselves at all. Civil servants and self-employed are not covered by the public health insurance, but are covered by a private health insurance. 88% of the population is covered by the public insurance whereas 10% of the population is covered by a private health insurance. (Busse 2008)

The health care system in Germany is financed mostly with the funds from the pooled compulsory contributions to the central health fund, which are then distributed to the sickness funds. In order to improve efficiency in the health care system, sickness funds receive a fixed payment for each insured (Stolpe 2011). Private health insurers charge risk-related premiums, but are not allowed by law to increase the premium after entry and may not exclude pre-existing conditions. The health care system in Germany remains heavily regulated (Busse 2008) for both public and private insurance.

Busse & Riesberg argues "*German health policy is primarily concerned about the contribution rates rather than the percentage of total health expenditures or statutory health insurance expenditures of the GDP since these have risen considerably faster than the rate of GDP*". (Busse and Riesberg 2004, p.59) Consequently, sickness funds incurred an increased amount of debts even after the increase of contributions.

Figure 16: Trends in Financing Statutory Health Insurance (1992 – 2003)

	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
SHI revenues (billion €)	103	114	119	120	124	126	128	131	134	136	140	141
SHI expenditures (billion €)	108	108	117	124	126	125	128	131	134	139	144	145
SALDO (billion €)	-4.8	5.3	1.4	-3.7	-3.6	0.9	0.3	0.3	0.02	-3.0	-3.1	-2.9
SHI expenditure												
– cash benefits (billion €)	9.6	9.3	8.7	11.1	9.4	9.7	9.3	9.3	9.4	9.9	10.3	8.5
– in-kind benefits (billion €)	99.0	99.2	109	113	117	116	118	122	124	129	133	136
as % of GDP	6.1	6.0	6.2	6.3	6.4	6.2	6.1	6.2	6.1	6.2	6.3	6.4
Average SHI contribution rate (%)	12.7	13.2	13.2	13.2	13.5	13.6	13.6	13.6	13.6	13.5	14.0	14.3
Contribution to long-term care insurance (%)	n. a.	n. a.	n. a.	1.0	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7
Total social insurance contribution (%)	36.8	36.5	37.2	39.0	39.2	40.8	41.9	42.1	41.1	40.8	41.3	42.1

Source: Federal Ministry of Health, 2004, as described by (Busse and Riesberg 2004, p.61)

In the period from 2001 and 2004, the contribution rates increased from 13.5% of gross earnings to 14.3%. Major health care reform, since 1977, continuously followed with the objective to contain costs. The tools for containing the health costs varied from standardized pricing for pharmaceuticals to

increased co-payments. Busse & Riesberg argue that health expenditure growth have been moderated due to these reforms. (Busse and Riesberg 2004)

Alternative financing, such as public private partnerships, have become more attractive for hospitals due to the investment backlog. Funds from federal states have been decreasing. The funds are currently 60% of the funds made available in 1991. (Schenk and Schmachtenberg 2007) The need for more investments has pushed public official to use former unconventional matters to provide the public health care through PPPs. PPPH has a marginal share, but currently has a growing trend. The investment share of PPP's in health care was only 8.2% of all PPPs, 4 projects, in 2009. However, in half of the projects, more than 50 million Euros were invested (Partnerschaften Deutschland 2009). So far, 9 projects have been contracted out and 12 projects are currently being considered. All projects, so far, had the aim to outsource infrastructure only.

2.1 Legal framework

No single body of law currently applies to the PPP model in Germany, but specific legislation have been implemented to serve specific sectors and to reduce disadvantages for PPP projects. The road sector, for example, has to abide by the *Fernstraßenbauprivatfinanzierungsgesetz ("FStrPrivFinG")*. This legal base is specific to the PPP F-model. "Under the F-Model, specific traffic infrastructure projects (such as bridges or tunnels) are planned, constructed and operated by a private company, financed by a toll collected directly by the private operator from those using the facility". (Schenk and Schmachtenberg 2007, p.3) Despite the efforts to stimulate this PPP model, only a limited amount of projects materialized of which some are challenged financially. (Schenk and Schmachtenberg 2007, p.3)

The PPP Acceleration Act, also called *ÖPP Beschleunigungsgesetz 2005,* was passed in 2005 to partially abolish the real estate transfer tax and to create open property funds related to PPP projects. (Schenk and Schmachtenberg 2007) This act "changes certain provision of other acts that play a key role in the implementation of PPP projects (public procurement law, tax law, investment law, budgetary law, Federal private Road Financing Act)" (Hausmann 2008, p.113). As mentioned before, no single body of law refers to the implementation of PPP projects and therefore different statutes are called upon for regulating PPPs. PPP project implementation usually applies under public procurement law, however the award of concessions does not. The tender is legally bound to be competitive, transparent and provide equal treatment. Tenderers have the opportunity to the challenge the award in which remedies can be provided in review procedures. The German constitution can restrict PPP from being implemented. A new law in these cases needs to be passed in order to authorize such PPPs. Apart from the federal and state legal framework, German municipal law needs to be taken into consideration. As many PPP projects are on municipal level, the municipal legal framework can provide significant obstacles in the implementation. Existing provisions and prohibition of the sale of real estate are generally the major obstacles on this level of government. (Hausmann 2008)

3. INSTITUTIONAL FRAMEWORKS

Currently, Germany lacks a centralized PPP unit partly due to its decentralized political and legal structure that includes the federal, state, independent municipal and, in some cases, even regional governments. Consequently, PPP can be implemented in various forms depending on which level the PPP will be operated. (Hausmann 2008)

The push for more and better organized PPPs, has pushed the Germany to establish a PPP competence network that includes the "Public PPP Steering Committee (*Lenkungsausschuss PPP im öffentlichen Hochbau*), Federal PPP Task Force, various PPP state competence centres and the Federal Association for Transport Infrastructure Financing (*Verkehrsinfrastrukturfinanzierungsgesellschaft – VIFG*)". (Hausmann 2008)

Former Chancellor Schroeder established the Public PPP Steering Committee after the launch of the PPP initiative in 2002. This committee consists of public sector representatives - e.g. federal ministries, state ministries and municipalities - and private sector representatives, e.g. Federal Association of German Banks.

The Federal Government and several regions have created the "PPP Task Forces" or "Centers of Competence", also called ÖPP Deutschland AG, to gather and provide information of best practices and non binding documents. (Schenk and Schmachtenberg 2007) This consulting firm creates a platform for the government, banks, construction companies and consultants for dialogue in the field of PPP. The state holds 57% of the shares while the private sector holds 43%, however there is a growing criticism that ÖPP Deutschland AG is tailored mostly toward the private sector's needs, lacks neutrality in its feasibility studies and does not communicate a market price. (Schlieter and Berger 2012)

4. LESSONS LEARNT

The move to scaling up PPPs in Germany has come with a distinct political willingness in a time that public financing are crunched. The push for PPPs from important politicians, e.g. former Chancellor Schroeder, was necessary to amend laws that were perceived as obstacles to the implementations of PPPs in Germany.

The German legal framework currently does not require a single body of law for PPPs, however specific legislation have been implemented to serve specific sectors and to reduce disadvantages for PPP projects. Even though German states and municipalities have a significant legislative authority, Germany can benefit from having a stronger legal framework on a federal level that will encompass the basic principles of PPPs. Given the political decentralized structure, a single body law for PPPs is currently not possible nor desired. Therefore, a single body of law is not necessary to facilitate PPPs successfully provided that other both public and private sector can refer to other laws, e.g. procurement law. Applied laws that refer to PPPs can differ depending on the level of governance (federal, state, municipality, or regional) and sector, which can lead to confusion in the private sector in general and companies that are willing to enter the market. Especially international firms are expected to experience more obstacles during the tender process due to language barriers and lack of experience on a local

level in Germany. Companies that are currently awarded contracts are expected to become more powerful and dominate the market over time which can lead to less public value in the longer term due to diminished competition. It is unclear whether PPP tenders on different governance levels have provided an optimal level of competition that will ensure a market value.

Germany has taken a longer time to warm up to PPPs in comparison to the UK. The institutional support in this process has increased steadily to facilitate a fair and transparent process for higher public value. Criticism of the institutional support in the media, however, is getting louder. Institutional support in which both the public and private sector are both shareholders are still considered “strange bed fellows” and can still lead to biased results in feasibility studies, miscommunications and adjusted prices for proposed services. In the case of Germany, a centralized government PPP unit is therefore strongly advised to assess the patterns of success and failures of PPPs on all levels of government in order to address structural deficiencies.

Portugal

The Portuguese political system is composed by a Central Government, two Regional Governments for Madeira and Azores, and Local Governments. The Local Governments are responsible for ruling the municipalities, and have some autonomy over Central Government, although the later is the main body in charge of administrative and budgetary procedures, which means PPP projects fall under Central jurisdiction.

In terms of health care, in 1979, the Portuguese National Health Service (NHS) was created, establishing that health care should be available and provided for all, regardless of their wealth. Ever since, Portugal registers more and more improvements in its population's health, but the NHS also generated an increase in expenditure. Looking into ways to decrease this extra burden, the country introduced PPPs into the health sector.

PPPs are very common in Portugal, but they started being developed before the country actually had any legal framework for it. With this legal void, government adopted specific legal regimes for each group of projects, basing itself in concessions and public hiring processes. Portugal was one of the first European countries to adopt PPPs for developing public infrastructure, and its experience shows a rapid development of infrastructure, provision of high-quality services, and overall effectiveness. The first PPP contract in the country was negotiated for the construction of the Vasco da Gama Bridge, in 1992. Today, PPPs are being largely used in several services, such as transportation, health, energy and internal security.

1. CHARACTERISTICS OF PPPS

The PPP contracts in Portugal are mainly based in concession agreements, in which a public sector function is transferred to the private sector. The country has an Administrative Procedure Code (Coding de Procedimento Administrativo – CPA), which defines the powers of the public sector in these types of contracts in its article 180 as follows:

- Power to modify the contents of the obligations of the concessionaire to the extent that both the scope of the contract and the financial balance is kept unchanged;
- Power to instruct the concessionaire as regards the way its obligations shall be executed;
- Power to unilaterally rescind the contract based on imperative reasons of public interest, without prejudice to the payment of a fair compensation to the concessionaire;
- Power to supervise the execution of the contract;
- Power to apply penalties in connection with events of default duly previewed under the terms and conditions of contract.

The Portuguese legislation defines PPP as "a contractual relationship, settled between a public entity ("public partner") and a private entity ("private partner"), with long-term characteristics, aimed at

providing a public service, in respect of which the funding is, in whole or in part, a responsibility of the private partner. The private partner is also responsible for the delivery of the public service (article 2 of Decree-Law number 86/2003).“

2. POLICY CONTEXT

The first PPPH contract established in Portugal was the private management of a public hospital, in 1996. From then on, this became the most common type of PPPH contract, being implemented in several other facilities, with the objective of focusing administration on human resources, improving efficiency, and quality of service. In parallel, the government introduced a system focused on financial and administrative independence, and a payment system linked to production and efficiency, in order to stimulate competition.

In order to increase the support of a comprehensive guideline and framework to new and existing PPP and PPPH projects, Portugal launched, in 2004, a PPP Programme for the Health Sector, aiming to boost its also new PPP procurement framework. From then on, the government announced its plans of expanding PPPHs, thus attracting private partners and increasing investment in the sector.

Between 2000 and 2009, local governments begun investing more aggressively in PPP projects, seeking to modernize existing facilities or build new ones from scratch. Management of hospitals was also reorganized. Hospital units in proximity were integrated and jointly managed, to maximize economies of scale and reduce administrative costs.

3. INSTITUTIONAL FRAMEWORKS

The first institutional framework focused on PPP projects was established in 2003 (Decree-Law 86/2003), naming the Ministry of Finance as main responsible for governing PPP projects. “Parpública” - a state holding company - was created, and is responsible for monitoring and supervising all PPP projects in the country, from preparation to development, as well as assessing the value for money and risks of each project. The company can be considered the PPP unit of Portugal. Prior to the establishment of the PPP Legal Frameworks, projects had issues with tender processes, and monitoring and evaluation. Respective ministers administered PPP projects, and there was no coordination between them.

After the “Parpública” supervises the preparation and development of PPP projects, the Ministry of Finance partners up with the respective Ministry responsible for the area the project will affect and produces the scope of the project, the tender programme, the technical specifications and the financing structure for the project. After that, an official announcement is made, inviting partners for the tender process.

In terms of procurement, there are some directives that regulate the procedure, and make it relatively well structured. “The paradigm of the public procurement procedures is the international public tender which comprises the following main stages:

- The “Contracting authority” must advertise the contract to be awarded in the Official Journal of the European Communities (JOCE) and also in the Portuguese Official Gazette (Diário da República). At this stage, the tender programme and the technical specifications (ledger book) must be in place referring, inter alia, to the award criteria, which is usually the most economically advantageous bid (in certain situations the lowest price of the bids is the chosen award criteria).

- After the bids have been received (note that there are minimum time limits for bidders to present their proposals, which avoids disadvantageous deadlines for bidders located in foreign countries), a public hearing (Acto Público) takes place wherein the bids are opened and in the course of which the bids are accepted or rejected by the appointed jury.

- Once the “public act” is finished the jury initiates the analysis of the admitted bids so as to prepare a “Preliminary Evaluation Report” in which the evaluation of the bids is included.

- The bidders are then notified to present their considerations towards the evaluation of bids entailed in the report (Audiência Prévia). The jury is obliged to take a position over those observations when drafting the “Final Evaluation Report”.

- Based on the “Final Evaluation Report”, the public authority decides to award the contract in question to the bidder who has presented the best bid, considering the chosen award criteria.” (Castelos and Melo 2006)

But even with this structure in place, the procurement process in Portugal is a long one, and delays the establishment of new PPP projects. On average, it takes 3.5 years from project launch to signature. As a consequence, the bidding costs are high, and results and completion dates are uncertain. The procurement processes involve a long list of entities and bureaucratic procedures, which help delaying decision-making. In terms of PPPH, the Ministers of Health and Finance must approve all the major decisions; there are Commissions responsible for the tender documents’ preparation, Commissions for bid valuation and negotiations, and the departments and entities of both Ministries of Health and Finance (e.g. public hospitals, regional administrations, inspectorates, etc.). Other than that, teams of advisors and consultants also are a part of the process, as is the Audit Office, the highest Portuguese body regulation public spending. As a result of this process, government changes happen in the middle of the negotiations, which means projects are inherited by other administrations, creating further delays and uncertainty.

Under the legal framework, there is no reference as to how remuneration of the private partner must occur, which means it is defined by contract, and can be taken by the end user, by the State, or both.

Figure 17: PPPH and Procurement Processes

	Launch	Bids preparation and presentation	Bids evaluation	Negotiations	Contract signature	Operation of the new hospital
Cascais Hospital	September 2004	6	6	17,3	5	February 2010
Braga Hospital	January 2005	7,5	3	21,7	1,6	May 2011
Vila Franca de Xira Hospital	December 2005	6	23	Current stage	-	-
Loures Hospital	February 2007	6,3	13	Current stage	-	-
Lisboa Oriental Hospital	April 2008	10	Current stage	-	-	-
Algarve Hospital	May 2008	Current stage	-	-	-	-
Gaia Hospital	*Launch preparation*	-	-	-	-	-
Average duration	-	7,2	11,3	19,5	3,8	-

3.1 First wave of PPPHs

The first wave of PPPHs in Portugal focused mainly in infrastructure and clinical services. The infrastructure PPPs involve the design, construction and maintenance of the hospital building and fixed equipment. The clinical PPPs include clinical services, ancillary services, and medical equipment acquisition and replacement. In terms of revenue mechanisms in clinical PPPs, prices were recalculated yearly, taking into account inflation rate and a mark-up. The annual payment could not be higher than the one resulting from applying the prices used by the public sector. There were annual negotiations to determine the maximum production per type of acute care activity, and emergency services have no cap. The private sector also had to share with the public sector the revenues obtained from third parties, such as insurance companies.

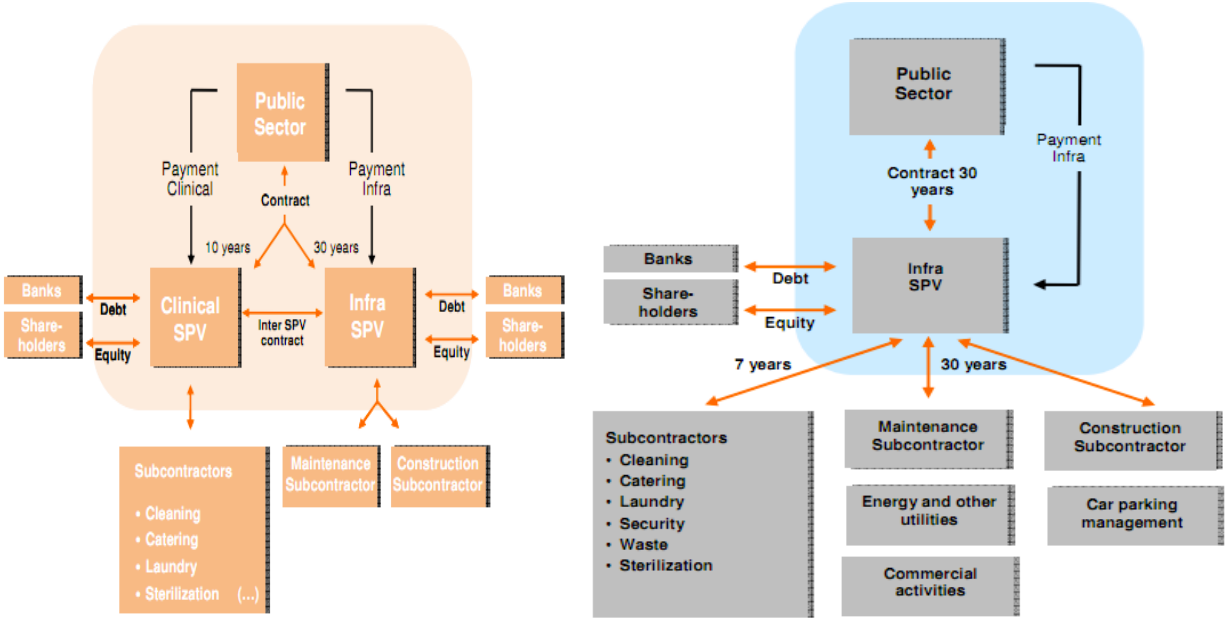
For the infrastructural PPPs payment mechanism, the availability was shared between current prices for the duration of the contract, and constant prices on the base date. Deductions were based on accessibility, safety, and use conditions, and service failures had a cap of 10% of the annual payment. The private sector had to share revenues from commercial activities, such as parking, with the public sector.

3.2 Second Wave of PPPHs

From 2008 on, the PPP Second Wave came to place, focused more on construction, operation of infrastructure, and ancillary services. Clinical services were kept under public responsibility. The contract comprises design, construction, and maintenance of the building and fixed equipment. The

payment mechanism is annual, and established in constant prices of the base date. The ancillary services are annually pay-per-service, also established in constant prices of the base date. There are volume adjustments depending on occupied beds, applied in the cases of sterilization, laundry and catering. Utilities payments such as water and energy consumption are deducted from the costs generated by the areas of the hospital occupied by the private partner, plus 20% of utilities costs of the whole hospital at contracted prices. Energy is paid at 80% of market price. Deductions are based on accessibility, safety, and use conditions. Service failures don't originate deductions, but fines are applicable.

Figure 18: Contract Structure of Portugal PPPH First and Second Waves



4. LESSONS LEARNT

From the Portuguese experience, it is possible to conclude that, despite eventual difficulties, the country has an overall successful history in PPP engagement. Portugal was one of the first European countries to invest in this type of contract, and it progressively learnt from its mistakes, increasing the public sectors' role and appropriate skills to deal with the complexity of bids and contracts negotiations. The country's experience also shows the importance of having a specific centre specialized in this type of negotiation, to facilitate the dealings with the private partner and attract more competition, along with programmes to incentivize contracts and procurements, and a legal framework that serves as a north to contractual negotiations.

Although the procurement process is still a sector in need of improvement, better guidelines and standardization are being more and more implemented, to facilitate markets acceptance and increase the value for money of the implemented projects.

United Kingdom

The Private Finance Initiative (PFI) is the most common form of PPP for the delivery of large-scale infrastructure and related services used in the UK. The initiative was introduced by John Major's Conservative government in 1992 as a way of enabling private investors to take on the financing, construction and operation of infrastructure projects. The role of state was kept to the minimum through privatization, contracting-out and delegation of authority for the provision of public services. The Labor party, which had been critical of the increased degree of institutional hybridity and fragmentation within the state, continued to expand this policy and harness the expertise and vaunted efficiencies of the private sector while maintaining public sector values after taking power in May 1997. (Raman and Bjorkman 2009, p.142) In addition to the PFI, the Labor government found new ways of integrating private sector into health services delivery in the health sector. The main drive of National Health System (NHS) reforms under the Labour government was through the introduction of a new innovative type of PFI, so-called Local Improvement Finance Trust (LIFT) and the establishment of Public Interest Companies (PICs) which are operated as semi-independent public companies in competition with other trusts.

Under market mechanism with incentives provided to health providers, it does not mean that the role of state is weakened. The role of state needs to be focused more on the regulatory function. Market functions efficiently under the watchful eyes of the government and stakeholders. In case of the UK, the regulatory mechanism of PPPs in Health consists of three independent regulators which are directly accountable to Parliament, each of which is in charge of ensuring *i) quality and safety, ii) finance and governance, and iii) health market*, while encouraging *competition* among NHS hospitals, empowering the *choice* of users (e.g. patients) and strengthening local ownership (e.g. local employees).

In light of the UK's experience, an ideological drive can be problematic and myopic at the expense of the public interest. The government's choice of PPPs for public services needs to be driven by practical possibilities as well as 'trial and error' rather than economic assumptions. Furthermore, the stakeholder governance arrangements are essential for tackling the "democratic deficit' and ensuring "transparency" to make PPPH more accountable to multi-stakeholders via participation and safeguard the public welfare under a small state. In addition, taking into account the health specific issues such as safety, a flexible organization form such PICs can be required to overcome shortcomings of contractual arrangements to secure the public interest.

1. CHARACTERISTICS OF CURRENT PPPS

The United Kingdom defines a Public-Private Partnership (PPP) as:

"Arrangements typified by joint working between the public and private sectors. They can cover all types of collaboration across the private-public sector interface involving collaborative working together and risk sharing to deliver policies, services and infrastructure." (HM Treasury 2008).

Two PPP initiatives are considered significantly well known; *Private Finance Initiative (PFI)* and *Public Interest Company (PIC).* While PFI originated in the late 1980s under a conservative government, PIC as a distinct type of PPP emerged in 2001 under a Labor government. (Raman and Bjorkman 2009, p.143) PIC is of recent origin, while PFI has a much longer history. Both types seek to delegate functions away from direct ministerial control while harnessing the expertise and capacity of the private sector, increasing efficiency within the public sector being the central objective (Flinders 2005, p.219).

1.1 Private Finance Initiative (PFI)[20]

Under a Under a typical PFI deal, the public sector enters into a long-term contractual arrangement with private sector companies, which undertake to design, build, operate (and often maintain) an asset. Whilst PFI projects can be structured in different ways, there are usually four key elements: *Design, Finance, Build and Operate* (DFBO). (Unison 2011) The obligations and entitlements of the SPV under the main project agreement are passed down to the Design & Build contractor and Operator sub-contractors through the respective sub-contracts. A company usually in the construction sector creates a "Special Purpose Vehicle (SPV)" to bid for a contract with a health authority to build and provide non-clinical services to a hospital. The successful contractor may need to enter into three types of subcontract: *i.e.* a consortium, one with banks to finance the project, one with a construction company to build the hospital, and one with a management company to manage the facility over the lifetime of the contract, typically 30 years. (Couttolenc 2009, p.20) PFI hospital contracts are awarded and managed by local bodies such as National Health Service (NHS) Trusts and local authorities[21]. The Department of Health is responsible for overseeing their PFI programmes and reporting to the public and Parliament on value for money.

In the UK PPP model, the 'core' and 'ancillary' services remain segmented. (Grimsey and K.Lewis 2004) The contracts use private funding to build and maintain hospital buildings, including ancillary services such as cleaning, catering and pottering. (National Audit Office 2010) The core services such as the clinical, medical and nursing services including doctors and nurses continue to be provided by the NHS. The NHS Trusts continued to the employer of clinical staff, with the private sector responsible for design, build, ownership, maintenance and delivery of ancillary services. Thus, the Government spreads the cost of new construction and the responsibility for support services is transferred to private companies. The Trust pays an annual fee or '*unitary charge'* for the contracted period. The unitary charges are composed of two elements: I) *availability charge*, which pays the private sector for providing buildings and equipment, ii) *service charge*, which pays the private sector for the provision of facilities management and ancillary services. (Hellowell and Pollock 2010, p.28)

There are around 700 PFI contracts in the United Kingdom. Over 500 of these are in England with a combined capital value of almost £50 billion. They are usually long-term arrangements typically

20 See more the pros and cons of PFI contracts in (National Audit Office 2011, 13)
21 39% are managed by Foundation Trusts, 49% by National Health Service Trusts, 12% by Primary Care Trusts; (National Audit Office 2010)

spanning 25 to 30 years. HM Treasury estimates that the total commitments on current PFI contracts for the next 25 years for the United Kingdom are approximately£200 billion. (National Audit Office 2011) Over the past ten years, the PFI has been the major procurement route for major health infrastructure projects. (House of Commons 2011, House of Commons 2011) As of April 2009, there were 76 operational PFI hospital contracts with a capital value of £6 billion. In addition, there are a small number of projects in procurement. Most recent contracts exclude support services such as cleaning, catering and portering[22]. The PFI differs from privatization in that the public sector retains a substantial role in PFI projects, either as the main *purchaser of services* or as an *essential enabler* of the project. It differs from contracting out in that the private sector provides *the capital asset as well as the services*. The PFI differs from other PPPs in that the private sector contractor also arranges finance for the project. Under the PFI, the public sector *does not own an asset*, such as a hospital or school, but pays the PFI contractor a stream of committed revenue payments for the use of the facilities over the contract period (G. Allen 2001, p.10, Corner 2006, p.40-41).

1.2 Public Interest Company (PIC)

The second common type of PPP, PICs have a wide variety of organizational forms such as not-for-profits, mutuals, and social enterprises23. The flexibility in its organizational form is a key advantage of this type of PPP.[24] Without shareholders usually, PICs deliver public services and are legally independent of government (Maltby 2003). The notion of shareholder is replaced by stakeholder membership in order to increase the sense of accountability towards the local community or users. They are run in a business-like manner, but are not owned or controlled by external private shareholders. As a result, all surpluses are re-invested in the organization. Although fully or largely funded by the state, PICs are allowed to raise money through the private market but under government supervision, whereas the PFI attracts private sector capital and therefore theoretically allows the government to transfer resources elsewhere. Elected boards drawn from the local community manage the Foundation hospitals (NHS Foundation Trusts) to increase the accountability of public service directly to local communities and the users of that service (Flinders 2005). In addition, plans for the creation of foundation hospitals as PICs include the establishment of the Office of the Independent Regulator for NHS Foundation Hospitals, that is, 'Monitor'. In accordance with the Health and Social Care Act 2004, this body will fix spending limits on the amount that these hospital trusts can borrow from the private sector, hence theoretically balancing the independence demanded by the health secretary with the control demanded by the chancellor of the exchequer. (Flinders 2005, p.227)

22 The Department of Health has not undertaken any evaluation to identify the merits of either including or excluding these services. However, 20% Trusts were not satisfied with the maintenance service provided within their PFI contracts. (National Audit Office 2010)

23 See the appendices 2

24 See the classification of PICs (Maltby 2003, 16)

2. POLICY CONTEXT

The UK was the first country in Europe to make extensive use of PPP structures to invest in social infrastructure such as hospitals. (PricewaterhouseCoopers 2010, p.36)The government has concluded that PPPs have the predominant role to play in its current hospital investment programme - the largest in the history of the National Health Service (NHS). (HM Treasury 2008, p.5) However, the public was perceived as demanding improved public services while being reluctant to pay increased taxes in the UK. To the Conservatives, the PFI was as a means of growing the private sector's role in parts of the public sector where outright privatization was politically unachievable. (Hellowell and Pollock 2010, p.24) The Labour party had been highly critical of the Conservative government's commitment to privatization and contracting out functions to the private sector[25]. However, when being in office, the Labour government was however determined to demonstrate sound economic management in order to reassure the private sector and leave behind the Labour party's image of producing financially incompetent governments as part of its modernization agenda. The New labour model, so-called 'Third Way', attempted to avoid ideological doctrine, and harness the expertise and efficiencies of the private sector while maintaining public sector values. In this context, PPPs signify the very essence of New Labour ideology. Thus, the Labour government has entered into a vast range of PPPs which include Local Improvement Finance Trust (LIFT) Companies, Public Interest Companies (PICs) and Community Interest Companies and the Private Finance Initiative. (Flinders 2005) For both the Conservative and Labour governments, PFI's alleged ability to deliver 'fiscal saving' has been an important attraction. In addition to this, private financed investment is invisible to national debt, due to "off-balance sheet" status. Thus, the politico-economic rationale was the main driver of PPPs in the UK.

3. INSTITUTIONAL FRAMEWORKS

There is no specific law governing the regulation of Private Finance Initiative projects (OECD 2010, p.77). Constitutional or other general law from contracting any activity to the private sector does not restrict UK governments. However, legislation was needed to assure private sector financiers that local governments could not later claim that they are not legally bound by a PFI contract, and that contracts signed by public sector Hospital Trusts would be backed by the government, if the Trust were to fail. (Spackman 2002) There are PFI-related laws, guidelines and standardized contracts issued by HM Treasury.

3.1 National Health Service (NHS)[26]

The NHS is the healthcare system in the UK, which is tax-funded with services provided in the public sector. The NHS is centralized with overall stewardship of the organization provided by the Secretary of State for Health and the Department of Health (DH). The Strategic Health Authorities, which are agents

25 Ibid.
26 See the appendices 2

of the DH, are in charge of regional planning and coordination. Some areas such as diagnostic and elective care are provided by the private sector. NHS services are free, except for eye tests, dental care, prescriptions and others. (Hellowell and Pollock 2010, p.27) Despite the rapid increases in NHS budgets from 2000 onwards, many NHS Trusts faced serious financial deficits by 2005. This raised concerns about the ability of trusts to manage their finances, the ability of the Department of Health to monitor them effectively and the appropriateness of the financial regime itself (The King's Fund 2008, p.6).

3.2 Health related Frameworks

3.2.1 NHS Local Improvement Finance Trust (LIFT)[27]

Local Improvement Finance Trusts (LIFTs) are an innovative form of PPP launched by the Department of Health in 2001 to meet the challenges of investing in small health schemes and to remedy the poor quality of primary care premises. This approach is in response to the years of under-investment suffered in primary care health facilities[28]. The mechanism is that individual contracts were grouped together or "batched" and standardized. Contract batching benefits from a coherent strategy, economies of scale and repeat contracts. Batching also attracts larger construction companies into the market. Private sector partners bring expertise in terms of project delivery and property development. LIFT was established to address premises improvement, increased co-location of healthcare professionals and recruitment and retention of GPs in one building with an integrated approach to Primary Care.

A 20-year 'Strategic Partnering Agreement (SPA)' will be made between a group of local NHS trusts and a consortium known as a 'LIFT company'. The purpose of the SPA is to establish a long-term partnership between LIFT co and the participants. A public sector representative sits on each LIFT company board, and private-sector personnel join with public-sector managers on 'Strategic Partnering Boards (SPB)' set up to plan local primary healthcare provision (Aldred 2008). SPB holds the LIFT Cos to account and is responsible for commissioning new LIFT developments and services as well as monitoring existing schemes.

3.2.2 Express Local Improvement Finance Trust (LIFT)

In 2008, the government announced the establishment of the Express LIFT framework. This model is intended to bring the benefits of the LIFT programme to Primary Care Trusts (PCTs) that have not conducted their own procurements. It allows these PCTs to choose from a list of pre-approved

27 (National Audit Office 2005, House of Commons 2006, Rassell 2008)

28 Most General Practitioners (GP) surgeries were in adapted buildings that needed redevelopment or replacement. About 80% were too small, most could not deliver modern healthcare and many breached the Disability Discrimination Act in terms of limited access for disabled users. There was no structure for private investment in GP surgeries, with 84% owned by the GPs; see (Couttolenc 2009)

suppliers, and the expectation is that this will reduce procurement times to just a few months. Express LIFT delivers a fast-track procurement option, bringing together all the advantages of the original LIFT programme without the lengthy and potentially costly initial selection, design and development period. The new Express LIFT Framework offers a choice of experienced pre-approved strategic partners[29] to work hand in hand with the public sector in delivering appropriate and tailored estates solutions.

Figure 19: Comparison between two PPP models: LIFT and PFI

- Unlike PFI deals, LIFT deals are based on the local LIFTCo, known as a consortium, with *an exclusive right to develop and own the premises*, which it builds and refurbishes. Revenues come from *rental payments*, leasing space to Primary Care Trusts, healthcare professionals and other interested social care tenants.
- PFI has been used as a route to develop *larger premises,* whereas LIFT to develop *small-scale premises* as the Treasury guidance suggests that PFI should not be used for projects under £20 million, taking transaction costs into account.
- LIFT is designed as a *batched* approach to investment in a portfolio of properties to make smaller projects viable.
- LIFT provides more than just health care by *co-locating health care services with housing and welfare advice* - "a wider range of services under one roof"
- Under LIFT, health centres will remain *owned by the LIFT* Co at the end of the lease period unless purchased by the NHS, whereas under PFI, hospitals can *revert to the public sector* at the end of the lease period.

Source: (National Audit Office 2005, House of Commons 2006, p.6, Unison 2006)

3.2.3 NHS Foundation Trusts: A new type of NHS hospital[30]

NHS Foundation Trusts (FTs) are a relatively new organizational form and established in law with a new adapted form of public ownership as independent Public Benefit Corporations[31] modeled on co-operative and mutual traditions. This principle is centered upon local ownership and involvement of patients, the public and staff rather than control from the Department of Health with greater financial

29 A list of suppliers on the framework was announced in March 2009.
30 (Department of Health 2012)
31 This is governed by the Health and Social Care (Community Health and Standards) Act 2003

and operational freedom than NHS Trusts. NHS foundation trusts are different from existing NHS trusts. Unlike ordinary NHS trusts, FTs are not directly accountable to the Secretary of State for Health and nor are they performance managed by Strategic Health Authorities. However, FTs are firmly part of the NHS and subject to NHS standards, performance ratings and systems of inspection conducted by the independent regulator called Monitor.

Furthermore, in terms of governance structure, anyone from the local community, anyone who has been a patient, or anyone who is an employee of the trust will be able to register as a 'member'. These stakeholder governance arrangements could help tackle the long-term criticized "democratic deficit' in the NHS. There have traditionally been few mechanisms for involving patients and the public in the NHS. (Maltby 2003, p.42) Foundation Trust staff and people living locally have the right to become members and vote for a Board of Governors which plays a role in helping to set the overall direction of the organization. Therefore, FTs are accountable locally to their members through the Board of Governors including NHS Primary Care Trusts and to Monitor. Just like NHS Trusts, most of their income is derived from agreements reached with local NHS Primary Care Trusts (PCT) to provide locally relevant services for NHS patients at the national tariff rate. Unlike NHS Trusts, FT's contracts with PCTs and other purchasers are legally binding. The model contract produced for them by the Department of Health includes an arbitration clause, so disputes are unlikely to get to the courts (Allen, et al. 2011, 80).The Department of Health intends that all of NHS hospital Trusts should transform themselves into NHS Foundation Trusts in due course if the former meets conditions and requirements assessed by the regulator Monitor (Department of Health 2010). Also, Foundation Trusts are subject to both the Healthcare Commission's - which was later replaced by the Care Quality Commission - assessments and regulation by the foundation trust regulator, Monitor, against their terms of authorization, financial conditions and governance standards.

3.3 Health PPP Regulations and Institutions

Broadly, regulation of healthcare in England encompasses the legislative framework within which the NHS and the independent sector operate as well as the more detailed guidance issued by the Department of Health. The need for a system of regulation on quality and safety was recognized in the Labour government's first health White Paper. At that time, there was no national policy covering all aspects of the quality and safety of health care provision (The King's Fund 2008). The focus of regulation is on *i) the quality and safety of all health services, ii) the financial performance, iii) the market in healthcare services*. The organizations currently performing these regulatory roles include the Care Quality Commission, Monitor, the Audit Commission and the Department of Health. [32]

32 See the appendices 2 for Roles and responsibilities within the NHS Performance Regime

3.3.1 Quality and Safety Regulation: Care Quality Commission

The Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission were merged into one single body called the Care Quality Commission (CQC) in 2008. It was intended to strengthen regulation by increasing the independence of the regulatory system and to reduce burden it imposed on providers, and to harmonize the regulatory regimes applied to non-NHS and NHS providers, resulting from perceived variation in current service quality, and to reduce the cost of regulation (The King's Fund 2008).

It is responsible for the regulation of all health and adult social care providers in England. All providers of healthcare including NHS providers, Foundation Trusts, NHS primary care providers and independent providers are legally bound to register with the Commission in order for them to provide services after meeting the registration requirements. The CQC has defined its missions as ensuring essential quality and safety standards, driving improvement and stamping out bad practice. The CQC is required to carry out performance reviews, so-called Periodic Reviews, of all NHS Trusts and FTs and of care provided and commissioned by PCTs. The CQC must provide annual reports to Parliament on the state of health care services. The Commission will have a wide range of enforcement powers including fines or imprisonment for failure to register. If trusts fail to comply with any enforcement action, then the trust boards will be subject to intervention by the Secretary of State. In particular, the Health and Social Act 2008 requires the new Commission to publish a Statement of User Involvement that should include details of how they will inform service users and carers about their functions and arrange for some of their functions to be exercised by and with the assistance of service users and carers.

3.3.2 Financial regulation: Monitor[33]

The introduction of NHS Foundation Trusts changed the system of accountability, with the explicit aim of encouraging greater independence from central government. In this context, established in January 2004 in line with the National Health Service Act 2006 as well as Health and Social Care Act 2012, Monitor's role is to authorize and regulate NHS Foundation Trusts as independent regulator of NHS Foundation Trusts. Its added roles include licensing providers, regulating prices for NHS-funded care, enabling integrated care and preventing anti-competitive behavior, supporting service continuity. This regulator is independent of central government and directly accountable to Parliament. These are a set of detailed requirements covering how foundation trusts must operate; 1) the general requirement to operate effectively, efficiently and economically, 2) requirement to meet healthcare targets and national standards, 3) the requirement to cooperate with other NHS organizations. Each foundation trust submits a plan and reports on a regular or ad-hoc basis to Monitor after assessing the compliance with the terms of authorization[34]. In case of failures and breaching the terms of authorization, it has powers to intervene in a foundation trust and to remove members of the trust board or even dissolve the trust

33 (Monitor 2012)

34 These include stipulations about the maximum amount of money a trust can earn through private income, the maximum amount they can borrow, and data they have to make available. Ibid.

entirely. Monitor's regulation is based upon risk-based system of regulation set out in the Compliance Framework and Quality Governance Framework to assess the terms of authorization and measure the structures and processes in place. Performance of NHS FTs is monitored by Monitor to identify actual and potential problems with a focus on finance and governance. Additionally, it publishes two risk ratings on finance and governance for each NHS foundation trust.

3.3.3 Economic regulation: Ensuring a 'fair playing field'

The introduction of market mechanism into the provision of healthcare for NHS patients has led to the emergence of a new area of regulatory activity. In addition, the introduction of new contractual mechanisms in primary care has also opened up the provision of some primary care services to independent and third sector providers including social enterprises. NHS bodies are not subject to the regulatory regime that applies to other parts of the economy and is enforced by the Office of Fair Trading and the Competition Commission. (The King's Fund 2008)

To regulate this new market in health care, there are sets of mechanisms in place. First, the department of Health sets a national tariff, which sets out the fixed-price-per case that hospitals will be reimbursed for treating NHS patients. Second, Competition is encouraged by the Department of Health through principles and rules including empowerment of patient's right to choose. (Department of Health 2010, Department of Health 2012) Primary Care Trusts (PCTs) are required to have a procurement strategy rather than a formal procurement process. To ensure fair competition among potential providers, a Cooperation and Competition Panel (CCP) has been established to monitor how PCT commissioners abide by procedural rules. A private provider can appeal a case to the CCP. The CCP is in charge of merger inquiries, procurement disputes, conducting inquire, advertising and misleading information disputes, non-case specific competition issues referred by the Department of Health or by Monitor (Cooperation & Competition Panel 2012). Third, mergers between providers, including vertical integration, are subject to Department of Health approval even though they are examined locally on a case-by-case basis. Mergers can reduce patient choice and competition, and this may have an adverse effect on patients and taxpayers by reducing the incentives that service providers have to improve services. Neither Monitor nor the Department of Health's Transactions Board will decide on a proposed transaction without advice from the CCP (CCP 2010).

Fourth, when it comes to market exit, the Department of Health published a consultation document on a regime for unsustainable NHS providers. There are sequenced stages: the appointment of a Trust Special Administrator, followed by the preparation of draft and final statutory resolution reports, and decided by the Secretary of State (Department of Health 2012).

3.3.4 PPP Dedicated Units

Partnerships for Health (House of Commons 2006) is a national joint venture established between the Department of Health (50%) and Partnerships UK (50%) to oversee and invest in LIFT[35]. Partnerships for Health takes a 20% shareholding in each local joint venture company (LIFTCo). A further 20% of the shares in the LIFTCo is owned by stakeholders in the local health economy[36] and the remaining 60% by a private sector partner, selected through open competition. Local LIFTCos enter a long-term strategic partnership with Primary Care Trusts (PCTs), giving them exclusivity, which is subject to value for money tests to develop and deliver future schemes in response to local health priorities and strategies.

Partnerships UK (PUK) is a delivery organization that provides customized support to projects and programmes on complex procurements including all forms of PPPs. PUK has a public sector mandate but is itself a PPP joint venture with 49% of the company being owned by government (Treasury and Scottish ministers) and 51% owned by the private sector. Operational Task Force (OTF) is based in PUK and acts on behalf of HM Treasury. The Task Force has a helpdesk to assist public sector partners with any operational issue on PFI projects. It also carries out regular reviews of the performance of operational projects.

3.3.5 Success and Failure

There was a temptation on the part of government to use the PFI in order to move government spending from the government's accounts, i.e., "off-balance" status. There is no clear evidence of whether PFI is any better or worse Value for Money (VFM) than other procurement routes according to the House of Commons (2011). In terms of innovation, in one hospital project in the UK, the contractor was able to cut down on cleaning costs by having windowsills at 45 degrees so that people could not put things on the sills and generate extra cleaning costs. PFI delivers increased efficiency in the building and managing of prisons and constructing roads but not in skill-intensive sectors like hospitals (Gaffney and Pollock 1999). Instead of transferring risk to the private sector, PFI tends to transfer risk to the government, users and taxpayers- particularly in designing, building and managing hospitals. Also, PFI increases the number of quasi-autonomous public bodies or hybrid bodies, thus increasing the complexity within state administration. The complexity is exacerbated by frequently creating other quasi-autonomous organizations to oversee and regulate the activity of these partnerships (Flinders 2005). For example, the failure case of the Paddington Health Campus illustrates that the project requires the active participation of many different types of stakeholders, with the difficulties in reaching agreement with all of them, combined with the high costs of the projects. (Mckee, Edwards and Atun 2006) When it comes to contractual arrangements, since PFI contracts are based on long-term perspective, the private partner becomes more powerful when the contract needs to be renegotiated because the government would have lost its own ability to provide the services. Also, the inflexibility of

35 See the appendix

36 Stakeholders involve Primary Care Trusts, Local Authorities, General Practioners who wish to take a shareholding

PFI limits the ability of NHS trusts to strategically plan for the future as they are contractually bound to pay for a building and a pattern of service provision. There are significant risks for the public sector relating to the long-term affordability (over 25 to 30 years) and inflexibility of PFI loans [37]. This presents risks to local health economies and results in reduced services for patients. This is the case of the Queen Alexandra Hospital in Cosham (BBC 2011) in which 700 jobs have been cut and about 100 of the hospital's 1200 beds have been closed since July 2009. PFI has enabled many more hospitals to be built that would otherwise have been the case. (House of Commons 2011)

According to (Rassell 2008, Beck, et al. 2010, 49), LIFT has been particularly successful as a catalyst for building healthy communities by helping to shift hospitals based services into primary care and by co-locating *health and social care*[38]. The NHS LIFT model illustrates an example of good practice in structuring a PPP, even though it has been developed recently. The Church Road centre in Newham, which was the first LIFT building to become operational, opened in September 2004. (Department of Health 2007) This scheme built one-stop primary care centre that has relocated 3 GPs practices into one state of the art development for patients. It comprises several extra services such as district nursing, dentistry, pharmacy, and diagnostics services (x-ray, ultrasound and blood testing, etc.). The positive side of LIFT is that the majority of the LIFT buildings, which had been built, were to a standard and quality not experienced before in primary care, and delivered on time and to budget. Another good side is that LIFT delivers a broader and more complex range of services to patients than typical primary care premises. The National Audit Office (NAO) report (2005) is positive about the benefits of the innovative structure of LIFT, particularly the requirement that projects are agreed in the context of a local strategic plan and the flexibility it allows. Nevertheless, the House of Commons (2006, pp. 15-16) examines that comparing the Value for Money (VfM) of LIFT with other procurement routes is not straightforward because the LIFT framework is designed to offer tenants more and better services than under a standard lease. In terms of LIFT's accountability and outcomes, the NAO points out the need for the strengthening of accountability and performance measurement frameworks. No formal framework to evaluate LIFT exists including the important issue of how it compares in practice to experience using alternative procurement routes. (House of Commons 2006) Furthermore, the effectiveness of Strategic Partnering Boards (SPB) is crucial to the performance of LIFT. Its members from local stakeholder bodies need to focus on being decisive and results-based rather than being a forum for debate to make LIFT effective to identify key local health issues as well as a priority for LIFT. Another negative side that some public sector stakeholders felt that the private sector was not as innovative and risk-taking as they had hoped, while the private sector stakeholders felt that the promised order book from the public sector in some cases didn't materialize (Rassell 2008).

A variant of PPP, the PIC such as the NHS Foundation Trusts is more locally driven and patient-focused to meet the needs. Flexible organization form and stakeholder governance based upon local ownership are required so that a patient focused service can be delivered through cooperation and competition under the watchful eye of the government who plays a role in regulating the market and ensuring health quality and standards in the interest of patients and through empowerment of patients' rights, *i.e.*, choice.

37 See written evidence from various stakeholders in (House of Commons 2011)
38 Social care is the professional provision of care, support and welfare for dependent or vulnerable groups or individuals.

4. LESSONS LEARNT

It is possible to suggest that the government's commitment to promote and advance PPPs in a dogmatic and ideological way can be myopic. The process needs more careful focus, a clearer and more explicit rationale and justification, combined with a robust framework to ensure openness and transparency for multi-stakeholders defer a Faustian bargaining to get short-term rather than long-term gains[39].

Additionally, there needs to be a reflection of underdeveloped skills and an imbalance of power and knowledge between the public and private sectors in the beginning of PPPs. (Holden 2009) The expertise on the public sector side of the PFI process is relatively underdeveloped compared with PFI consortia bidding teams. Whereas few health authorities will have undertaken a large capital development, the consortia will have done several. (Mckee, Edwards and Atun 2006) Also, future PFI projects need to consider whether contracts can be designed to more easily allow organizations to change the way they operate and adapt to a more competitive market, *i.e*. *flexibility*. This is because it will be difficult in practice to recover large costs from contracts because of the legal difficulties of renegotiating some contracts. In addition, it is difficult for NHS organizations to find alternative uses for buildings that maintain income and to allow flexibility on service provision because the PFI costs cover not only the costs relating to the design and construction of building designed for clinical use, but also long-term service delivery contracts. (National Audit Office 2011, House of Commons 2006)

As illustrated by the NHS Foundation Trusts, in order to deliver better quality and responsive public services, the government needs to have a full range of organizational forms, which can be responsive and tailor-made to specific contexts and sectors. The basic organizational form of a public service has an influence on service quality. However, the organizational form such as Public Interest Companies (PICs) is appropriate under conditions that contracting for complex public services where the public interest or issues such as safety are key, and when the usual reliance on a contract alone is unlikely to be enough to secure the public interest. Ideological presumptions can be problematic. The government's choice of organization forms for public services need to be driven by practical possibilities. Considering the health specificity, this institutional structure needs to be based upon local ownership and involvement of multi-stakeholders rather than a top-down approach to ensure that ex-ante commitments concerning the public interest are fulfilled instead of relying on market and state alone. While encouraging *competition* among NHS hospitals along with a flexible organization form to safeguard the public interest, empowering the *choice* of users and strengthening *local ownership* is essential to make PPPH work.

39 The Local Government and Public Involvement in Health Act 2007 introduces the concepts of local improvem ent targets and local area agreements, and includes a new duty to consult with those members of the public who are likely to be affected by provision of the services. In addition, the Freedom of Information Act 200 ensure a public right of access to information held by public authorities.

9. HANDS-ON EXPERIENCES: PPPH IN THE FIELD

Here again the concept of multiple case studies is used as base for the field research project. In order to obtain a full grasp of the scenario PPPH is immersed in developing countries, two countries were chosen as models for the study – Turkey and the Philippines.

PPPH in the Philippines have been growing at a fast pace, and the health sector has been evolving and thriving more and more. The country's emerging economy presents a great opportunity for PPP projects to thrive. Turkey is also an emerging economy and developing country, but it is currently more developed than the Philippines, so the field study provides new perspectives, expectations and experiences. It's plan for reform to establish a universal health care system, provides many opportunities for PPPHs, either to make the current system more efficient or the universal care more sustainable.

Philippines

1. POLITICAL BACKGROUND

The Republic of the Philippines is a sovereign country formed by an archipelago with 7107 islands. The multi-party democratic republic consists of a presidential representative system, comprised of a president who is the head of state and government, a Legislative branch, an Executive branch, and a Judicial branch. The president is elected by popular vote, and the country's mandate is of six years.

The Philippines became officially independent in 1946, after being part of empires such as the Spanish, the United States, and the Japanese. Occupying a territorial area of over 300 000 square kilometers, the country is divided into 17 regions, 80 provinces, 138 cities, 1 496 municipalities, and 42 025 barangays (villages).

The country is a member of the United Nations, and a big ally of the United States, having signed a mutual defense treaty in 1951. The Philippines is also part of the Association of Southeast Asian Nations, an organization focused on promoting growth and cultural exchange between members.

Economically, the Philippines present a steady growth – "gross national product (GNP) grew by an average of 5% per year during the period from 2000 to 2009, with growth peaking in 2007, when the economy grew by 7.5%. It even posted a growth rate of 6.2% in 2008, the year when there were food and fuel price shocks globally." (WHO 2011, p.336) Despite a decrease in growth in 2009, the country's economy recovered quickly, showing a GDP increase of 7.3% in the first semester of 2010. (WHO 2011, p.336) Of the almost 95 000 000 Filipinos, (WHO 2011, p.336) around 10% live overseas, (Collymore 2003) and send remittances home, which represents a strong economical stimulus.

2. HEALTH CARE IN THE PHILIPPINES

In 1999, the Department of Health launched a Health Sector Reform Agenda (HSRA), with the objective of improving health care to the Filipino population. Under the HSRA, many changed were predicted and implemented, including the FOURmula ONE for Health (F1) framework. This framework's objective was to "ensure access to and availability of essential health packages; assure the quality and affordability of health goods and services; secure more, better and sustained financing for health; and, improve performance of the health system within the medium term." (Health Policy Development & Planning Bureau 2006, p.5)

Health Financing was one of the main pillars of this reform, and financing is, to this date, the main focus of the government, and the path to obtain the ultimate goal – universal health care. In 2010, the Aquino Health Agenda (AHA), was launched to "improve, streamline and scale up reform interventions espoused in the HSRA and implemented under F1", (WHO 2011, p.342) focusing especially on pro-poor policies. Along with health financing, the agenda focuses on service delivery, standards and regulations, governance, human resources, and information. Healthcare spending per head in the country in 2009 was US$68 (at market exchange rates), slightly above US$60 in Indonesia and US$39

in Vietnam, but far lacking behind US$297 in Malaysia and US$1,414 in Singapore. (Economist Intelligence Unit 2010)

According to the Philippines DoH, the average life expectancy in 2008 was 70.5 years, lower than its neighboring country Malaysia with 72.8, and Singapore with 81.9. Infant mortality rate in 2008 was 2.19%, while the number in Thailand was 1.82%, and 0.23% in Singapore.

As a developing country, the Philippines are still affected by diseases such as tuberculosis, malaria, and dengue. Approximately 17 000 cases of malaria were registered in 2010, mainly among farmers, migrant workers, indigenous groups, and settlers in frontier areas. In the same year, 135 355 cases of dengue were identified, with 793 deaths. The region is also vulnerable to viruses such as SARS, and the pandemic and pathogenic types of influenza A (H1N1 and H5N1). (WHO 2011, p.339)

Non-communicable diseases are also a threat, and mostly linked with risky lifestyle habits like tobacco and alcohol use, and lack of physical activities. They "are considered a major public health concern in the Philippines, accounting for six of the top 10 causes of death." (WHO 2011, p.340) In 2004, the country's leading causes of fatal diseases were heart disease and vascular system disease. Heart disease alone killed 70, 860 people in that year.

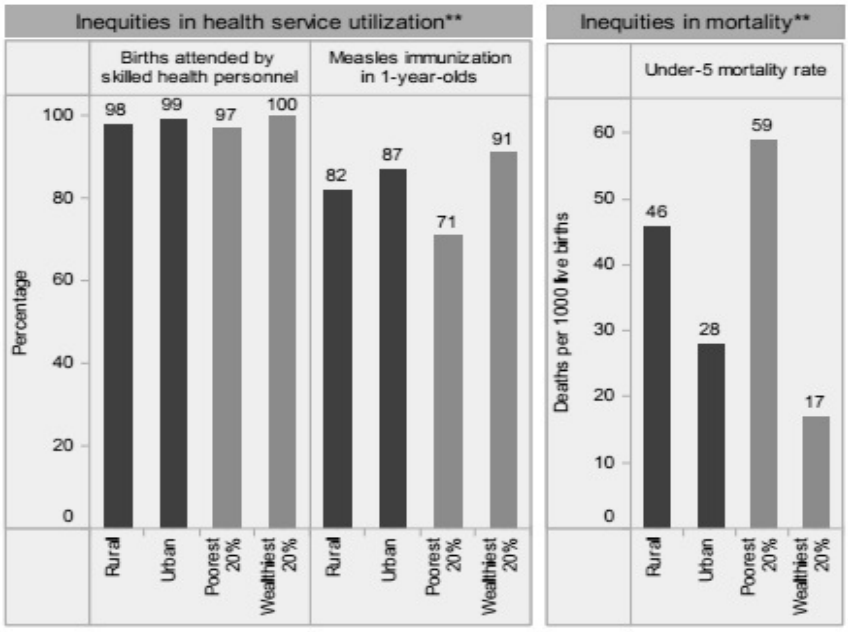
Even with 63% of its population living in urban areas, (WHO 2011, P.5) the Filipinos still suffer from inequality in services, derived from the fact that the population is highly distributed among the different islands of the archipelago, which influences the degree of access to health care. This can be seen especially when it comes to under-5 mortality rates. The Philippines is one of the 42 countries accounting for 90% of global under-5 death rates.

Like many developing countries, the Philippines are facing a transition in the burden of diseases. The increase in non-communicable diseases is a trend, but they still have to deal with the communicable ones, which translates into a double burden.

In 1969 the Philippines introduced MEDICARE, the social health insurance, largely based in the United States model. The main focus of MEDICARE was hospitalization and access to private care. The program was successful among formal sector employees, but the informal sector had a high deficit of enrollment. In 1995, the National Health Insurance Act was instituted, with the development of the Philippine Health Insurance Corporation as a main pillar. The insurance, known as PhilHealth, is a government corporation with a board of directors composed not only by government officials, but also by a number of private sector actors and health care providers. The Secretary of Health is the chairman, and the corporation has a president and CEO, with a fixed term of office. (Banzon)

"The goals of PhilHealth are as follows: (1) to be able to provide health insurance coverage for all Filipinos, (2) to ensure affordable and quality health care services, and (3) to manage its resources economically." (Ong 2011, p.3) The insurance works as follows: each member pays an annual premium, and thus PhilHealth can cover eventual health expenses of all its members. Premiums are more expensive for the population with bigger income rates, so that the poorest members can pay less and enjoy the same benefits. Families that earn less than P25 000/month pay only P1 200/year for the insurance.

Figure 20:



Source: (WHO 2011)

Despite the fact that PhilHealth is supposed to be mandatory, this measure was only applied among the formal sector. Many political and cultural constraints prevented the primary universal coverage goal of the program. There were changes in the structure to accommodate these difficulties. For the formal sector, the payment is shared between the employer and the employee. For overseas Filipino workers, self-payment is applied. Subsidies and sponsoring from local governments is available to poor informal sector members, and from 60 years old on, lifetime free membership is available.

Besides universal coverage, one of the main problems PhilHealth faces today is delay in payments for hospital services. This is an issue especially for private hospitals, which have no incentives to accept government-subsidized patients, or provide the best possible care. To avoid this, the corporation is currently in the process of implementing an automated system inside hospitals, and providing its members with identification cards, to facilitate the exchange and have a more comprehensive database. There are also undergoing campaigns to increase coverage in 2012, from 85% to 100% of the population. 23% of the PhilHealth beneficiaries were under a sponsorship scheme for the poor.

PhilHealth accredited more than 90%, of the country's hospitals. By 2008, 3,750 health institutions, including hospitals, clinics and maternity units and 21,600 professionals were accredited. Only after the accreditation can patients use PhilHealth insurance scheme in a hospital.

There were 1,921 hospitals in the country at the end of 2006 and 1,202 of them were private. However, public hospitals are, on average, larger than private hospitals. In 2006, the average bed in a public hospital was 67, almost twice as much as 38 in a private hospital. The country now has 93,180 hospital beds, and public hospital accounts for 51% of those.

As suggested by the Economist Intelligence Unit, PhilHealth insurance scheme, in general, can only cover part of the medical treatment fee. Out-of-pocket payment is a common practice in both public and private hospitals for the rest. This indicates that as the share of out-of-pocket spending in total health expenditure has increased the in the past few years indicating the enlarged inequality between the rich and the poor, reflecting fiscal constraints on government health expenditure.

Like most of other countries in the world, Philippine health system also suffers from imbalance resource distribution in urban and rural area. Outpatient care in urban area is mainly provided by public hospitals with supplementary by private hospitals. However, in rural area, primary care lacks infrastructure, investment and human resource staying at basis level. (Economist Intelligence Unit 2010)

While there are still big disparities in the Filipino health care system, the undergoing reforms and initiatives aim to provide a more equal and quality service to the population. The Health Care Reform Agenda addresses the financial inefficiencies of the system and opens new doors to partnerships aiming at increasing investments.

The Economist Intelligence Unit predicts that total health spending and healthcare share in public expenditure are expected to grow in the coming years, and will reach US$9.9bn in 2014. This is due to the growing need to improve healthcare coverage, increasing life expectancy and the growth of urban population. (Economist Intelligence Unit 2010)

Figure 21: Healthcare indicators: Philippines

	2005a	2006a	2007a	2008a	2009b	2010c	2011c	2012c	2013c	2014c
Life expectancy, average (years)	69.6	69.9	70.2	70.5	70.8	71.1	71.4	71.7	71.9	72.2
Life expectancy, male (years)	66.7	67.0	67.3	67.6	67.9	68.2	68.5	68.7	69.0	69.3
Life expectancy, female (years)	72.6	72.9	73.2	73.5	73.8	74.2	74.5	74.7	75.0	75.3
Infant mortality rate (per 1,000 live births)	24.0	23.2	22.5	21.9	21.2	20.6	19.9	19.3	18.8	18.2
Healthcare spending (P bn)	171.0	190.0	211.0	242.0	282.0	297.0	335.0	383.0	435.0	486.0
Healthcare spending (% of GDP)	3.5	3.5	3.5	3.6	3.8	3.9	4.1	4.3	4.5	4.6
Healthcare spending (US$ m)	3,043.0	3,455.0	4,114.0	5,250.0	6,343.0	6,065.0	6,506.0	7,515.0	8,796.0	9,914.0

Healthcare spending (US$ per head)	35.0	39.0	46.0	58.0	68.0	64.0	68.0	77.0	89.0	99.0
Doctors (per 1,000 people)	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2
Hospital beds (per 1,000 people)	0.9	0.8	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9

a Actual b Economist Intelligence Unit estimates c Economist Intelligence Unit forecasts

Source: (Economist Intelligence Unit 2010)

3. PPPH PROJECT FEATURES IN THE COUNTRY

A survey done by Bernard among eleven PPPH projects[40] indicates general features of the current health partnership in the Philippines.

1) Contrast to usual practice of the PPPH projects in developed countries that hospital infrastructure building is provided by private sector, **most of physical asset of PPPH in the Philippines is owned by national or local public entities.** Equipment, which in most of the cases are removable, belong to the private implementing entities.

2) **Most of the PPPH models are expansion of coverage, efficiency and improved quality of care.** There are three different purposes of PPPH, such as operation and management of a particular service for TB DOTS, maternal and child health care, or dialysis; non-health technical services like training for marketing assistance; or non-health support services like security and laundry service.

3) **Due to the nature of lease contract type of collaboration, the usual contract length of PPPH in the country is much shorter than that in developed courtiers, ranging from 1 to 5 years**. In the case of National Kidney & Transplant Institute, Hemodialysis Center, the service contract length is only five years.

4) Another important feature is that **many of the programs were innovations and pilot projects where international aid and donors are commonly seen in the picture**. The aim is to set pilot project for PPPH in the country. In this survey, 9 out of 11 projects were sponsored by USAIDS, World Vision, prism, EU, the Global Fund, and Pfizer etc. Thus, the long-term PPPH financial viability and the private sector's financing capability in the country should not count the temporary support of donations and grants. The financing responsibility of PPPH primarily lies with the private sector.

40 The eleven PPPH projects are: Public Private Mix DOTS (PPMD) for TB DOTS- the De La Salle TB DOTS Center, The SAFEMOMO Projects: Strengthening Approaches on Family Health Efforts by Motivated Midwives, La Union Medical Center, National Kidney & Transplant Center, KLM: A Movement against Malaria by Pilipinas Shell Foundation, KASAPI: A Social Health Insurance Partnership to Reach Informal Workers, Carmen Health District, Inc, Health Plus the National Pharmaceutical Foundation (NPF), The New Capiz Integrated Health Services Council, Leaders for Health, and Botika ng Barangay.

5) **Department of Health is the main public partner in PPPH, followed by provincial and municipal Local Government Units.** The governance of PPPH was not shared, but maintained by their boards or directors, similar to the characteristics of a project management or corporate program.

6) **Most of the PPPH have binding legal contracts, primarily Memoranda of Agreements or Memorandums of Understanding, but the thoroughness of each contract varies in different project.** For example, National Kidney & Transplant Institute, with the help of BOT Center, has a better-analyzed contract than the loose contract case of SAFEMOM. Other than La Union Medical Center and National Kidney & Transplant Center, there seemed to be a laid back attitude to enforce the contracts of partnership among the rest projects.

7) **All PPPHs are announced with monitoring and evaluation systems. However, no evidence supports that there was a review on the contract.** In general, there is no award for good performance, nor penalties for low or non-performance. In the for-profit project, the sanction would be termination or non-renewal of the contract.

SUPPORTING OPINIONS & SUPPLEMENTARY INFORMATION ACQUIRED IN THE FIELD

Those features are confirmed in the field study to Manila

PPPH in the Philippines is working towards, but not yet reached, a mature stage for hospital infrastructure building. Service contract limits the scale and the degree of collaboration of PPPH in the Philippines. Short contract length suits current service cooperation mode, but it won't fit the requirement hospital infrastructure BOT mode.

8) **All PPPH projects considered themselves as successful, mostly rating from Good to Excellent.** The benefits brought by the projects include, but not limited to: increased financing process of PPPH, significant health quality improvement, service accessibility, geographic reach, high patient satisfaction, improved management, and improved information system etc. The private sector indicates the benefits are: safety of equipment, profits, increase in PhilHealth membership, and serving as good model for others etc. (Couttolenc 2009)

4. FOUR THEMES FOCAL RESEARCH IN THE PHILIPPINES

4.1 Institutional Design (Policy Framework)

a) The Philippines has one of the earliest and most comprehensive BOT laws in the region.

The republic Act 6957, "the BOT Law", was first enacted in 1990, aiming to mobilize greater private sector participation in public infrastructure. Four years later, the amended BOT Law, Republic Act 7718 was released. In 2006, a further revised implementing rules and regulations (IRR) to the BOT law were implemented. In the first section of 2006 BOT law, it explicitly states that the policy of BOT law is to "recognize the indispensable role of the private sector as the main engine for national growth and development and provide the most appropriate incentives to mobilize private resources for the purpose of financing the Construction, operation and maintenance of infrastructure and development projects normally financed and undertaken by the Government."

The law provides a legitimate standard for PPP infrastructure in the country, defining nine different PPP typology contractual agreements.

i. Build-and-transfer (BT)

ii. Build-lease-and-transfer (BLT)

iii. Build-operate-and-transfer (BOT)

iv. Build-own-and-operate (BOO)

v. Build-transfer-and-operate (BTO)

vi. Contract-add-and-operate (CAO)

vii. Develop-operate-and-transfer (DOT)

viii. Rehabilitate-operate-and-transfer (ROT)

ix. Rehabilitate-own-and-operate (ROO)[41]

Further than defining the typologies of PPP in the country, it regulates the eligible project types which are mainly infrastructure building, such as highways, railways, airport, power generation, telecommunication, water supply, education and **health** etc. The BOT Law has 15 sections, providing detailed requirements and instructions in a complete PPP project cycle, from prequalification, bidding, performance standards to contract implementation, and termination, etc.

While the Philippines government takes the initiative to solicited PPP projects, the amended BOT law in 1994 opened up the possibility of unsolicited project proposals from private sector, by which they can identify the possible infrastructure cooperation needs.

41 See appendix 3 for details definitions of these nine typologies

It has been stimulated private sector's interest in infrastructure provision in the country, and provided the huge financing requirement of building those gigantic infrastructure facilities, like airport terminals and highways. (Couttolenc 2009)

DIFFERENT VOICES IN THE FIELD

However, it was found in the field trip that unsolicited proposals are not actively promoted by the government. Furthermore, it has been compliant that too much information was released to the public and to competitors at the invitation for comparative proposal stage. The concern was on the protection to the property right of the original PPP proponent. Such arrangement before the bidding may jeopardize original proponent's benefit considering the amount of funding and effort made to identify the PPP opportunity, thus undermine private sector's interest to PPP investment.

b) PPPH specific regulation: Department of Health Administrative Order

For health sector PPP, besides the general BOT law instructing the health facilities construction and renovation, National Objective for Health sets a broadly PPP policy framework: using PPP as a cross cutting strategic trust to improve country's health performance and results. In DOH reform agenda, partnership with private sector is cited in the four key pillars: health financing, regulation, service delivery and good service. Specifically, DOH policy document, Administrative Order, promotes the PPPH in the country. There were three implementing guidelines set up by DOH related to the establishment of PPPH.

i. AO 146 s of 2002: Implementing guidelines on the Electronic Procurement System in the Department of Health Central Office using a Private Partner Sector Platform

ii. AO 154 s of 2004: Implementing Guidelines for the Creation of National and Regional Coordinating Committees on Public-Private MIX Dots

iii. AO 2006-2008: Guidelines on Public Private Collaboration in Delivery of Health Services Including Family Planning for Women of Reproductive Age (Couttolenc 2009)

The last AO is to enhance public-private collaboration to provide health goods and services by DOH attached agencies, government health agencies and private entities. DOH is expected to assist private health providers to recognize benefits from cooperation with public sector, while private providers are encouraged to benefit of referrals, share information, gain from positive perception of public and to participate in policy advocacy. It also gives specific three PPP financing strategies. First, DOH will progressively increase the budget to procure goods and services from private provider in replacement of self-producing. Second, Local Government Units (LGU) will adopt local policy to encourage local private sectors to provide population-wide essential health service care. Third, DOH encourages LGUs to make inter-local health zone functional and to integrate public and private providers in the organizations. (Couttolenc 2009)

Current DOH ministers are also promoting collaborations from public sides. However, the private sector's involvement is limited due to lack of conductive policies, incentives and mechanisms for stakeholder collaboration. (Department of Health 2005)

SUPPORTING OPINIONS & SUPPLEMENTARY INFORMATION ACQUIRED IN THE FIELD

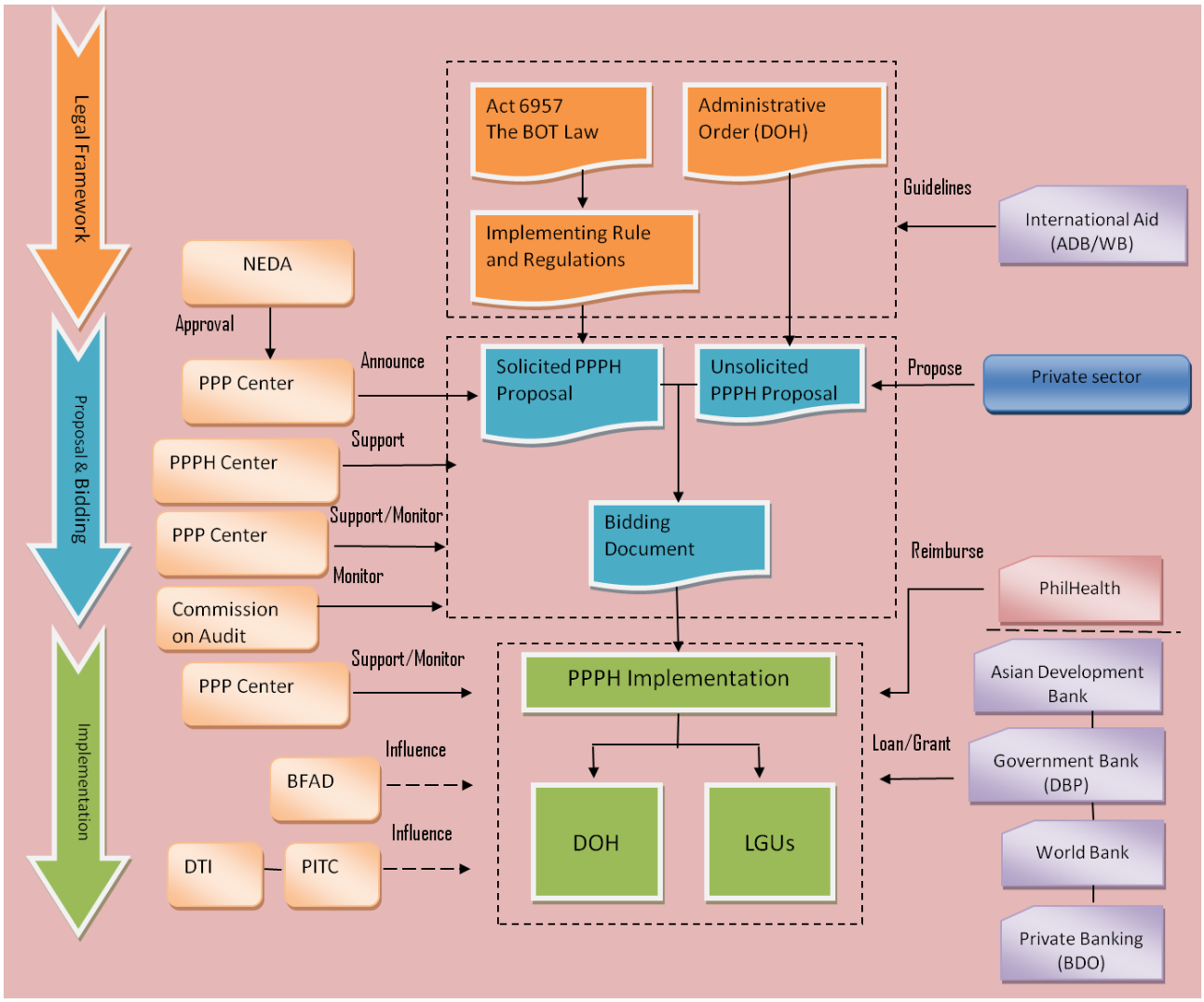
The general feedback collected among current BOT law and PPPH specific regulatory in the country is satisfactory. It is regarded as one of the earliest and most comprehensive PPP laws in the region, successfully providing progressive guides among PPP projects to both public and private sides. The Implementing Rules and Regulations released in 2006 are deemed as clear and practical. Major concern on the law is not with articles or procedure design, but on the implementation and enforcement in the country.

c) Institutional Framework of PPPH

PPP in the Philippines has a strong Presidential support. The major institutional roles regarding PPPH are Public-Private Partnership Center (BOT Center), National Economic and Development Authority (NEDA), DOH, Center of Excellence on Public-Private Partnerships in Health, Local Government Units (LGUs). Other involved government departments include: Commission on Audit, Bureau of Food and

Drugs (BFAD), Philippine International Trading Corporation (PITC)[42] under Department of Trade and Industry (DTI), Financially, it involves PhilHealth, Government Bank like Development Bank of the Philippines (DBP) and other international organizations, like ADB and the WB. Below is a framework covering the major actors involved.

Figure 22: Philippines Health Public-Private Partnership Framework



42 PITC is aiming to promote competitive price of medicine among large pharmaceutical companies in the Philippines.

National Economic and Development Authority (NEDA) set up a Public-Private Partnership Center, which was also known as BOT Center. The center has a legitimate background of Republic Act 7718 BOT Law and its IRR. The center aims to provide project development & monitoring facility service, capacity building & knowledge management service, project development service, legal service and policy formulation, evaluation & monitoring service. It supports solicited national PPP projects by drafting transaction documents, conducting procurement process, establishing and managing PPP data bases, as well as carrying out financial and risk analysis. Moreover, the center promotes, facilitates and monitors the PPP approach both at national and LGUs level. (Public-Private Partnership Center)

DIFFERENT VOICES IN THE FIELD

Nevertheless, the Center itself has neither the decision right to solicited PPP projects, nor the approval right to unsolicited proposals. The rights are still largely retained by NEDA and project related departments. Lacking of core decision rights undermine the positive influence of the center to PPP in the country. And the administrative function among on-going PPPs is restrained by the government red tape. The center's role of monitoring and evaluation on PPP requires more funding and human resource input to concrete the agenda. It is not serving as a one-stop shop for PPP.

DOH takes the role of secretary, providing policy instruction to PPPH projects, collecting resources to support PPPH and setting up solicited PPPH framework and cooperation methods. DOH established a Center of Excellence on Public-Private Partnerships in Health, to support PPPH best practice, policy study and relevant initiatives and activities. In the end, DOH also takes the common responsibilities of the public role in a PPP to monitor and regulate, but it requires more human resource to properly implement the role.

Commission on Audit is an independent government entity, which plays the monitoring role on government expenditure, including procurement and PPP. It directly report to the President and Congress, and its exclusive authority is protected by law. (Philippines Constitution 1987)

International aid agencies, like ADB and the WB have the loan or grant programs that guide the PPP legal and institutional reform, and promote PPP projects in the country. From 2011 to 2016, ADB will extend $3.8 billion in loans and technical assistance to the Philippines under its new Country Partnership Strategy. (Business Inquirer 2011)

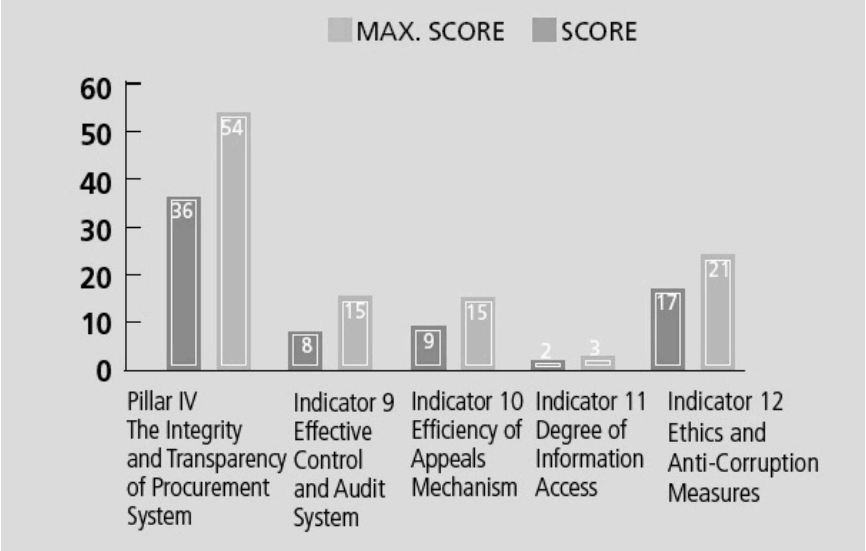
d) Limitation on government's capacity, transparency and official's tenure

Although Philippines government had been push hard on PPP, the outcome is not yet reaching government's expectation. Government's insufficient capacity in handling PPP, low transparency and official's short tenure are the major problems.

In the famous legal dispute with its German private partner Piatco on the Manila Airport Terminal Three PPP Project, both sides have different views and reasoning, and it is still not yet properly settled. It obviously add-up private side's cautious level on entering PPP field with the government. In 2011, the government aimed to bid out 10 PPP projects, while actually achieved 7. Some projects were delayed or modified due to slow work on feasibility test. (Osorio 2011) These, to certain extent, reflect skepticisms on government's capacity and effectiveness in handling PPP.

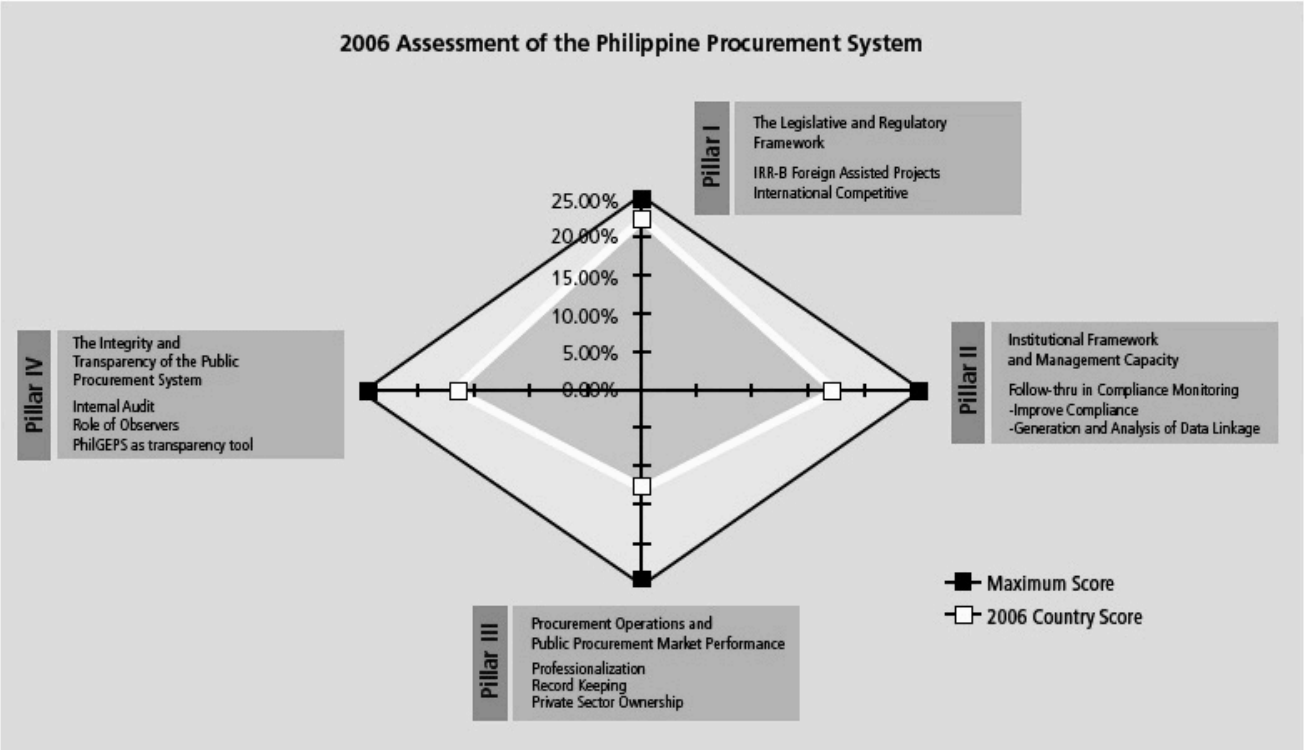
A joint study done by Philippine government, ADB and WB on the country's procurement system also supports such skepticism. The procurement system, in general, has a large improvement space in its Pillar II indicator, institutional framework and management capacity. While the public procurement market performance, professionalization and the transparency and integrity pillars also requires improvement.

Figure 23: Integrity and Transparency of the Public Procurement System



Source: (Philippines Country Procurement Assessment Report 2008)

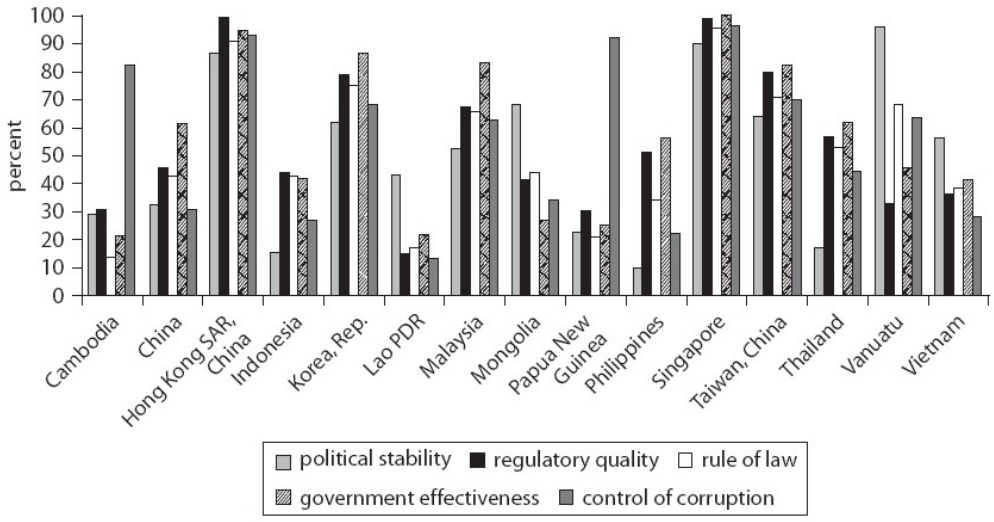
Figure 24: Graphical Representation of the BLI Pillars for the Philippines Public Procurement Systems in 2006



Source: (Philippines Country Procurement Assessment Report 2008)

In another recent WB study, Philippines governance ranking is relatively low between East Asia and the Pacific region, particularly on government effectiveness and control of corruption.

Figure 25: Governance Indicators in East Asia and the Pacific, 2007



Source: (Financing Health Care in East Asia and the Pacific: Best Practices and Remaining Challenges 2011)

SUPPORTING OPINIONS & SUPPLEMENTARY INFORMATION ACQUIRED IN THE FIELD

Specifically on PPPH, DOH, the National Statistical Coordination Board and PhilHealth have the primary source of information regarding health system.

i. However, not all the information is electronically coded.
ii. Furthermore, there is a lack of transparency on budget and expenses for health, bidding process, and a high risk of misuse of funds.
iii. DOH has guidelines in regulating and monitoring the performance of health sector, but lacks sufficient funding to support capacity building to improve the regulating officers' competency.
iv. The devolution of health system created difficulty of implementation at DOH local offices with possible obstacles like lack of funds, manpower, or knowhow.
v. Finally, the devolution of health system generated problem among LGUs who did not have prior experience in managing hospitals. 1

PPP is also affected by the official's tenure. In the Philippines, presidential tenure is 5 years and LGUs official is only 3 years. A concern was raised in the interview that in a country with a culture to overrun previous tenure's political work, short official tenure limits the contract length of PPP project, particularly at LGUs level. The political risk of discontinuing the PPP contract after the tenure is relatively high.

4.2 Contractual Arrangement (Risk Sharing, Incentives)

As discussed above, most of the PPPH models are expansion of coverage, efficiency and improved quality of care. And ways of cooperation includes operation and management of a particular service, non-health technical services and non-health support services.

Due to the absence of infrastructure transfer process in the PPPH projects, the risk is controlled at the minimum level. Most of physical assets of PPPH in the Philippines are owned by national or local public entities. Private side usually provides equipment, which in most of the cases are removable. Thus the risk of investment on non-removable infrastructure is largely avoided in the context of Philippines PPPH.

Operational risk is largely transferred from public side to private side in the short length of service contract. Form private perspective, short contract length requires a very competitive operational performance to win the renewal contract. And the initial project preparation cost may require a longer than one contract length to recover. Usually, there is no guarantee or financial subsidy provided by government or public hospital in the contract. In a typical service contract case, a fixed user-fee is set in the leasing contract, subjecting to a minor adjustment margin due to inflation and foreign currency exchange rate fluctuation.

SUPPORTING OPINIONS & SUPLEMENTARY INFORMATION ACQUIRED IN THE FIELD

In the Philippines, PPPHs are mostly in the form of service contracts and can hardly be categorized as "Build-Operate-Transfer".

Hospital infrastructure building type of PPP is not yet a common practice.

In the PPPH projects, the initial investment responsible falls on private side, such as purchasing equipment, hiring manpower etc. **Different from infrastructure PPP, which requires large capital investment in construction and rehabilitation at the construction period, PPPH project as a public service provider, requires long-term steady finance income covering continuously incurred health expenditure.** PhilHealth is expected to serve as a long-term steady financial resource to health expenditure. Currently, part of the service fee is covered by PhilHealth insurance scheme, despite the fact that universal healthcare is not yet achieved. PhilHealth's long reimbursement cycle increases the financial burden on both hospital and private company side. Moreover, patients share the financial burden of health care, regardless of PPP. Out-of-pocket payment (OOP) accounts for 45% of the country's total health financing, which is the one of the highest share in East Asia and the Pacific Region. (Somanathan 2011)

As PPPH in the country is still at initial stage, some PPPHs are initiated and financially supported by International organizations through grant or loan, donation countries, foundations or pharmaceutical companies, targeting at health system and PPP reform. Government bank, like Development Bank of the Philippines (DBP) and Land Bank of the Philippines, is another financing resource for PPPH. ADB is currently supporting two PPPH projects in two of the poorest provinces in the country, Sarangani and Northern Samar, to improve health service and equity. The infrastructure cost is covered by ADB and it involves private partners in pharmacy, lab and management of the hospital with 3 to 5 years service contracts. The projects are financially viable with the support of PhilHealth. As in those two provinces, majority of the populations are below the poverty line, thus their health costs are entirely covered by PhilHealth according to relevant pro-poor policies. In 1999 and 2005, under ADB's development program, German Development Cooperation supported credit line for small and medium enterprises (SMEs) and SME Finance Program through Kreditanstalt für Wiederaufbau (KfW) with a total amount of 70 million USD. (Asian Development Bank) 90% of the borrowers are from Metro Manila, benefiting from low interest rate, low cost and high credibility. Part of funding was used on hospital infrastructure building.

Besides international development bank and government bank, strong and vibrate commercial banks are now competing for the PPP project financing opportunities. For instance, the largest

SUPPORTING OPINIONS & SUPPLEMENTARY INFORMATION ACQUIRED IN THE FIELD

Most of the operational risk and financial burden lies on private side. Without financial or administrative guarantee from public side, the private company provides only equipment and maintenance that is movable to reduce the risk sharing. On the other hand, DOH and LGUs are firmly holding the ownership to hospital building, provision of clinical service and hospital management. There is limited room for private sectors to function in the partnerships.

Current PPPH condition reflects low confidence level between public and private sides to each other. Due to lack of confidence to government, private sectors are hesitating to get involved deeper into risk taking in partnership, despite public's strong push for PPP. To achieve infrastructure type of PPPH in the country, it requires stronger ties of partnership, wider scale of cooperation, and higher level of trust between public and private sectors.

commercial bank in the country, Banco De Oro (BDO), is now making loans to large PPP infrastructure projects, such as highways and power generations. Regarding PPPH, though indicating certain concern on provincial and municipal level government's capacity in handling PPPH and transparency issue, commercial banks have the financing capability and willingness to support PPPH projects and on both solicited and unsolicited proposals which generate reasonable financial returns. [43]

Government also established funding to support PPP. Although it implicitly indicated that does not apply to unsolicited proposals, Public-Private Partnership Strategic Support Fund (PPPSSF) is a lump-sum appropriation included in an implementing agency's budget to fund the government's share in executing PPP initiative. Recently regulated by Department of Budget and Management (DBM), it can be used to cover costs of right of way, resettlement, designing, building, and the government's counterpart fund in the implementation of a PPP project. On the other hand, Project Development and Monitoring Facility (PDMF), can be used for the preparation of project feasibility studies and required project documents, but not for loans to private partners. (Department of Budget and Management 2012)

4.3 Institutional Quality (Equity, Efficiency & Effectiveness)

According to the 11 PPPH projects' analysis done by Couttolenc, 10 out of 11 graded their own initiates from Good to Excellent. Only "Health Plus" is considered as average. Though regulated with monitoring role, the PPP center doesn't have the capacity to conduct such evaluation on regular basis. The commission on Audit, on the other hand, focuses more on regularly government procurement and financial perspective.

DIFFERENT VOICES IN THE FIELD

There isn't an effective independent external evaluation entity, or social watchdog performing social cost & benefit evaluation of PPPH projects.

Hospital In this analysis, due to insufficient data to do a parallel evaluation to the outcome among all PPPH projects, *National Kidney and Transplant Institute* is selected as a case study to view the outcome of PPPH in the country from a limited scope. The research team picked the case since it is in a typical service contract between a public hospital and a medical service company.

43 Due to limited number of financially independent PPPH projects and business confidentiality, the exact number for the profit margin of user-fee service contract is unknown.

4.3.1 PPPH Case Study: National Kidney and Transplant Institute, Hemodialysis Center

Background: The National Kidney and Transplant Institute (NKTI) is a tertiary medical specialty center specializing in the treatment of renal disease. Presidential Decree established it in 1981.

Since 1995, the institute experienced difficulties in the management of its Hemodialysis Center. The machine was old and cannot be replaced or upgraded due to limited financial capacity. The rising cost of repairs and shutting down frequency composed a big concern of operation. The shutting down time of a dialysis machine before repaired was too long, ranging from 8 days to 1 year and 11 months, to satisfy increasing patient's need. Bacterial contamination is another concern. Emergency cases cannot be accommodated immediately due to insufficient number of machines. Patient's dissatisfaction rate increased due to frequent shift of regular treatment schedule for urgency cases. (Couttolenc 2009)

In order to solve the problem, NKTI board decided to engage a private partner through a long-term lease agreement.

Business Format: Long-term lease contract, categorized as "Build-Operate-Transfer" Scheme

Public & Private Partners: National Kidney and Transplant Institute & Fresenius Medical Care

Based in Germany, Fresenius Medical Care is the world's largest integrated provider of products and services for individuals undergoing dialysis because of chronic kidney failure.

Way of cooperation: NKTI Hemodialysis Center is a Php 54 million PPPH project. NKTI had a minimum equity participation of 20 percent while Fresenius Medical Care put up 80 percent. The first contract period ran for five years, between 2003 and 2008.

Role of NKTI: 1) Lease the facilities from service provider and operate them over the period; 2) pay service provider a lease fee per treatment according to pre-agreed lease payment schedule. 3) Provide the space, staff and utility requirement. 4) Maintain quality service and incompliance with international standards and government regulations.

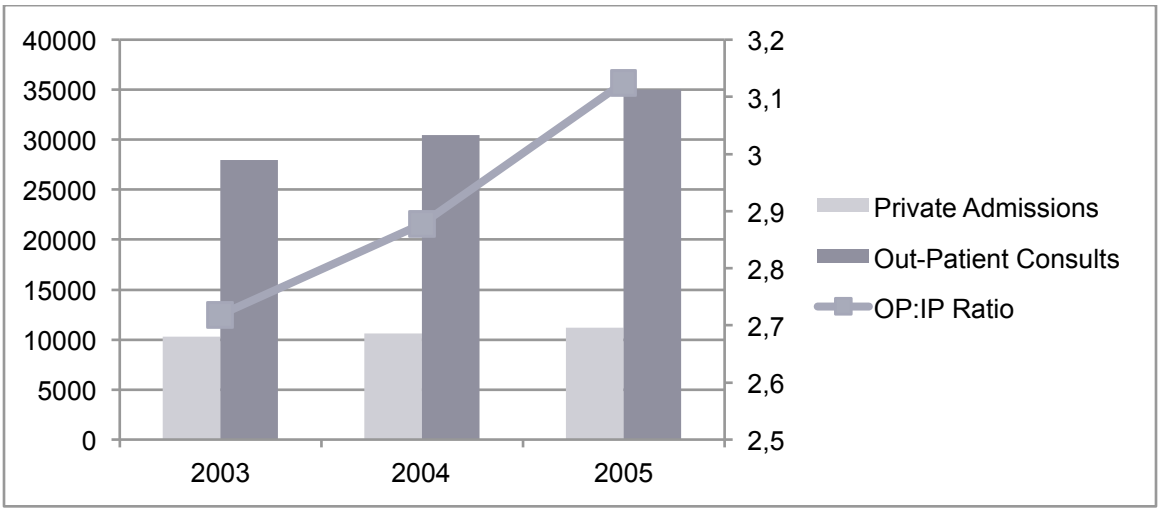
Role of Fresenius Medical Care: 1) Supply all hemodialysis equipment including wastewater treatment and dialysis reprocessing machines. 2) Provide maintenance of service technicians at all time. 3) Ensure availability of hemodialysis supplies and solutions at all time.

Program performance: In 2005, Commission on Audit did a financial audit to NKTI PPPH project, which also have indicators, related to health service access. Below is the performance result based on both the audit and interview with the hospital management.

1. NKTI was able to expand the service to more patients and acquire the latest available technology in dialysis treatment at the same cost of treatment and less risk to the government.

2. According to interviews with hospital management, access especially among patients with limited ability to afford treatment in the private sector has been enhanced. And the hemodialysis rate at NKTI is far more competitive than comparable private providers.

Figure 26: Admissions and Out Patient Visits CY 2003-2005

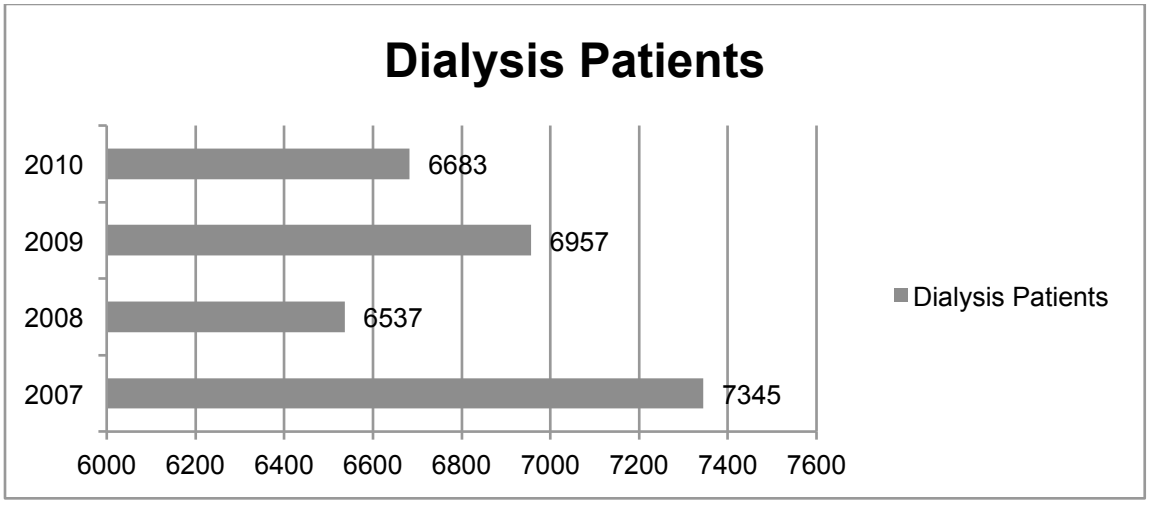


Source: (Republic of the Philippines Commission on Audit 2005)

3. Improved equipment intensified nurses' training programs and improved rotation of nursing staffs. The high turnover rate of nurse before the PPPH project has been controlled.

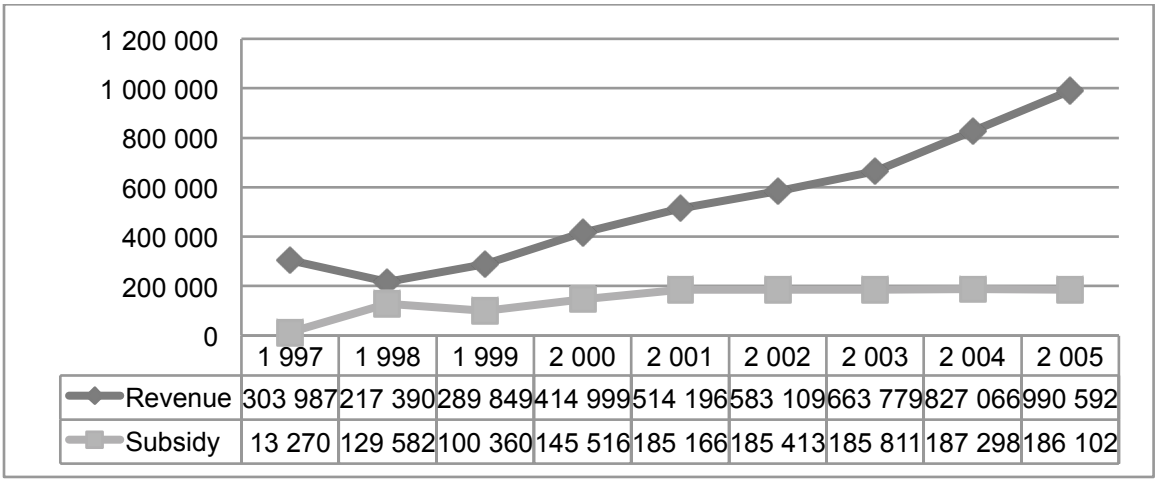
4. While the hospital's annual government budget remained constant since 1998, its fee revenues have dramatically increased. Moreover, hemodialysis revenue has consistently outpaced the lease fee ever since the scheme started.

Figure 27: HKTI Hemodialysis Center dialysis patients 2007 to 2010



Source: (National Kidney and Transplant Institute 2011)

Figure 28: Revenue and subsidy CY 2003-2005



	1 997	1 998	1 999	2 000	2 001	2 002	2 003	2 004	2 005
Revenue	303 987	217 390	289 849	414 999	514 196	583 109	663 779	827 066	990 592
Subsidy	13 270	129 582	100 360	145 516	185 166	185 413	185 811	187 298	186 102

Source: (Republic of the Philippines Commission on Audit 2005)

Demonstrations: In April 2011, the government announced to press social service PPP, including health and education. And a modernization of the Philippine Orthopedic Hospital PPP project was proposed as a solicited proposal with an estimated cost of Php 3.4 billion. DOH also proposed the 5-in-1 vaccine pentavalent PPPH. (National Kidney and Transplant Institute 2011)

In general, NKTI PPPH has achieved a satisfactory outcome, with increasing capacity to deal with more patients, higher machine efficiency, better waste water treatment, higher satisfaction rate etc. This has been confirmed in field study interviews and site visit to the hemodialysis center. NKTI has successful avoided the financial burden of investment in public side and brought the management and operation efficiency from private side.

The concern of too much financial risk sharing taken by private side is also proved in the NKTI case. The revenue generated by hemodialysis center has always outpaced the lease fee to the private partners. Due to business confidentiality, research team doesn't have the access to the data of financial risk & revenue distribution between two partners. With the limited publications and information collected during field study, it is generally believed that the private side takes more financial risk than public side in PPPH.

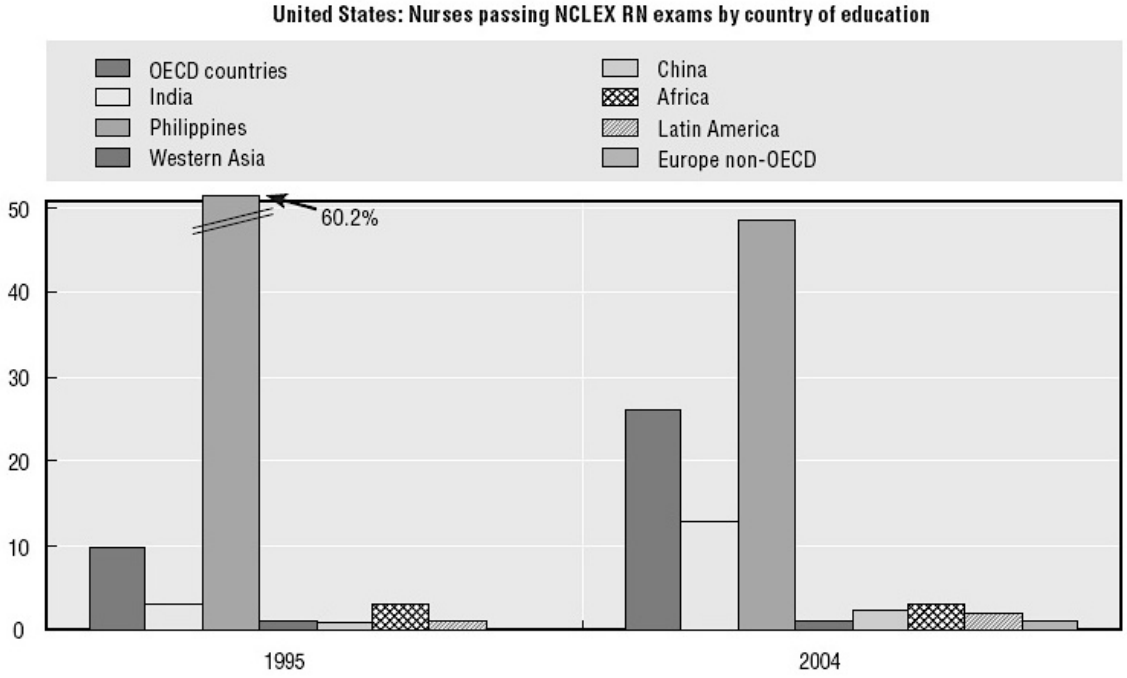
4.4 Institutional Environment & Trade (Political, Economic & Social Context)

The Philippines didn't make a commitment on General Agreement on Trade in Services (GATS) agreement on Health and social services. However, the country doesn't limit the foreign private partnership to enter the market. Foreign investors are commonly seen in PPP infrastructure projects. In the case of NKTI, the private partner is a German health service company. International

pharmaceutical companies also have the access to the country's health market, though certain level of protectionism was reported.

The Philippines is a major exporter of medical staffs and healthcare workers to the developed countries. Overseas Filipino workers consist of significant percentage of doctors and nurses. Thus, domestic healthcare human resource provision is facing negative impact from international competition. The brain drain, especially in the rural area of the country, is a major challenge to provide health service.

Figure 29: Distribution by origin of immigration inflow of health professionals in the United Kingdom and the United States 1995-1997, and 2002-2004



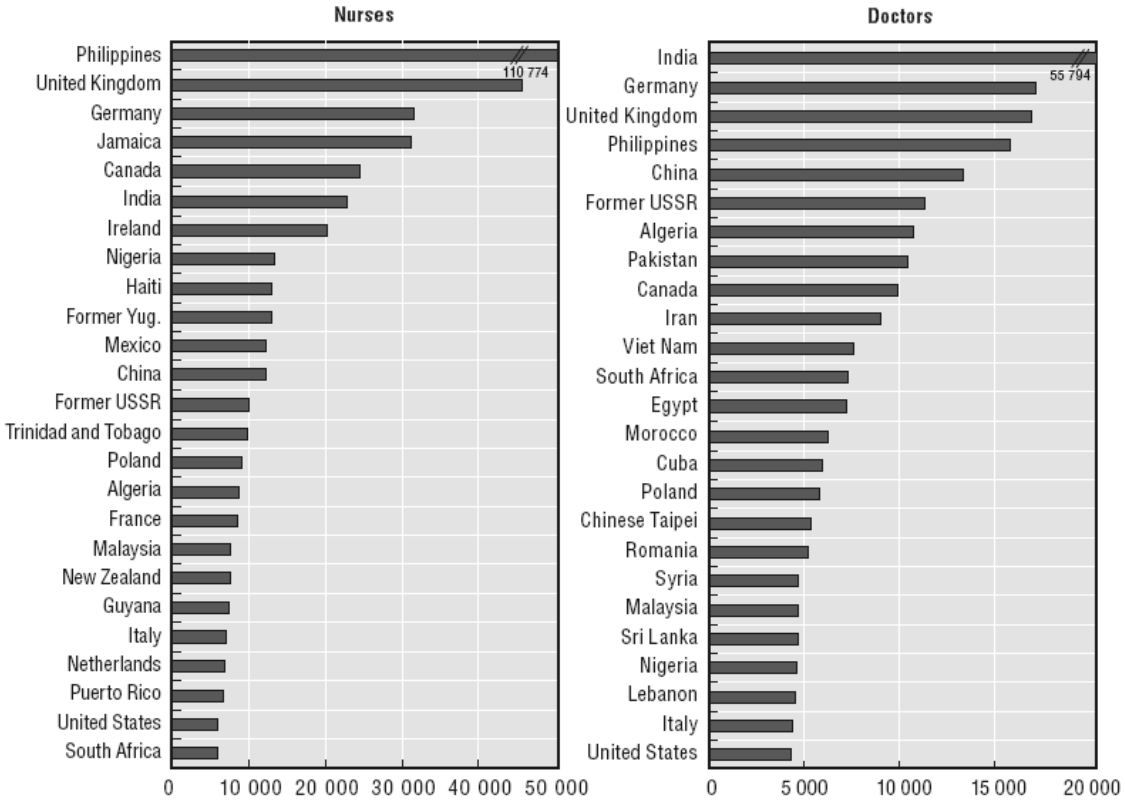
1. South-Asia almost represented totally by India.
2. East-Asia almost represented totally by Philippines.
3. African countries includes the following countries: Botswana, Cameroon, The Democratic Republic of Congo, Eritrea, Ethiopia, Gambia, Ghana, Lesotho, Liberia, Malawi, Mauritius, Nigeria, Sierra Leone, South Africa, Tanzania, Zambia, Zimbabwe.

Source: (OECD 2007)

The OECD study shows that between year 1995 and 1997, Philippine health professionals accounted for 60% to total immigrated health professionals to UK and the US, far exceeding other regions in the world. In 2002 to 2004, the number dropped a little bit, but still takes almost half of the total immigrants.

In terms of Foreign-born doctors and nurses in the OECD countries. Pilipino nurses take the absolute first place in the population, which has more than double of the number of the second nurse exporting country, the United Kingdom. In the ranking of Foreign-born doctors, the country takes the fourth place, with a number of approximately 16,000, following India, Germany and United Kingdom.

Figure 30: Foreign-born doctors and nurses in the OECD by main countries of origin (top 25), circa 2000



Source: (OECD 2007)

SUPPORTING OPINIONS & SUPPLEMENTARY INFORMATION ACQUIRED IN THE FIELD

The brain drain is confirmed in the field study. The problem in general affects more to the rural area of country. While in urban area, like Manila, the concern is more on the competition of health professionals between private and public hospitals affecting the health service delivery over equity issue.

As a developing country, the Philippines also receive significant amount of official development assistance (ODA) from donation countries, funding etc. The country's net ODA increased more than 11 times in 3 years, from 28 million USD in 2008 to 535 million USD in 2010. Most of the ODA, around 90%, is in the form of bilateral cooperation. Its largest three donor countries are Japan, United States and France. Between 2009 and 2010, health and population received around 4% of the total ODA. The

largest ODA investment was on economic infrastructure & service, with more than 25% of the share. Foreign assistance directly injected the capital in PPPH to initiate and financially support the projects. It is suggested to revisit ODA support and find out the possible opportunities to promote PPPH in the country.

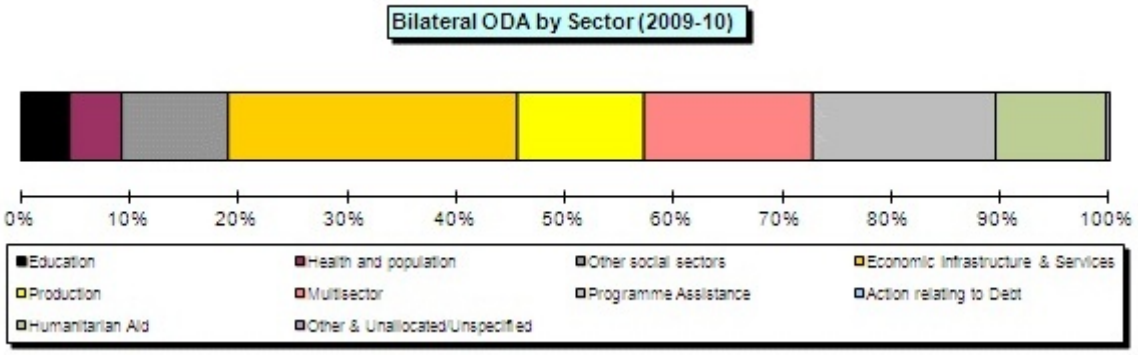
On the other hand, grants and loans from international organizations are also significant assistance. As the holding country of ADB, the Philippines government should continue to work closely with the bank to promote its PPPH on capacity building, procedure reform, access equity and financial viability etc.

Figure 31: Philippines Official Direct Assistance 2008-2009

Receipts	2008	2009	2010
Net ODA (USD million)	48	309	535
Bilateral share (gross ODA)	91%	91%	90%
Net ODA / GNI	0.0%	0.2%	0.3%
Net Private flows (USD million)	- 699	1 846	2 125

For reference	2008	2009	2010
Population (million)	90.2	91.7	93.3
GNI per capita (Atlas USD)	1 770	1 870	2 060

Top Ten Donors of gross ODA (2009-10 average)		(USD m)
1	Japan	686
2	United States	135
3	France	104
4	Australia	100
5	Germany	58
6	EU Institutions	51
7	Global Fund	41
8	Spain	38
9	Korea	27
10	Canada	17



Source: (OECD,The World Bank)

DIFFERENT VOICES IN THE FIELD

The political sensitivity of privatization is high in the country. There is a general perception in the public that PPP in terms of health will harm general public's right, particularly the poor. The suspicion and criticism towards PPPH within the government, academic and media doesn't give credit among public's trust to PPP.

5. OTHER RELATED INFORMATION COLLECTED IN THE FIELD STUDY

5.1 PhilHealth

PhilHealth is the crucial point to the future of PPPH in the country. It is the long-term financial source to finance health service expenditure. With a new assigned CEO, the company is moving towards the right direction, but it requires much significant and fast reform to meet the demand of the health system. The following problems and concerns are raised in the field trip.

1. Self-acclaimed by the company, it has covered approximately 80% of the population. However, inconsistent information was received in interviews with other relevant parties. It is estimated that only 15%~30% of the patients going to public hospitals are reimbursed through PhilHealth.

2. PhilHealth has been criticized of not being transparent and the audit didn't turned out to be an effective monitoring method. Until today, electronic financing system has not yet been adopted.

3. PhilHealth holds an estimated Php 90 billion reserve while the law regulates the amount should be within two years equivalent to annual expenditures, about 30 billion.

4. The reimbursement cycle has been compliant for too long which increases other relevant parties' financial burden.

5. Unreasonable procedure of medicine price setting, which gives hospitals incentives to prescribe higher price drugs.

5.2 No comprehensive database regarding health system in the country

The country doesn't have a comprehensive database including health professional database, patient's history, medical treatment, financial payment and social insurance etc. Most of the transactions and records are either not kept or kept by paper. It creates a lot of difficulties in management and increases the violation risk.

5.3 Private: lack of confidence to government and PPPH / lack of experience in real PPPH

Private sector doesn't have enough confidence to government's capacity to PPPH. The short-term lease contract is the closest typology to common type of PPP in developed country. Private entities are inexperienced in real BOT type of PPP which involves infrastructure building, long-term cooperation and risk transfer. Government's unwillingness to guarantee a reasonable profit margin to private sector also discourages private sector to enter, particularly under current condition of insufficient confidence and trust. Such guarantee, on the other hand, can have negative impact on the partnership, that encourages moral hazards in private side.

5.4 Financing: lack of confidence to PPPH

International development bank, like ADB and WB, are more focusing on health system reform and PPP encouragement as a whole. It has lower interest rate than commercial banks and usually has attached condition to PPP project, like capacity building or pilot project. Government banks, currently, don't have enough financing resource to support all PPP projects, including PPPH. Commercial banks, with sufficient capability and capacity to support PPPH, are waiting for solicited proposals of PPPH. It also depends on the project's profitability, government's supportiveness on PPPH, and financial viability in the long term. Concerns with corruption and capacity with LGUs were raised with PPPH. Such concern may again enlarge the health service gap and inequality between urban and rural area.

6. RECOMMENDATIONS

The following recommendations are given to facilitate and promote development of health system, PPP and PPPH in the Philippines.

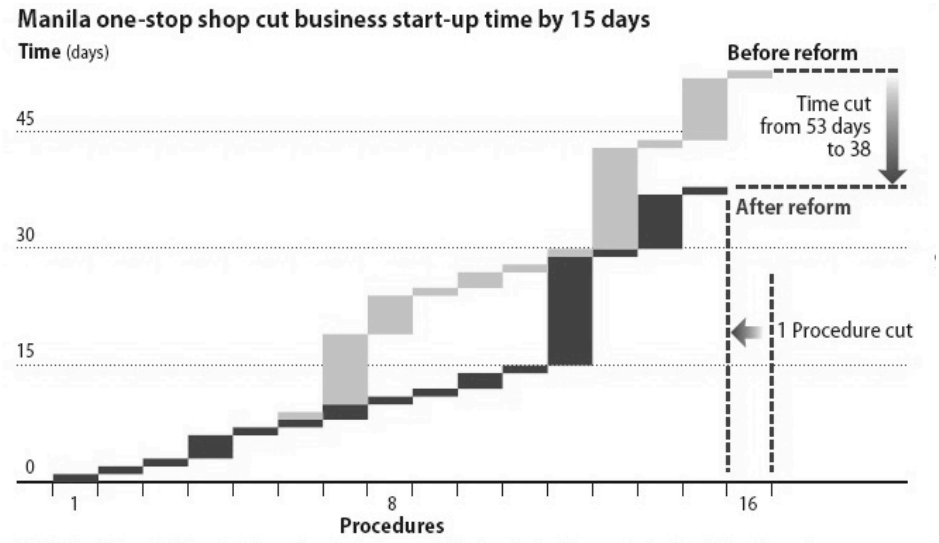
6.1 PPP: Set up One-stop shop in government to simplify PPP administrative procedures

Under the mindset of providing service to private partners, this one-stop shop is designed to connect and perform all the PPP related department functions, such as registration and evaluation, in one organization. On the government side, it not only helps to smooth the internal communication and resolves conflict interests between departments, but also reduces administrative cost and improves the government efficiency. On the private side, it greatly assists the communication and significantly speeds up the administrative process. Besides service to winning bidders of PPP projects, this one-

stop shop should also serve as information center to private sectors on PPP. One-stop shop can be started at Central level, several pilot provinces and cities and technically supported by PPP Center.

In the Philippines, government red tape issue is a concern to the private companies. The number of procedures to start a business is much higher than average of East Asia and the Pacific countries. Construction permit process time varies in different regions from 46 days Zamboanga in to 169 days in Manila. It is shorter than China and Malaysia, but longer than Singapore. The construction permit cost has the largest variance in the country. Iloilo city is ten times more than that in Davao.

Figure 32:



Source: (Doing Business in the Philippines 2011)

The country has successful experience on one-stop shop to cut red tape before. In 2009, with an introduction of Standard Business Registration and Permit Process, one-stop shop was established to simplify and standardize business registration and permit process in the Philippines. In Manila, after establishment of a physical one-stop shop, called the Business One-stop Shop (BOSS), business start-up time was cut by 15 days. (The International Bank for Reconstruction and Development / The World Bank 2010)

6.2 Health System: Import Information Technology system to form comprehensive databases, covering health professionals, patients, medical treatment, social insurance, finance etc.

Information technology system is suggested to be applied in every possible aspect of the country's health system. In general, it helps to improve transparency & integrity, increase the opportunity cost of

corruption, provides reliable & comparable data records, identifies organizational risks and improves system effectiveness & efficiency.

Without a comprehensive citizen database in the country, the health sector can initiate a national wide health database, which requires the assistance from all health facilities. Such database helps the diagnosis of each patient and monitoring on the national health condition.

Besides database on citizen and health condition, it should be also applied to the financing of health system, covering hospital financial inflow & outflow, PhilHealth, and private insurance company etc. This is basic to serve the reform of PhilHealth to increase reimbursement rate and shorten the reimbursement cycle.

Finally, a database with all registered health professionals helps better management of DOH and allocation of human resources.

6.3 Health System: Reform on PhilHealth

To PPPH financially viable in the long term, a reform on PhilHealth is inevitable. This national health insurance company should first start to adopt IT system to improve its financial and administrative transparency. A more effective monitoring is required to promote the company's efficiency to meet the health system's demand. Universal coverage, as they are promoting now, should be continued. The company's bigger than required reserve should be intended to improve the reimbursement rate and reduce out-of-pocket payment. On the other hand, PhilHealth should also come up with schemes to curb user's incentives to cheat and deceive.

No country's insurance pool can support unlimited demand of health service. Thus, to make the insurance pool itself financially viable in the long term, incentives should be set to discourage avoidable unhealthy life style, like use of alcohol and tobacco. For instance, it can provide certain percentage of refund if the user's health expenditure is lower than average. To control the expenditure on chronic diseases, like diabetes, a regular checking scheme on use of medicine among the patients can be set as a condition of next phase insurance reimbursement.

6.4 PPPH: Building confidence on the government by providing guarantees and having capacity building

These are to encourage the country's strong and robust private sectors entering into PPPH. Confidence and trust is the first step of any partnership, thus government needs to address the foremost two concerns of private sectors: private company's financial return and government's expertise in handling PPPH.

Providing financial and/or administrative guarantees to private companies greatly promotes PPPH. Currently, financial burden on private sectors is heavy and the rigid contract articles on change of user

fee further prevents the private sectors entering the field. The type of guarantee can be a longer contractual period, a more frequent and wider variation range of contractual price, a larger initial financing share of public sector, or any other form of agreement that gives confidence to private sectors. Government should respect the agreement made and have a continuous and stable PPPH policy.

DOH and LGUs can hold regular workshop with private sectors, academic institutes and other PPPH experts to have the direct communication on ways of cooperation and capacity building.

6.5 PPPH: Utilize foreign assistance to enhance rural and poor area where health costs can be covered by PhilHealth

The two ADB projects in Sarangani and Northern Samar, two less developed provinces in the country, demonstrated a possible way of PPPH. In that poorest region, where LGUs wouldn't be able to provide sufficient health service to the residents, foreign assistance is a way to fund and set up initial hospital infrastructures and equipment. And private sectors are introduced in providing the services. It immediately improves the health access, particularly to the poor in the regions.

Financially, in the long run, PhilHealth will largely support the health cost of those hospitals after accreditation. Since majority of the residents are below poverty line, the social insurance program will cover the entire health cost.

6.6 PPPH: Pilot projects in major cities, like Manila and Cebu, to promote real infrastructure involved PPPH

To promote real hospital PPPH, pilot projects can be done in economically developed cities, like Manila and Cebu. Several projects involve infrastructure building and transfer is at preparation stage in Manila. The success of those projects will greatly attract private sectors to enter PPPH.

6.7 PPPH: Five modalities of possible PPPH

In the two ADB Sarangani and Northern Samar projects, PPPH experts are also working on five modalities of possible PPPH in the country. The study is still on-going and their main working directions are to involve private sectors in: hospital management for new hospitals, hospital management for existing hospitals, laboratory services, pharmaceutical services, and out-patient services. (Mary Anne Velas-Suarin 2011)

Overall, in the Philippines, the PPPH requires improved level of trust between public and private sectors. A strong political support and leadership is crucial to improve government's image on PPPH by

providing a constant policy, more financial support, reduced red tape and sufficient capacity and competency.

Turkey

1. INTRODUCTION

Turkey is divided into 81 provinces, which are subdivided into 923 administrative districts. Provincial governors and district administrators, appointed by the central administration, rule the provinces and the administrative districts. “The country has a population of 72.5 million people and an average annual population growth rate of 1.45 percent. According to the 2009 census, 75.5 percent of the population lives in urban centres.” (Yıldırım and Yıldırım 2011, p.180)

Politically, Turkey had two major left and right parties, and constant disagreements led to several military coups, in 1960, 1970 and 1980, each lasting three years. Today, the parliamentary, representative democracy is comprised of a Legislative branch, an Executive branch, and a Judicial branch. Presidential elections are held every five years, and the elected president is the head of state, while the Prime Minister is the head of government and of the multi-party system. Although Muslims constitute more than 99% of the population, there is no religious interference in laws, regulations, and in the various governmental structures.

Turkey has been a member of the UN since 1945, a member of NATO since 1952, and a candidate for the European Union since 1999, carrying ascension talks since 2005. Long-term policies and political stability have often been threatened by the constant change in government and administrations.

In terms of economy, although Turkey has suffered with the 2001 crisis, the country now finds itself in a path of stable economic growth, “due to political stability and the implementation of an economic programme and structural reforms leading to an environment of increased market confidence and macroeconomic stability. Following the growth rate of 6.2% achieved in 2002, the economy maintained its high growth performance, growing by 5.3% in 2003 and 9.4% in 2004 and 4.5% in 2007.” (WHO 2011, p.1)

2. HEALTH CARE IN TURKEY

The Turkish Republic was established in the year 1923 under Ataturk’s leadership. (Lovell 2011) As the Ottomans power declined in the 19th century, the focus of the Turks shifted to Europe for education, finance and ideology. (Lovell 2011) This process in the literature is referred to both “modernization” and “Westernization” (Çelebi 2011) and was accompanied with great reforms. This focus shift to Western Europe resulted in “Latin alphabet, surnames, the weekend, civic nationalism, secular government, and ultimately multi-party democracy were the work of Atatürk and his successors” (Lovell 2011, p.174) A constant factor throughout the Ottoman and Republican period is the role of the government in providing welfare, such as health care, for its people.

Although the Ministry of Health (MoH) was set up in 1920, key legislation of the Turkish health system was put forward in the period 1923-46. The MoH in this period was assigned the tasks of “planning, organization and execution of health programmes” (OECD, 2008, p. 40). The health system was

designed to implement top-down preventive health policies and control communicable diseases. In the period 1946-1960, the focus shifted to integrated health services administered by the MoH instead of the local administrations. Furthermore, the health insurance Sosyal *Sigortalar Kurumu (*SSK), provided by Social Insurance Organization, was established to serve employees in the public and private sector (OECD, 2008).

A legal benchmark in the history of the health care in Turkey is the Law of Socialization of Health Services (Law 224) in 1961, which built the legal foundation for the national health services in Turkey and stated "that health services should be delivered in an equitable manner, continuously and in accordance with the needs of the population" (MoH, 2010, p.19). The Integrated Health Service Scheme (IHSS) was established soon after to provide publicly funded health care for all at almost no cost. Due to lack of capital investments, infrastructure development and medical equipment were not maintained (MoH, 2010). Although the Turkish population has more legal access to health care, the quality of care provided lagged behind.

From 1980 to 2002, Turkish citizens gained the constitutional rights regarding social security. In 1982 all Turkish citizens were empowered with "a right to social security, and the State shall take the necessary measures and establish the necessary organization to provide this security" (MoH, 2010, p.19). The constitution also states: "To ensure that everyone leads their lives in conditions of physical and mental health and to secure cooperation in terms of human and material resources through economy and increased productivity, the State shall regulate central planning and functioning of the health services. The State shall fulfill this task by utilizing and supervising the healthcare and social institutions both in the public and private sectors" (MoH, 2010, p. 19). In sum, Turkish citizens are constitutionally entitled to government provided health care.

In 2000 and 2001, economic crisis hit Turkey resulting in significant currency depreciation, a 68% inflation rate and an economic contraction of 8%. As food prices, inflation and unemployment rose, so did the vulnerability to poverty. Consequently, a large shift was observed from formal insurance to the "Green Card" applications (OECD, 2008). The Green Card Scheme covered the poor (earning less than one-third of the minimum wage).

The Turkish health care system has been undergoing its biggest transformation since 2003 - from a fragmented system to a universal one. Prior to 2003, the country had a number of independent insurance schemes that covered specific sectors of the population. The most notorious one is the Green Card Scheme. Due to all the attempted reforms, and increased government stability, especially after the 1980s, there has been major improvement in health indicators.

Figure 33: 1970 to 2010 indicators for mortality and health

	1970	1980	1990	1993	1998	2000	2003	2005	2006	2007	2008	2009	2010
Life expectancy at birth (years)													
Female	56.3	60.3[a]	69.5[b]	70.6[b]	72.4[b]	73.1[b]	74.4[b]	75.2[b]	75.6[b]	76.0[b]	76.3[b]	76.5	76.8
Male	52.0	55.8[a]	65.4[b]	66.4[b]	68.3[b]	69.0[b]	70.2[b]	71.0[b]	71.2[b]	71.4[b]	71.5[b]	71.7	71.8
Total	54.2	58.1[a]	67.4[b]	68.5[b]	70.3[b]	71.0[b]	72.1[b]	73.0[b]	73.3[b]	73.6[b]	73.8[b]	74.0	74.3
Mortality rate, (per 1000 live births)													
Infant	145.0	117.5	51.5	52.6[c]	42.7[c]	31.6[c]	28.5[c]	18.4[c]	16.9[d]	15.9[d]	17.0[c]	13.1[d]	10.1[d]
Under 5 years	201.0[e]	133.0[e]	82.0	61.0[c]	52.0[c]	44.0	37.0[c]	29.0[e]	28.7[d]	26.6[d]	24.0[c]	17.0	13.0

Sources: OECD, 2008; WHO Regional Office for Europe, 2008; TURKSTAT, 2010; Hacettepe University Institute of Population Studies, 1994, 1999, 2004, 2009; Ministry of Health General Directorate of Mother and Child Health and Family Planning, 2010, (unpolished date); World Bank, 2009, as described in Tatar, Mollahaliloglu, Sahin, Aydın, Maresso, Hernández-Quevedo, 2011, p. 10.

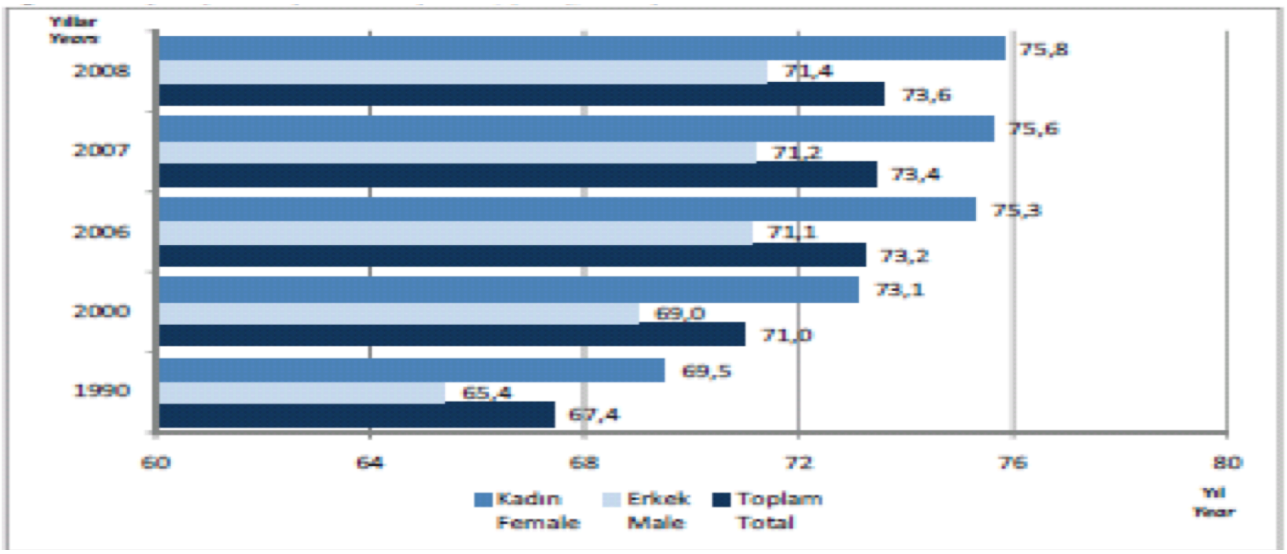
The Green Card Scheme was established in 1992, and financed by the MoH. But the project had many issues that ultimately made it inefficient. Due to delays in government reimbursement, most public hospitals declined treatment to green card holders; and care is only given when the beneficiary is hospitalized, so there is no preventive scheme. Due to lack of data and information in government institutions, there were also issues with assessing income levels and determining whether one person was eligible for the card or not. Lack of information among poor communities also compromised the scheme – some people didn't even know they were eligible for the card.

Health status is of great significance to nations in general as it has become a proxy for "individual's economic and social well-being" (Kisa, Younis & Kisa, 2007, p. 693). A better health status is understood to lead to a higher productivity, better economy and higher quality of life (Desai, 1987; Wolfe, 1986). In order to improve the general health status, it is imperative for policy makers to measure valid health status indicators, e.g. infant mortality and life expectancy, and level of health care intervention, e.g. expenditure (Kisa, Younis & Kisa, 2007). For Turkey, the emphasis on health status is further amplified by its potential membership to the European Union. Kisa, Younis and Kisa (2007) argue that Turkey's health status can become a liability in the future to enter the Union if it is perceived as a burden on EU resources.

In the last four decades, Turkey has experienced many improvements in the general health conditions, however Turkey still scores worse than average in comparison to other WHO European Region in some health indicators (WHO, 2011). Although population growth declined in this time frame, urbanization has had steadily accelerated. According to the WHO (2011), the urban areas are inhabited by 75% of the Turkish population. Consequently, faulty controlled construction practices in Turkey's booming economy, can lead to growing concerns in safety and hygiene.

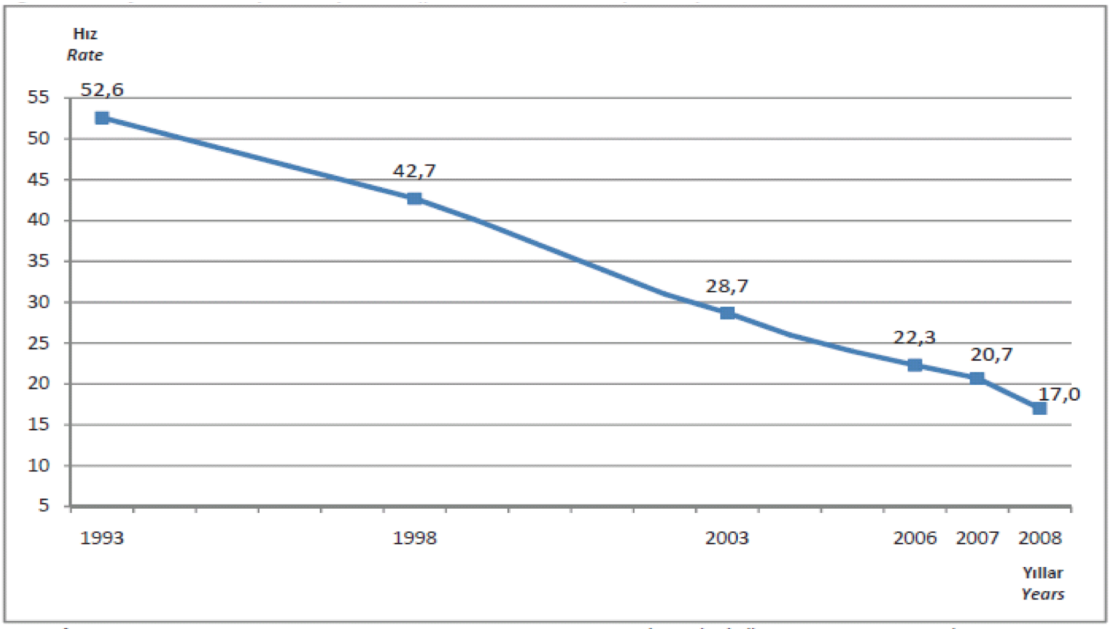
Infant, under-five age, and maternal mortality has decreased in Turkey, especially in the last 10 years. While the infant mortality rate in the year 1993 was still 52,6 per 1000 live births per year, in the year 2008 it dropped to 17 (Turkish Demography and Health Statistics, 2008). A similar trend occurred with under-five age mortality. Among the 1000 live births, mortality dropped from 51 children under five in 1993 to 24 in 2008. Maternal mortality improved from 70 in 1993 to 19 per 100.000 live births in 2008 (Privatization Administration, 2010). Life expectancy at birth is currently 71,4 for men and 75,8 for women (Turkish Demography and Health Statistics, 2008).

Figure 34: Life expectancy at birth by years



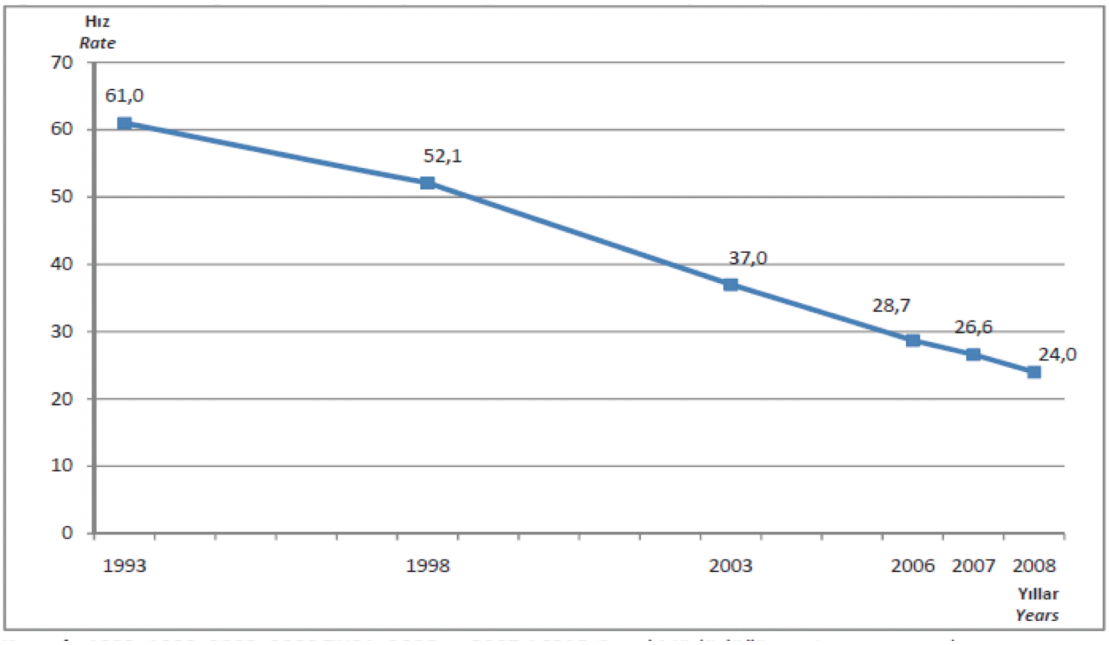
Source: (Turkstat, as described in Turkish Demography and Health Statistics, 2008, p. 11.)

Figure 35: Infant Mortality Rate by Year, (per 1.000 Live Births)



Source: (TDHS, 1993, 1998, 2003, 2008; GD-MCHFP, 2006, 2007 Survey results, as described in Turkish Demography and Health Statistics, 2008, p. 12.)

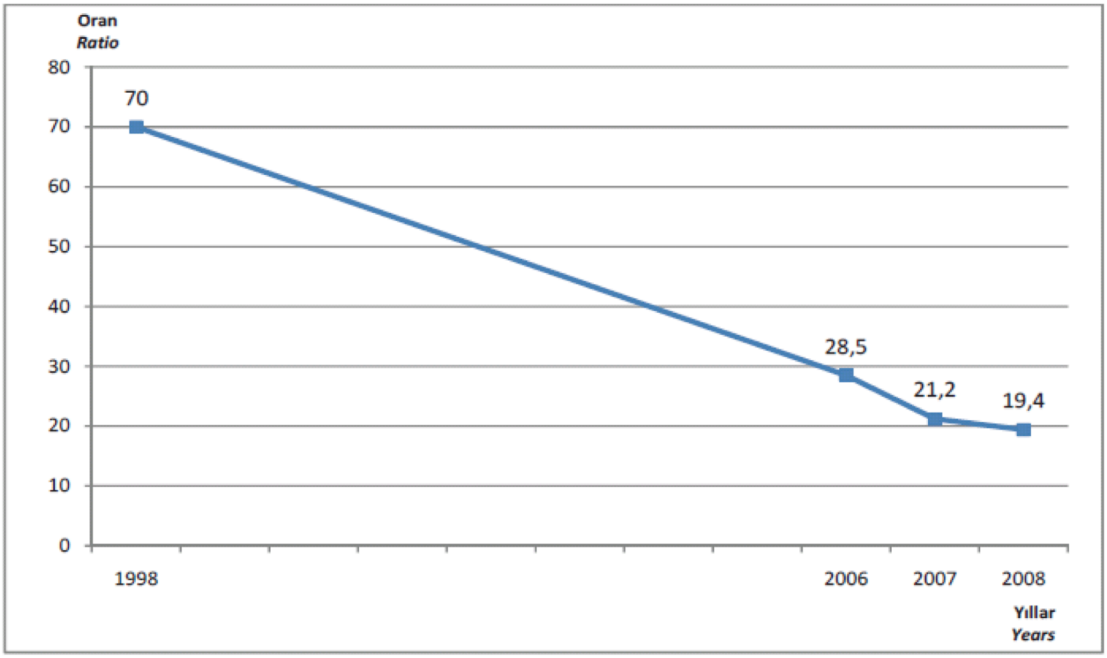
Figure 36: Under-5 Age Mortality Rate by Years, (per 1.000 Live Births)



Source: (TDHS, 1993, 1998, 2003, 2008; GD-MCHFP, 2006, 2007 Survey results as described in Turkish Demography and Health Statistics, 2008, p. 12.)

Figure 37: Maternal Mortality Ratio by Years, (per 100.000 Live Births)

Figure 2.8. Maternal Mortality Ratio by Years, (per 100.000 Live Births), Turkey



Kaynak: AÇSAP Genel Müdürlüğü
Source: GD-MCHFP

Source: (GD-MCHFP, as described in Turkish Demography and Health Statistics, 2008, p. 15.)

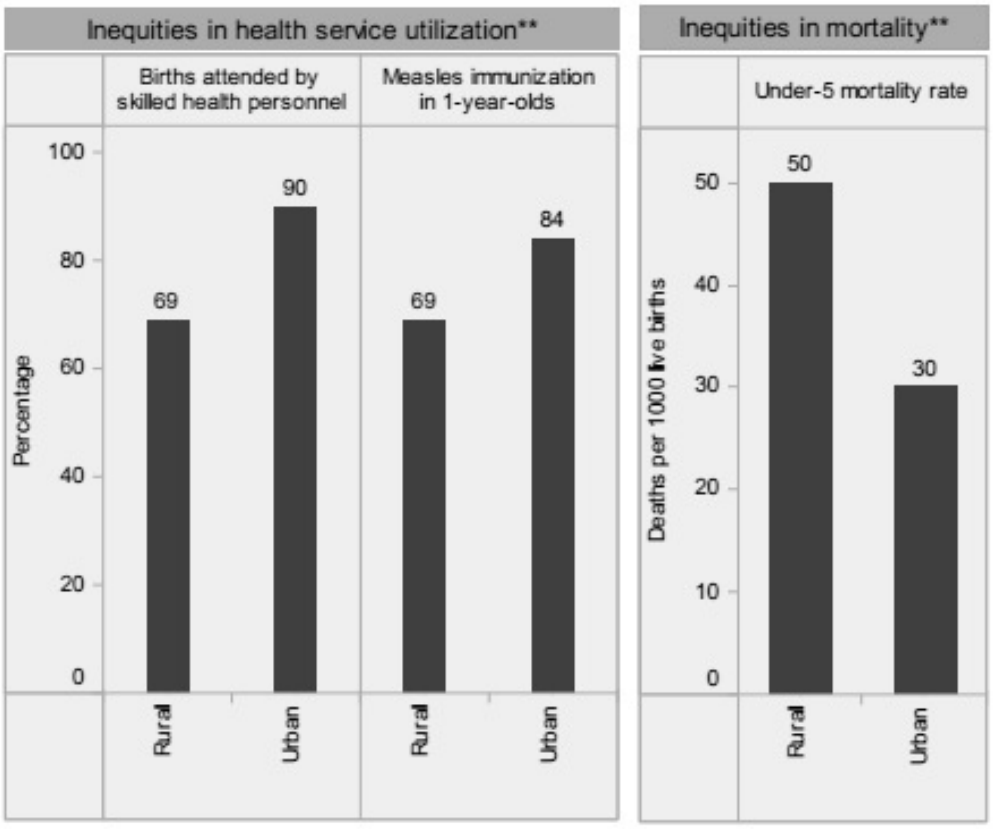
Turkey has progressed impressively in "expanding financial protection to the population through expansions in the breadth and depth of health insurance coverage combined with service delivery reforms to improve equity in access to health services" (OECD, 2008). Health expenditure has increased in proportion to the income increases. Further improvement of the health status however will prove to be challenging. The reasons underlying will be discussed in greater depth further in the report.

2.1 Level of health care intervention

According to the OECD (2007, p. 28), the health care system in Turkey before 2003 "was a combination of a national health service, providing limited health services free of charge to the population, and a number of social health insurance schemes covering formal sector workers and their dependents." The poor and vulnerable were assisted through a special targeted social program also referred to as the "Green Card". Under this system nearly 85% of the population was covered, but the health financing and delivery was fragmented and out-of-pockets payments were substantial, especially among the unemployed poor. Furthermore, access to quality health services in the rural in comparison to the urban areas was limited, more expensive, inefficient and understaffed. Concerns about equity, transparency and accountability were raised in relation to rampant informal payments in the health sector (OECD, 2007).

The HTP was announced in 2003, and the most important changes under this policy were the establishment of a General Health Insurance Scheme (GHIS) and the Social Security Institution. Basically, this meant that there was now a single social health insurance fund, financed by a single purchasing agency, for the whole population, to better provide access to health services and ensure equity and efficiency. “Average life expectancy reached 71.8 for men and 76.8 for women in 2010. The infant mortality rate decreased to 10.1 per 1000 live births in 2010, down from 117.5 in 1980. Despite these achievements, there are still discrepancies in terms of infant mortality between rural and urban areas and different parts of the country, although these have been diminishing over the years” (Tatar, et al. 2011, p.1).

Figure 38: Inequities in health service utilization and mortality



Source: (WHO, 2011, p. 1.)

“Total expenditure on health as a proportion of gross domestic product (GDP) has risen from 2.4% in 1980 to 6.1% in 2008. The share of health expenditure from public sources as a proportion of total health expenditure was 73% in 2008. Health expenditure between 2000 and 2004 increased mainly because of reform initiatives that improved access to health care services and changes in the provider payment system. This trend has continued, with a rise in the share of public expenditure on health as a proportion of GDP from 2.9% in 1999 to 4.4% in 2008. This increase is mainly the result of improvements in the public provision and financing of health services that have decreased the share of

out-of-pocket (OOP) expenditure" (Tatar, et al. 2011, p.16). The Social Security Institution - an administratively autonomous public corporation - is responsible for all social benefits and it's composed by the General Directorates of Health Insurance, Social Insurance, Payments without Premium, and Service provision. Another change in the system is the Performance Based Supplementary Payment, in which health professionals are entitled to additional payments, according to quantitative service criteria.

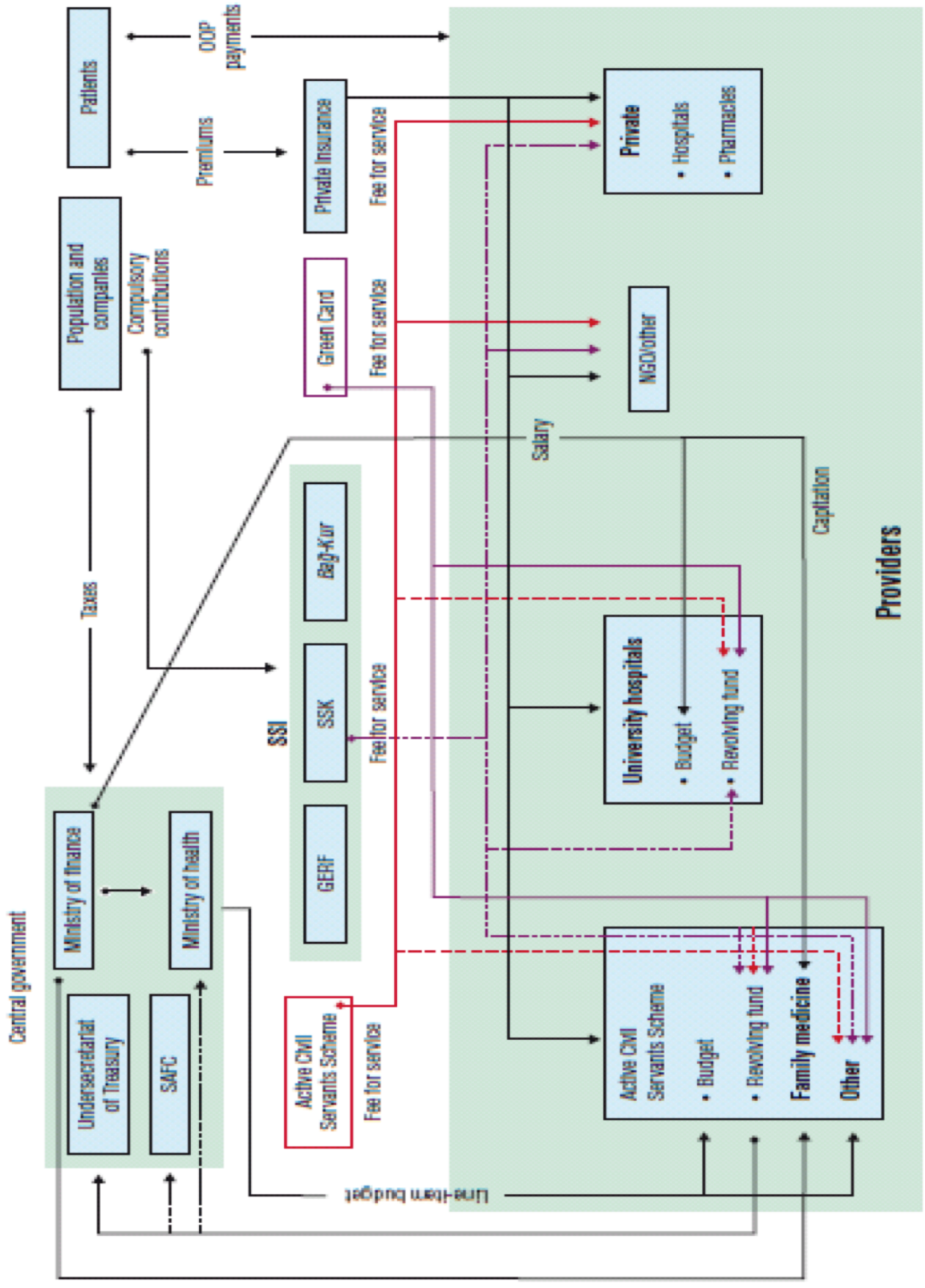
Under the GHIS, all Turkish citizens are covered by the system, including refugees and foreigners residing in the country for over a year. The system is compulsory and universal. Contributions are earning-based, depending on a person's ability to pay, and set at 12.5% of their gross income. There are also state contributions and user charges. "In practice, however, people who are able to pay premiums but do not do so or those who fall behind in paying their contributions are excluded from the scheme, except in emergency situations. Even poor citizens who have not proven their status are excluded from coverage" (Yıldırım & Yıldırım, 2011, p. 188).

The comprehensive GHIS law includes benefits such as "primary care and preventive services, including personal preventive care and protective care for drug addiction; ambulatory and inpatient care benefits, laboratory services, patient follow-up, rehabilitation services, emergency health services, organ, tissue and stem cell transplantation and curative services; maternal benefits as well as in vitro fertilization treatment, with limitations on the coverage of in vitro fertilization treatment. Eligibility is defined as between the ages of 23 and 39 years and a maximum of two attempts are funded. The insured must have had at least 5 years of coverage and the insured must not have been able to obtain results from other available treatment methods within the last 3 years; general oral and dental care (50 percent of costs of the orthodontic treatment for those under18 years and 50 percent of costs for teeth prosthesis for those under 18 years and over 45 years); and blood and blood products, bone marrow, vaccinations, medicine, medical devices and equipment as required. There are a few exclusions from the above package, namely, cosmetic services and cosmetic orthodontic treatment, health services that are not licensed and authorized by the Ministry of Health, and services that are not accepted as health services by the Ministry of Health (Resmi Gazete, 2006b, 2008)."

In terms of facilities, hospitals in Turkey can be private, public, or university owned, and care is provided in all of the three models. "In 2010, there were 1439 hospitals, of which 843 were owned by the Ministry of Health, 62 by universities, 489 by the private sector and the rest by other public organizations such as the Ministry of National Defense." (Tatar, et al. 2011, p.18).

The GHIS reform is a big step towards more equal and well-distributed health resources throughout the Turkish population. Challenges now consist in making the system financially sustainable in the long-term, maintaining the same or higher level of quality of care and improving efficiency and equality. Below is an overview of the Turkish health system with the elements discussed.

Figure 39: Overview of the health System



Source: (Mollhilloglu *et al*., 2007)

3. PPPH PROJECT FEATURES IN THE COUNTRY

PPPs in the health sector are still a new phenomenon. In comparison to the Philippines, the experience in Turkey in this field is still in the preliminary phase. The first tender is currently in the finale stage and many more are currently in the pipeline. The Kayseri Integrated Health Campus project will be implemented for a local population of 2.8 million with an assumed capacity of 10000 patients per day with 1548 beds. The project will foresee four hospitals, social facilities and commercial areas in which the private sector will be "responsible for the construction works as well as the provision of medical equipment and furniture and the non-medical services. The most appropriate healthcare facility design and service specifications, meeting the demands of the Ministry, have been determined by taking into account the proposals, through a new tender procedure applied for the first time in Turkey."(Aceton, 2012).

- PPPs in healthcare will mostly be focused on providing healthcare infrastructure, e.g. buildings, equipment with the aim to increase access to services and quality of care at a lower cost. Clinical services are expected to remain completely under the authority of the government.
- By upgrading and up scaling the equipment and infrastructure, Turkey intends to attract more medical tourist not only from the neighboring countries and the Middle East, but also Europe.
- Due to the nature of the private sector involvement, providing infrastructure, contracts are expected to vary from short term for equipment, 3-5 years, and 20-30 years for major infrastructural operations in which the ownership will be transferred to the government after completion.
- The tender process in the bid for the Kayseri Integrated Health Campus project proceeded slowly. Misunderstandings on the process and allegation of the winner of the bid being predetermined surfaced. Transparency of the pre-requirements is considered an "area for improvement". Furthermore, the contracts are currently not public and are not available for further research.
- It is currently unclear on which indicators the bidding process and the implementation of the PPP projects will be assessed for monitoring and evaluation purposes.

SUPPORTING OPINIONS & SUPPLEMENTARY INFORMATION ACQUIRED IN THE FIELD

With new advanced machines, Turkey has managed to the lower the costs for an MRI scan from 200E to 30E. In PPPH, Government will simply have a managing role of the clinical services in our hospitals. Contracts can be 29 years after which property is transferred to the state. Turkey currently has several open tenders for a PPPH for state of the art equipment for short time periods, e.g. 3 year.

4. FOUR THEMES FOCAL RESEARCH IN TURKEY

4.1 Institutional Design (Policy Framework)

a) Turkey currently has an unorganised structure concerning its PPP legal framework with a narrow scope, but it is aiming for one a single legal framework to welcome new PPPs.

Public infrastructure services that involved private sector prior to 1980 were implemented with the concession model. Concession Law of 1910 however failed to provide a detailed legal framework and divided the risk equally between the public and the private sector. Under this legal framework, superior authority was granted to the public sector (Burosu, 2011).

According to the Prime Ministry Privatization Administration (2010), Turkey has been a front-runner in setting up its own PPP legislation. One of the first laws to have been enacted is Law 3096 in 1984, which allowed private sector involvement in power plants projects. In 1994, Turkey passed a general Build-Operate-Transfer (BOT) law, Law 3996, for multisectoral infrastructure projects. With this legal framework, projects in mainly electricity production have materialized. Between 1995 and 2001, "nearly one fourth of Turkey's power production capacities have been completed under the BOT and BO models."[44]

Although many different PPP models exist, four types have been used frequently in the Turkish context (Minasyan & Uslusoy, 2011):

(i) Build-Operate-Transfer ("**BOT**")

(ii) Build-Operate ("**BO**")

(iii) Transfer of Operational Rights ("**ToR**")

(iv) Build-Lease Model ("**BL**")

In the last three decades, several laws regarding PPPs haven been enacted. Minasyan & Uslusoy, (2011) summed up the following:

Law No. 3096 (1984) - "Generation, Transmission, Distribution and Trade of Electricity by Third Parties Other than the Turkish Electricity Authority"

Article 33, Law No. 5335 (2005) – State Airport Authority transfer of operation rights

Law No. 3465 (1988) – "Construction, Maintenance and Operation of Highways"

Law No. 3996 (1994) – "Realization of Certain Projects under the Build-Operate-Transfer (BOT) Model"

44 http://siteresources.worldbank.org/WBI/Resources/213798-1259011531325/6598384-1268250381749/PPPEPECAGT.pdf

Law No. 4283 (1997) – “Establishment and Operation of Electricity Generation Plants and Energy Sales under the Build-Operate (BO) Model”

Law No. 5396 “2005” – Health Sector under the Build-Lease (BL) Model

Turkey is currently considering a Draft Law to address structural challenges and weaknesses of the current legal framework. The major shortcomings in the current legal framework are the “unbalanced risk distribution between the public and the private sector, limited number of the PPP models in the existing legislation, lack of harmonization in the PPP legislation” (Kordel, 2008, p. 3). The current legal framework lacks a coherent legislation that governs all PPP models, definition of PPPs, main principles, clear requirements for a tender process with regard to transparency and, corruption and doesn’t refer to the main institutions that need to safeguard the process to a successful PPP in Health (Kordel, 2008). In the Draft Law the purpose, coverage, main principles, detailed requirements for an open and competitive tender process have been drafted to cover all PPPs. (Kordel, 2008). At the time of writing of this report, the law has not yet been approved.

SUPPORTING OPINIONS & SUPPLEMENTARY INFORMATION ACQUIRED IN THE FIELD

Participants generally agree that the legal framework is currently inadequate to address the future up scaling of PPPs in general and PPPH. More coherent legal framework was advised to prepare the tender and successfully implement PPPH in the future on a larger scale. Transparency was questioned multiple times concerning the bidding process.

b) PPPH specific regulation

In 2005, Law No. 5396 was enacted specifically for PPPs in the Health Sector under the BL model. Principles for the infrastructural element of health facilities has been set forth in this law. Furthermore, in 2006 the “Regulation on the Health Facilities to be constructed in Return for Lease and Renovation of Health Facilities in Return for Operation of the Services and Areas Other than the Medical Service Areas” was enacted (Minasyan & Uslusoy, 2011). The first PPPs in the health sector, e.g. İkitelli Integrated Health Campus, Kayseri Integrated Health Campus and Ankara Bilkent Integrated Health Campus, will be implemented under the BL model. As Turkey has yet to embark on the implementation of PPPH, it is difficult to estimate the adequacy of the legal innovations with regard to PPH.

It is expected that innovation in a comprehensive PPP legal framework will increase the likelihood for PPPs in different sectors, to become more viable. Consequently, innovations in PPPH related law are expected to materialize in more PPPH hospitals with new equipment. As access to health care is constitutionally bound, the access to citizens is expected to increase as well. This raises the justified

criticism whether the government of Turkey will be able to afford PPPHs in the long run without raising the service fees. Furthermore, Turkey does not have enough doctors and nurses to place in the case of grand upscale of PPPH across the country.

SUPPORTING OPINIONS & SUPPLEMENTARY INFORMATION ACQUIRED IN THE FIELD

According to our interviews, Turkey currently has 120.000 medical doctors, whereas France has 217.000 doctors. Although students in medical school have increased from 5000 to 8000, benefits are expected to be reaped 8 years after.

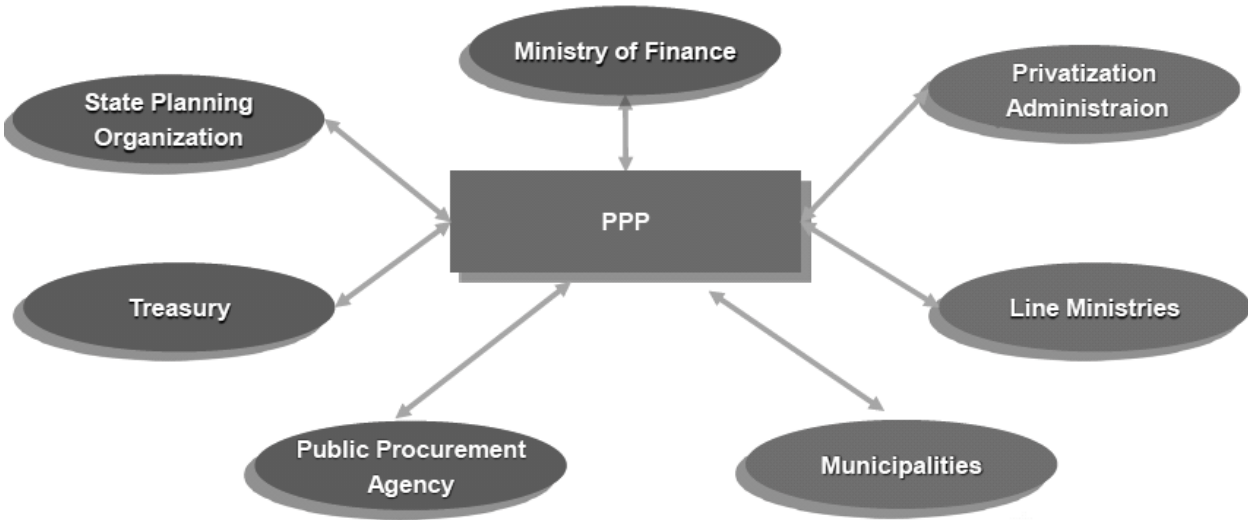
Costs and affordability of PPP are difficult to estimate. Turkey doesn't have the capacity to accurately assess the liabilities that will be incurred from PPPH.

Although Turkey's health budget has tripled due to growth of GDP, expenditures have been growing faster than the health budget and more than expected.

c) Institutional Framework of PPPH

As described before, the Ministry of Health has a significant role, if not the most important, in providing health care. Apart from the MoH, the major stakeholders in PPPH are the Ministry of Finance, Privatization Administration, Line Ministries, Municipalities, State Planning Organization, Treasure and Public Procurement Agency (Privatization Administration, 2010)

Figure 40:

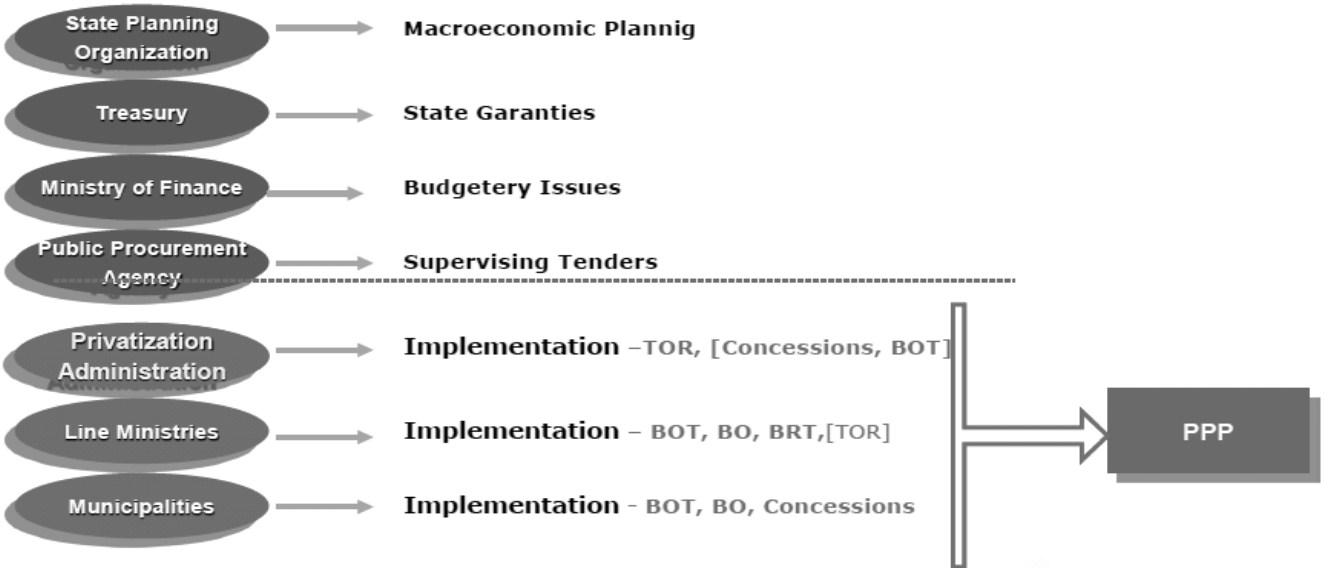


State Planning Organization, Treasury, Ministry of Finance, Public Procurement Agency respectively focus on macroeconomic planning, state guaranties, budgetary issues, supervising tenders. Depending on the type of PPP, the implementation will be done by the Privatization Administration, Line Ministries or Municipalities. Effectively, fragmentation and lack of oversight is a major concern. Burosu (2011, p.3) argues "the absence of any sponsoring and supervising institution in the government to guide public entities through this complex public service procurement method can be cited as general shortcoming". The MoH currently lacks the necessary PPP unit to implement the project cycle, approve feasibility studies and contracts. The bidding process for the first PPPH contract led to misunderstandings about the project, unpredictability, allegations of bias concerning the pre-requirements and lack of transparency. It is unclear who will implement the Monitoring & Evaluation and which indicators the performance will be assessed. Turkey currently does not have an independent body that can objectively safeguards the tender process regarding transparency, corruption, procedure and fairness. The lack of capacity and experience of the Turkish government to draft PPP agreements and different applications by the public sector entities has been perceived to be a weakness.

SUPPORTING OPINIONS & SUPPLEMENTARY INFORMATION ACQUIRED IN THE FIELD

Government is a major stakeholder given its fiscal impact. Government is looking for investments in the private sector, but currently hasn't mapped the winners and losers in society. With the potential for more health trade, serious concerns have been raised as to whether Turkish citizens will be able to benefit from this specific trade. It is unclear what strategy the government will apply to mitigate potential negative externalities that will affect the local population.

Figure 41:



4.2 Contractual Arrangement (Risk Sharing, Incentives)

Despite the profound experience in particular PPP models, e.g. concessions, BOT, BL, “there still remains an unbalanced risk between the public and private sectors and a lack of political, economic and legal stability. Apart from energy and airport terminal projects, participation of the private sector has not increased as much as it had been expected to increase” (Burosu, 2011).

In contrast to previous PPP contracts, Enkur (2011) states that the BL contracts in HealthCare will be under private law as opposed to administrative law. The private sector here will have a relatively balanced risk sharing. Under the administrative law contracts, the public sector would have bearded less risk. Also, the contractor is legally bound to provide the full financing for the construction of the infrastructure projects. No less than 20% of the investment is expected to be invested under the contract, however the contracts will include penalty clauses in case the Ministry fails to meet its financial obligations (Enkur, 2011). After the expiration of the contract term, the ownership of the land and construction will be transferred back to the Treasury.

Although the BL will be covered under private law, the tender process is “completely "administrative", meaning that starting with the decision of the Board or the Ministry respectively; to construct or to renovate health facilities, all decisions granted by the administration may be taken to the administrative courts in the form of an annulment lawsuit” (Enkur, 2011).

The MoH has made an assessment of the risk allocation in the PPPH project in Kayseri (see table below). The government here has allocated the full risk to itself for planning, tender process, administration for setting design standards, construction requirements, however accuracy for design data, tender documentation and preliminary design fall under the risk profile of the project company. All risk of construction, operation, maintenance, financing, currency fluctuation is fully taken by the private sector. (MoH, 2009)

Figure 42:

Legal Risk		Public	Private	Shared
Changes in law	General changes in Law		x	
	Discriminatory Change in Law	X		
Health and safety	Compliance with health and safety standards and law		x	
Indemnity	Indemnity for Direct Losses sustained as a consequences of: 1. death or personal injury or respective			X Each party provides an indemnity to the other party for

	employee 2. death or personal injustice of third party 3. physical damage to the facilities 4. loss of or damage to third party property or assets	direct losses

4.3 Institutional Quality (Equity, Efficiency & Effectiveness)

The main objective of PPPH is to create maximum public value by involving both public and private sector in an optimal fashion. Institutions hereby are imperative to safeguard "transparency, accountability, participation, efficiency and citizen satisfaction" (ECORYS, 2008, p.113). Given the circumstance that PPPH have not been implemented yet in Turkey, lessons on equity, efficiency and effectiveness will be drawn from other PPP experiences in Turkey to assess the institutional quality.

SUPPORTING OPINIONS & SUPPLEMENTARY INFORMATION ACQUIRED IN THE FIELD

There was a general agreement that the Turkish government and Ministry of Health currently lack the capacity, knowledge and experience to build strong institutions that will qualify Turkey for being well prepared to upscale PPPHs across the country.

Turkey has actively encouraged private investment in the energy sector under the BOT-model, which has led to 24 different projects with a new capacity of 2500 MW. The government hereby provided guarantees to Take or Pay over a period of around 20 years to attract investors in foreign currency (USD). During the economic crisis of 2001 and the consequent devaluation of the Turkish Lira, the costs of the PPP projects skyrocketed beyond budgeted expectations. Public authorities could not "to provide sufficiently skilled internal resources to negotiate these more complex financing deals, and many of the electricity generation contracts were awarded without competition" (ECORYS, 2008, p.50). The Turkish government in 2001 tried to withdraw from its financial commitments to the involved project companies, but was overruled but the Turkish constitutional court in 2002 to compensate the private sector.

Birecik Hydro Project, one of the energy projects, was successful in attracting equity, but the project failed to incentivize maximizing efficiency, minimizing overheads, or paying a market rate for the services procured (ECORYS, 2008).

As mentioned before, Turkey currently lacks a coherent institutional basis to build fruitful PPPH from. Turkey currently lacks a strong supervisory PPP unit with the capacity to conduct quality feasibility

studies, set up contracts that will attract equity, incentivize efficiency, effectiveness and cost control, safeguard transparency, accountability, and stakeholder's participation during tender while providing a quality service for the public in health. Turkey has learnt from its mistakes in the past by not directly negotiating contracts with the private sector, but to create competition through a bidding process. With its profound experience with BOT, Turkey has significant potential to create more value for the public by implementing PPPH projects. Turkey's willingness to provide quality health care for its people encourages the government to be proactive in seeking investments. However, without a strong institutional backbone, the likelihood for Turkey to make similar mistakes as it did in the past will remain substantial. PPP's in these particular cases might lead to better access to quality health care, but will be accompanied with spiraling health care costs that in the long run are not affordable for the Turkish taxpayer. For PPPs in Health to remain sustainable, affordable and provide a better quality service to Turkish citizens, stronger institutions are an absolute must.

4.4 Institutional Environment & Trade (Political, Economic & Social Context)

Turkey has expressed its desire to become a haven for medical tourists. PPPH is assumed to be a strategy to provide high quality health care services for both Turkish citizens and health tourist. Turkey is already welcoming health tourist from the Middle East and even Sweden, but seeks to extend high quality health services to a broader market.

Medical tourism industry is growing market. From 2006 to 2010, the industry grew from $60 billion worldwide to an estimated $100 billion worldwide (Herrick, 2007). Medical tourists often seek health care services elsewhere as services are becoming too costly in the countries they reside in. Health care costs in North America and Europe are getting more expensive. This combined with long waiting list for necessary treatments back home makes for a growing interest in health services elsewhere. For example, open-heart surgery in the UK surmounts to US$40,000, whereas a similar treatment in Turkey will be US$18,000 (Herrick, 2007). Although up and coming Asian countries are currently dominating this market, Turkey wants to compete for its share. Its location is ideal for medical tourists from Europe, Middle East and Africa that want to receive medical treatments that can easily be combined with a vacation. Medical brokers are currently offering menu packages for targeted services.

Quality remains a decisive factor in attracting medical tourists. Quality can be signaled through brands, e.g. non-profit American Hospital in Istanbul, that currently offer high quality services with state of the art equipment. Public hospitals in major cities, e.g. Istanbul, are getting better hospitals, however it remains very questionable that access to quality health care is following the same trend. Unequal access to health care is already a cause for concern (WHO, 2006). PPPH projects, due to the scale, are focused on major cities to attract more patients. Therefore, PPPH can broaden the urban-rural gap in health status.

Medical tourism, when done without proper preparation and calculations, can function as a double-edged soared. Turkey currently has a limited amount of human resources in terms of doctors and nurses. According to the OECD (2006, p. 2), "Despite an increase in the number of doctors in recent years, Turkey continues to have the lowest doctor-to-population ratio of all OECD countries. In 2003, Turkey had 1.4 physicians per 1 000 population, less than half the OECD average of 3.0. Similarly,

there were only 1.7 nurses per 1 000 population in Turkey in 2003, compared with an OECD average of 8.3. The number of acute care hospital beds in Turkey in 2004 was 2.4 per 1 000 population, below the OECD average of 4.1 beds per 1 000 population. In most OECD countries, the number of hospital beds per capita has fallen over recent decades, but not in Turkey, where it has increased from 1.5 per 1 000 population in 1984." With an increase in PPPH hospitals and a higher quality of care that will come to serve medical tourists in public hospitals, Turkish citizens eventually might not benefit from the innovations and quality brought by PPPH to the public. The excellent doctors in Turkey could easily be poached by non-profit hospitals and renowned public hospitals to serve medical tourists. At the moment, Turkish government has not yet come up with a strategy on how to mitigate potential negative externalities of medical tourism.

5. RECOMMENDATIONS

5.1 PPP: Set up One-stop shop in government to simplify PPP administrative procedures

An analysis of PPP projects brings with it an analysis of the role of the State, its structure, activities, and response to the needs of society. By engaging in a PPP project, the public sector opens its doors to the assistance of the private sector, and contracts are negotiated bilaterally and consensually. Despite the fact that PPPs projects are not new, there is an increasing will to regulate and make the process of engaging in such venture more uniform, in order to increase efficiency and sustainability of PPPs.

PPPs are an instrument of local development, and in times of economic crisis, come about as a way to reduce the role of the State without undermining it, with punctual projects, inserted in a well thought out strategic plan. They are a hybrid form of approach to take care of the collective needs of the population, through a contractual relationship, collaboration between the public and private realms – that blurs the boundaries of public and private actors.

The need for an institutional and regulatory framework in the case of PPPs and PPPHs is clear. Countries that have such mechanisms in place prior to the development of a new PPP project have a smoother process of preparation, development, and implementation of PPPs. A clear set of rules helps the negotiation process, and make each role clear. The public sector can thrive by borrowing expertise and efficiency from the private sector. And the private sector is more stimulated to seek its engagement in PPP projects.

Having an agency to promote PPP projects and act as a one-stop shop, connecting and performing all necessary procedures and stages of the process of implementing a PPP projects, is also an important step to guarantee more sustainable projects and a better understanding between the public and private partners. The institutionalization of PPPs through this process reinforces and reassures the relationship and makes for a smoother negotiation and clear roles, as well as better risk sharing. A PPP unit also improves government efficiency, unifying the needs of different departments, and resolving internal conflicts, reducing administrative costs and speeding up the process. These are characteristics that

attract the private sector, removing bureaucratic obstacles, increasing transparency, and ameliorating the overall process. The one-stop shop also serves as a best practice bureau,

In the health care sector, the establishment of PPP projects can be controversial. There is a general conception that profit should not permeate this sector, but the need for efficient delivery of services and better quality of care, especially in developing countries, comes as a strong reason to engage in PPPHs. In a PPPH project, the role of the State changes from sole provider of care, to a partner that must guarantee and oversee the delivery of care to the population.

Turkey, with the right preparation, can benefit from PPPs by assessing the business cases thoroughly beforehand by having a strong coherent PPP Unit that will assess the quality of care, financial risk, tender, communication with the line ministries and municipalities and monitoring and evaluation. The PPP Unit should safeguard the transparency, competition, procedure, accountability, stakeholder participation, efficiency and effectiveness during the bidding process, as well as in the pre-requirement stage and setting up the contract (ECORYS, 2008). All contracts should be entirely open to the public.

5.2 Health System: Import Information Technology system to form comprehensive databases, covering health professionals, patients and medical treatment.

The current health system in Turkey has a wide coverage and a wide scope accompanied with low service fees. Although Turkey's ambition and willingness are significant to embark on up scaling of PPPHs, caution is recommended. Turkey is advised to move at a slower and better-informed pace to steepen its learning curve from a limited number of PPPH that will be implemented in the near future. An important tool in assessing the performance of the government, private sector and medical personnel in this learning process is by setting up important information technology system. The scope of the database established by such information technology systems should keep track of pre-set indicators for each phase in the PPP process: pre-requirement phase, the full subsequent tender process, implementation and monitoring and evaluation. These databases should gather all necessary financial information to assess the affordability of every PPPH and the effects PPPH hospitals had in comparison to full government hospitals.

By assessing the full process based on accurate and valid information, the government will be able to shape it strategy for the future based on facts, not on momentarily popularity of PPPH.

5.3 Health System: Reform for Financial Sustainability and Quality of Care

Turkey is currently experiencing an economic expansion, however the costs of health care are currently spiralling and growing faster than the current health budget. If the costs of health care would continue to augment on the similar pace in the near future, Turkey will continue to have growing deficits. Many similar welfare states in the EU, e.g. France and the Netherlands, are currently facing painful budget

cuts in the health sector. These countries can therefore serve as a cautionary tale on the necessity to balance finances.

From our interviews, Turkey has a potential to lower its health care costs while maintaining quality of care is through prevention and health education. As non-communicable diseases due to lifestyle factors are on the rise in Turkey, which is characteristic for developed countries, the potential for prevention increases. More access to health care may be political favourable, but may come at the expense of quality of care as more voters expect more and better care. Through prevention, Turkey can live up to expectations set, by lowering the strain on the current health care system and lowering costs.

5.4 PPPH: Building confidence on the government by having a coherent legal framework that will cover all PPPs including PPPH

Turkey has already been drafting a new coherent legal framework that would include the definition of PPP, laws related to PPP, main principles. This new legal framework for PPPs has not yet been passed. It is recommended for Turkey to implement a limited number of PPPH projects for a shorter contract periods. By doing so, Turkey can learn from the challenges faced on a small scale before scaling up to the rest of the country. The new legal framework is expected to bring political and legal securities to the playing field, which may attract investors. The draft PPP law, given its significance, should therefore be accurately communicated to all the stakeholders, including medical personnel, to prevent further miscommunications, smooth implementation and prevent future arbitration with the private sector.

5.5 PPPH: Mitigate health inequalities between urban and rural

PPPH are currently planned in the major cities of Turkey and will concern mostly big infrastructural projects. The PPPH is expected to increase the quality of care in cities, whereas the rural areas are expected to deliver similar quality of care. Effectively, more PPPHs in cities are expected to increase the health inequality between urban and rural. As the health inequality between the urban and rural areas is already apparent in Turkey, further growing health inequality is a cause for concern. Furthermore, with an increase in PPPH hospitals and a higher quality of care that will come to serve medical tourists in public hospitals, Turkish citizens eventually might not benefit from the innovations and quality brought by PPPH. The excellent doctors in Turkey could easily be poached by non-profit hospitals and renowned public hospitals to serve medical tourists. At the moment, Turkish government has not yet come up with a strategy on how to mitigate potential negative externalities of medical tourism and health inequality consequent to PPPH.

By earmarking the premiums of health services of medical tourists, these funds can be redistributed to serve the Turkish population in the rural areas. In order for Turkey to become the next haven for medical tourist, more doctors need to be educated to serve not only potential medical tourist, but also to keep providing good medical services to their own people. Given the long duration of a medical

education, PPPH should be implemented gradually to mitigate negative externalities for the Turkish citizens.

10. ANALYZING THE FINDINGS

In this session we will explore our initial hypotheses, taking into account the multiple case studies as a basis for an analytical and objective response to the questions previously established.

Hypothesis 1: Regulatory setting prior to the implementation of PPPH Projects is more likely to reduce agency costs and potential errors (regulatory governance).

The hypothesis is valid because in terms of institutional settings, the establishment of PPPH Units can address capacity gap between the public and private sectors in the beginning. Specialized PPP Units are generally created in response to weaknesses in the existing machinery of government's ability to manage a PPP program effectively. It refers to these weaknesses as "government failures" such as lack of skill and information. Governments in different countries will suffer from different institutional failures in PPP procurement. Compared with traditional procurement, this dedicated PPP unit with more organizational flexibility is required to ensure that lack of skill, information and coordination can be solved in order for the public sector to reduce high transaction costs involved in PPPH and mitigate potential failures. In the UK, this government failure was evidenced. All of countries we examined have set up a PPP unit. Among the developing countries, the Philippines have two PPP centers - one general PPP center, and one health specific PPP center. Turkey has PPPH department within the Department of Health. However, the PPPH department is understaffed to fulfill the functions of monitoring and evaluation. PPP units can facilitate PPPH by ensuring the Value for money and achieving optimal risk allocation.

In terms of legal frameworks, Canada and the UK, which have the common law system without specific PPP laws, have independent regulatory agencies to monitor and evaluate PPPH, while encouraging competition in the market to overcome market failures and opportunistic behavior. Instead of reliance on contractual arrangements, PPPH is highly related with safeguarding the public value such as safety. The role of the state focuses on this regulatory function for the two countries.

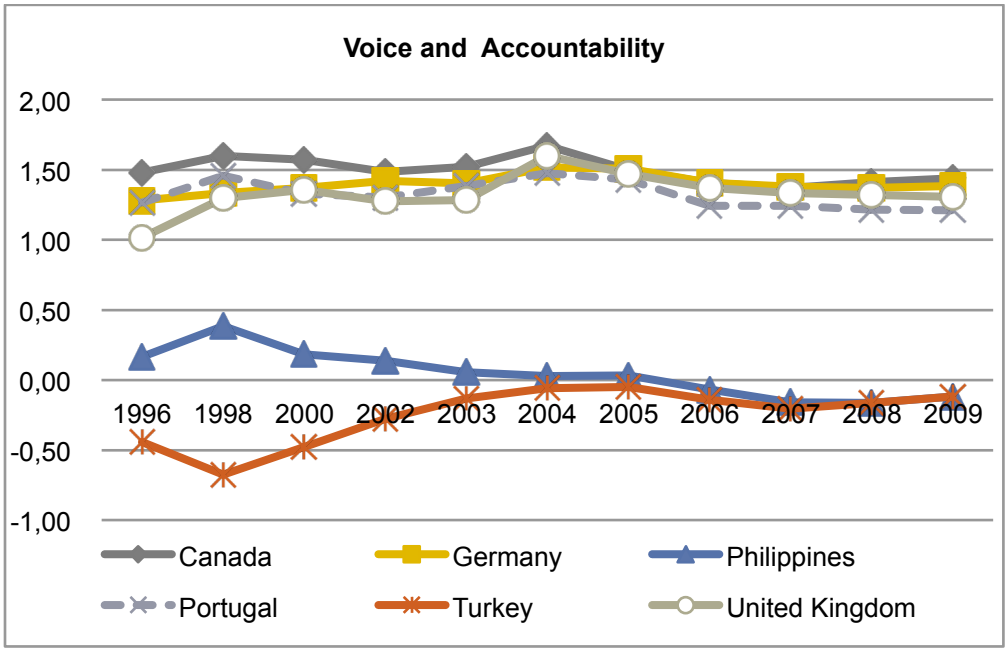
On the contrary, Portugal, Germany, and Turkey and the Philippines, which are characterized by the civic code, have PPP specific laws. Turkey has a PPPH specific law in place, but the country is currently harmonizing all PPP related laws, including the one related to health infrastructure. This harmonization process which still in a drafting stage. The Philippines have a comprehensive regulatory framework on PPPs, along with its PPP units. In the countries with the civic code, PPP laws serve as default rules in addition to PPP contracts to avoid an actor's moral hazard. This difference suggests that before embarking on PPPH, either independent regulatory agency or judicial review needs to be established, taking into a country's legal system to provide a PPPH enabling environment.

In particular, the EU Members (Germany, UK, Portugal) are characterized by "the duty to consult with the private sector". The EU directive "competitive dialogue" requires EU member countries to initiate a consultation before contracting with the private sector to reduce asymmetric information and allocate

adequate risks between the two parties. Especially, in the UK, the duty to consult at local level with main stakeholders is required by law, showing that the effective rule of law based on citizens' fundamental rights is put in place to safeguard the public interest. Stakeholder participation may reduce potential corruption between the public and private sectors, balance biased interest and make PPPH more accountable to taxpayers. However, Turkey and the Philippines lack third party involvement such as CSOs and NGOs (see graph below)

In terms of institutional quality defined by quality of contract enforcement, the developed countries compared with the developing countries are evidenced with more effective rule of law along with more PPPH development. This indicates that to attract a private sector and sustain long-term relationships like PPPH, the public sector needs to provide stable and predictable rules to investors (see graph below).

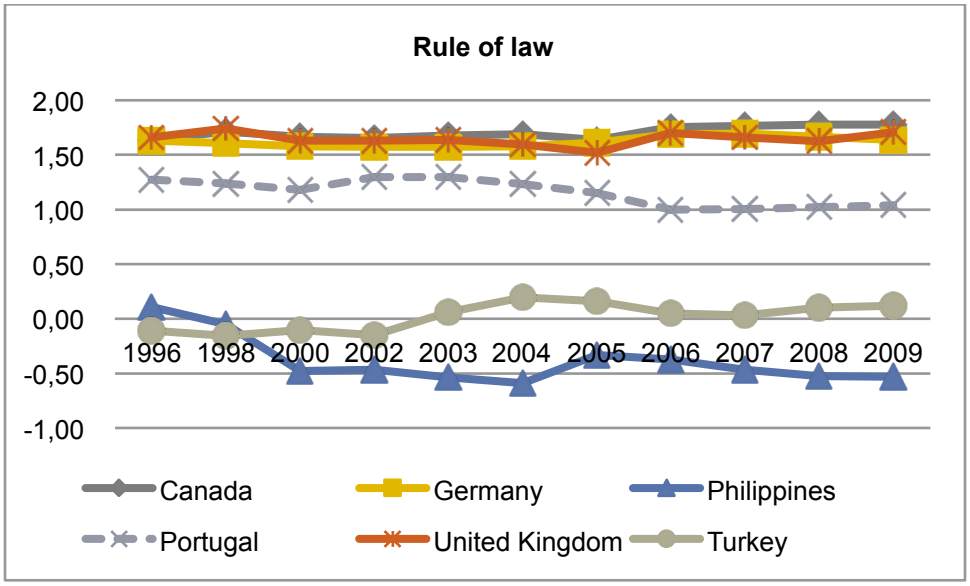
Figure 43:



Note: the extent to which a country's citizens are able to participate in selecting their government, as well as freedom of expression, freedom of association, and a free media

Source: World Bank Indicator

Figure 44:



Note: Rule of law measure the extent to which agents have confidence in and abide by the rules of society, including the quality of contract enforcement and property rights, the police, and the courts, as well as the likelihood of crime and violence

Source: World Bank Indicator

Hypothesis 2: The success and sustainability of PPPH Projects will depend on the public sector's capacity efficiently and effectively implement regulatory and institutional frameworks aiming to safeguard the public value.

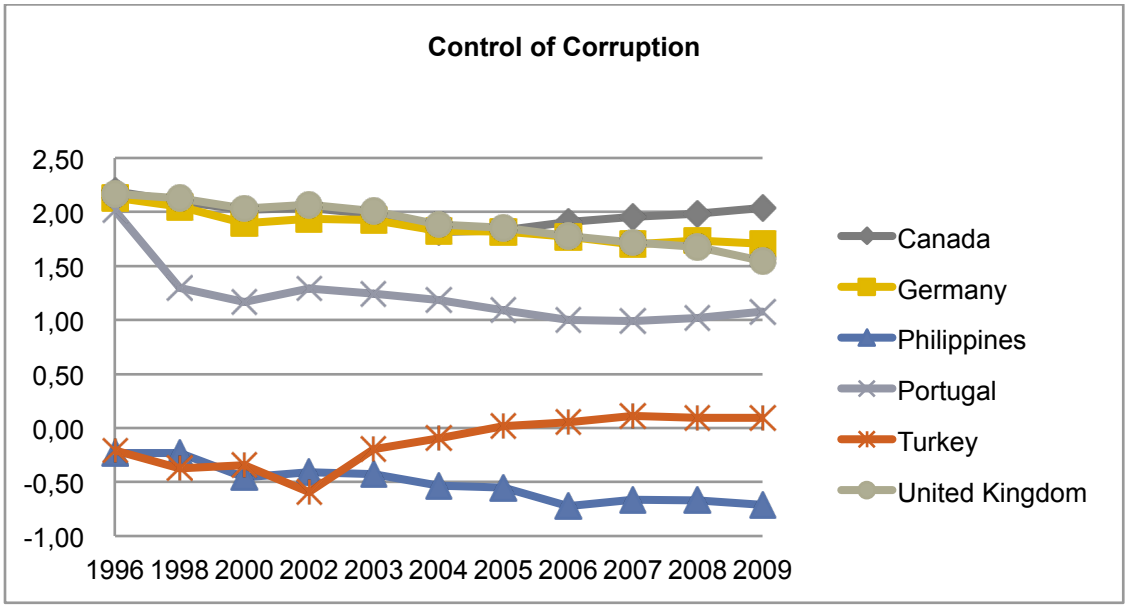
In light of the UK's experience, a lack of the public sector's expertise and skills to deal with PPPH projects in the beginning was evidenced, which generated a number of long-term issues. This suggests that before implementing PPPH projects, the public sector needs to be skilled for negotiation, to balance bargaining power with the private sector. The Portuguese experience was vastly improved after the government increased it capacity by creating the company "Parpública" - responsible for supervising all PPP projects in the country. In Canada, centralized institutional framework and federal and provincial level authorities are responsible for the capacity building on both public and private sectors. Besides serving as knowledge centre, they also promote and facilitate PPPH. Germany, by developing a PPP specific unit, created a platform for both the public and the private sector to exchange knowledge and negotiate contracts concerning PPP.

In the Philippines, the government capacity is relatively low. Although unsolicited proposals are welcomed, most of the proposals are based upon solicited proposals. Current capacity of the government is impaired by corruption and lack of trust, especially at LGUs.

In Turkey, similar issues arise currently the government lacks a coherent unit to attract potential private investors to create transparent competition set fair and balanced prerequisites and have transparent and stakeholder inclusive tender process. As Turkey and the Philippines are experimenting PPPH along with economic and political developments, they need more capacity at the governmental level to countervail the power of the private sector and guarantee the public welfare.

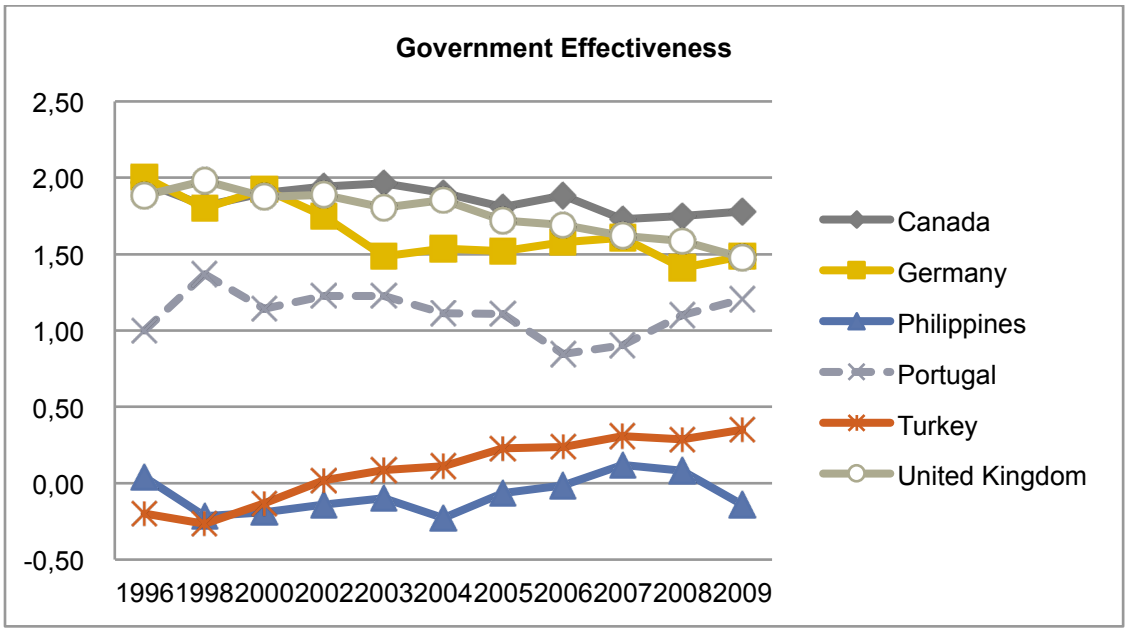
Comparing with developing countries, developed countries in general have established well-structured governments and achieved higher capacity level, which are reflected in the World Bank indicators. Take *control of corruption*, *government effectiveness* and *regulatory quality* between year 1996 and 2009 of six countries from WB databank, which are deemed as key performance indicators of government's capacity. There is a clear gap between the group of four developed countries and the two developing ones. Such gap reveals the different levels of governance between two groups of countries, and it affects the government capacity on implementation of policies, including PPP and PPPH. Among all the countries, the Philippines scored lowest in all three indicators, which support the concern during field study on government's capacity in handling PPPH from almost all sectors.

Figure 45:



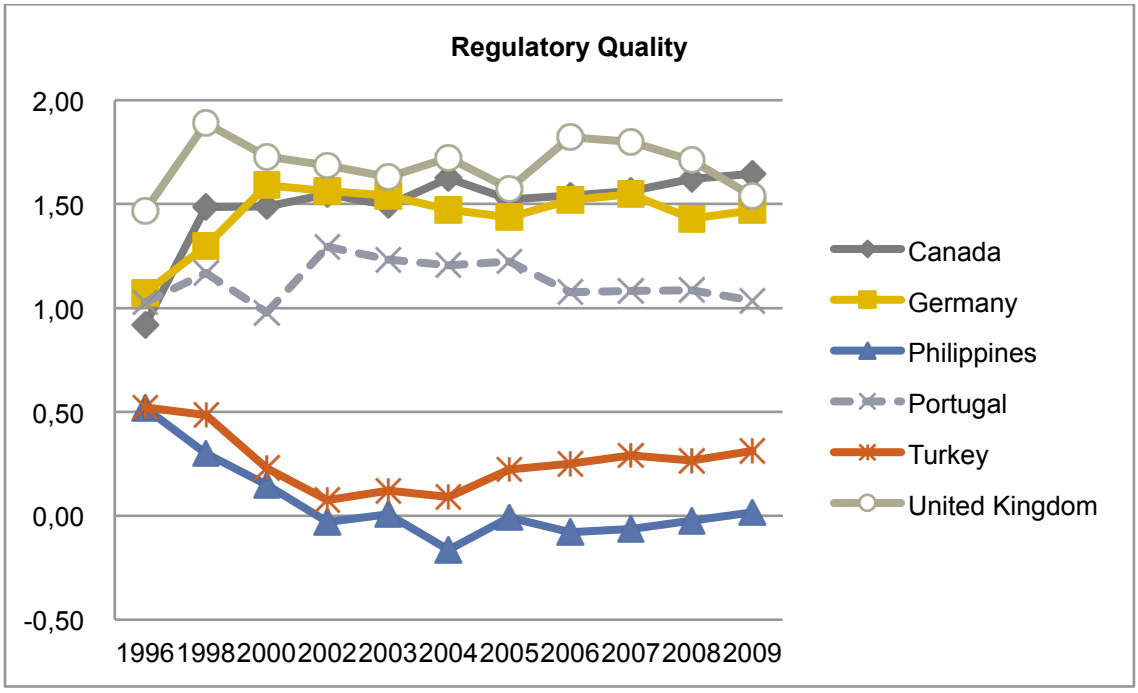
Source: (World Bank Databank)

Figure 46:



Source: (World Bank Databank)

Figure 47:



Source: (World Bank Databank)

Government's general capacity and structure defines basic setting to government's ability in handling PPPH. Healthcare, a politically sensitive public service applies to all citizens, requires more concentrated and rigorous resource and human capital input to be able to generate mutually beneficial outcome among public and private sectors in PPPH. The nature of long-term contract among infrastructure type of PPPH requires strong monitoring and performance evaluation mechanism from public side after the contract had been signed to avoid moral hazards, agency costs and to protect the poor's equal access to healthcare.

Learning from the both the success and failure experience from developed countries, more transparent bidding process of PPPH, a well-established database of citizen's health condition and health professionals, better-linked system between social health insurance to health facilities (e.g. health insurance card) are suggested. These can be achieved with several comprehensive and concurrent information technology systems. Universal health coverage, another basic method to improve health system and healthcare access, should be an objective in developing countries. It is also an important long-term financial resource to service type of PPP, like PPPH, for its financial viability. Finally, the government in developing countries should have the capacity to perform feasibility studies of PPPH projects predicting the upcoming incurring costs, risk control, and pro-poor strategy etc.

General Remarks

Based on the findings, Hypothesis 1 stating that regulatory setting *prior to* the implementation of PPPH Projects is more likely to reduce agency costs and potential errors, is valid in both developed and developing countries. Hypothesis 2, stating the success and sustainability of PPPH Projects will depend on **the public sector's capacity** efficiently and effectively implement regulatory and institutional frameworks aiming to safeguard the public value, is also validated in developed countries experience. Despite the fact that developing countries are at the beginning stage of PPPH, capacity building is fundamental and urgently needed to safeguard a fruitful process to PPPH with the aim create more welfare to the public. Thus, the better regulatory quality and institutional environment, increases the probability of incentives to induce investments and limit opportunistic behaviour.

11. CONCLUSIONS

Public-private partnerships (PPPs) are an important tool for governments seeking to expand and improve the provision of infrastructure and other social services for their citizens in times of economic crisis, come about as a way to overcome financial burdens and take advantage of expertise and technology from the private sector. They are a hybrid form of approach to take care of the collective needs of the population, through a contractual relationship, collaboration between the public and private realms – that blurs the boundaries of public and private actors.

However, unlike PPPs in other sectors, PPPs in Health necessitate a more salient attention and different approach. In the health care sector, the establishment of PPP projects can be controversial. There is a general conception that profit should not permeate this sector, but the need for efficient delivery of services and better quality of care, especially in developing countries, comes as a strong reason to engage in PPPHs. In a PPPH project, the role of the State changes from sole provider of care, to a partner that must guarantee and oversee the delivery of care to the population.

Theoretically and empirically, the report suggests what conditions are necessary by looking into cross-country examples in order to make those relationships sustainable and successful without having recourse to courts and PPP divorce. It also describes how other broader tools and institutions, such as PPP laws, regulatory entities, and PPP units are needed to ensure the long-run success of PPPs: the importance of understanding their impact on the transaction at hand at an early stage of project preparation, their role in ensuring the coherence and consistency of the PPP program, and their role in providing stability, transparency and predictability in the rules over the lifetime of the project. Thus, those necessary preconditions need to be met beforehand.

The need for an institutional and regulatory framework in the case of PPPs and PPPHs is clear. Countries that have such mechanisms in place prior to the development of a new PPP project have a smoother process of preparation, development, and implementation of PPPs while reducing potential trials and errors. A clear set of rules helps the negotiation process, and make each role clear. The public sector can thrive by borrowing expertise and efficiency from the private sector. And the private sector is more stimulated to seek its engagement in PPP projects.

Moreover, an analysis of PPPH projects brings with it an analysis of the role of the State vis-à-vis market and the public-private responses to the needs of society. PPPH is not limited to long-term public-private relationships, but society (stakeholders such as patients, doctors and nurses) needs to be included to make both public-private sectors more accountable to their needs. Under PPPH, a new governance mechanism is emerging.

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APPENDICES 1 :

Figure 48: A Summary of Theoretical and Analytical Underpinnings

NIE Theoretical Frameworks	Main problems	Suggested solutions	Pros and Cons
Principal-Agent Model (Laffont and Martimort 2002)	• Moral hazard (or hidden action) • Adverse selection (or hidden knowledge) • Non-verifiability of efforts	• Contract specifications • Setting up of an independent regulatory body	• Cheating by the principal such as sudden breach of contract • Social norms not considered
Coase Theorem (R. H. Coase 1960)	• Conflict of interest (private value vs. private value) • Negative externality (low quality, inequity)	• Property rights allocation • Negotiation and consultation between parties	• Responsive not only to changing technological environments, but also to institutional environments
Incomplete contracts Theory (Hart 2003, Lonsdale 2005)	• Unforeseen contingencies (or imperfect foresight) due to uncertainties • Bounded rationality (or decision costs) • Bounded observation (or imperfections of the judicial system)	• Law as default rules • Revelation mechanism through competition or a network knowledge in case of cheating from the public and private sectors	• Post-contractual renegotiation is inevitable • Not responsive to uncertainties such as technological developments
Transaction Cost Economics (Williamson 1979, Williamson 1998)	• Unhidden costs: legal and financial advisory costs • Hidden costs: Principal-Principal problem, opportunistic renegotiation (regulatory capture), hold-up due to asymmetric power relations	• Use of Official Development Assistance for developing countries • Renegotiation necessary to avoid hold-up problem • Third party involvement to assess performance • Well-designed specific performance contract with incentives	• Governance structure and regulatory design can reduce transaction costs • Social norms such as reputation not considered
Theory of Institutions (North 1990)	• Efficiency of coordination depends on institutional quality shaped by internal capacity and institutional environment	• Institutional arrangements such as market, hierarchy and hybrid • Credible, stable, and predictable rules to resist influences and pressures • Capacity building of the public sector • Effective rule of law such as citizens' fundamental rights	• Beyond one-size-fit all • Country-specific factors need to be considered. For example, historical trajectories, socio-economic, and political contexts

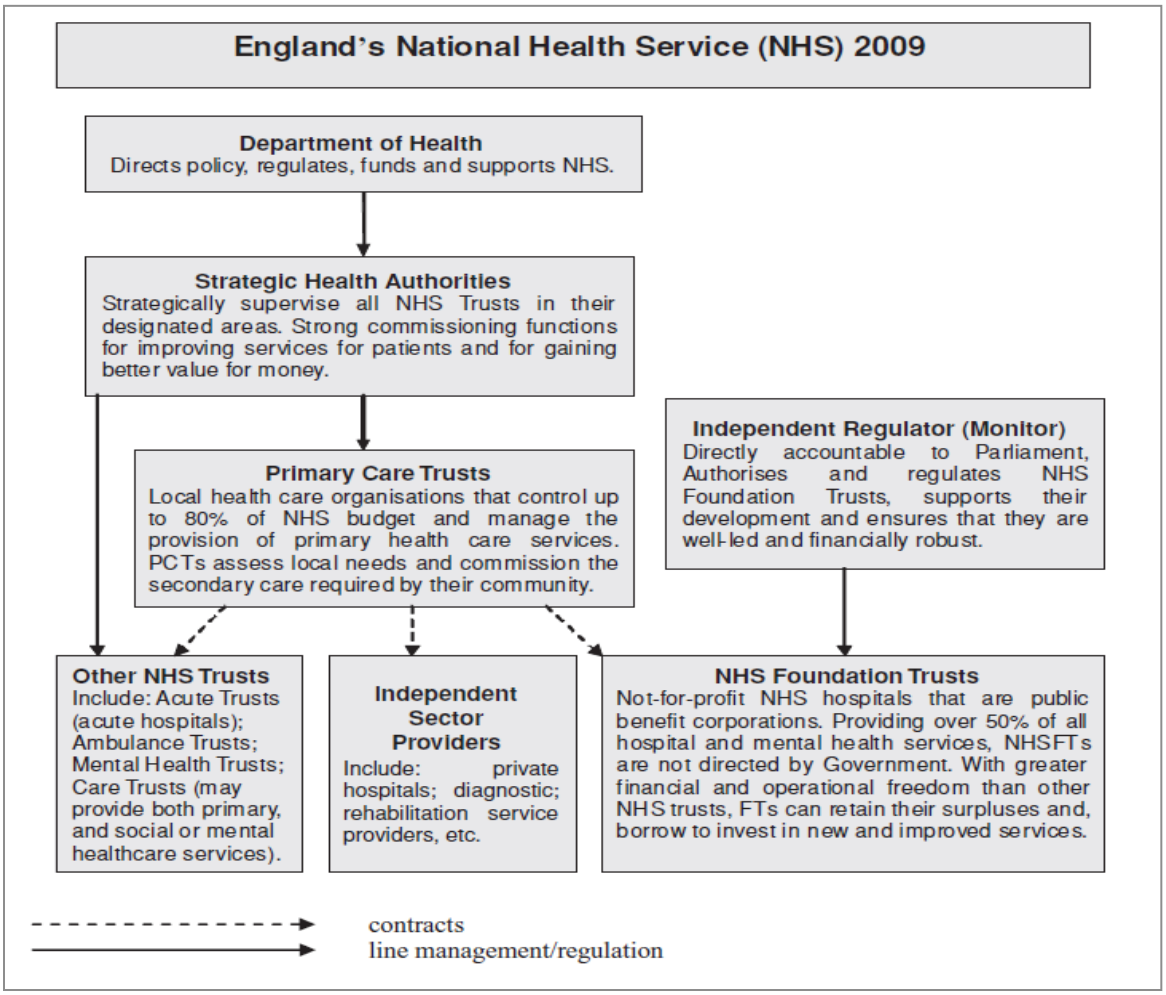
Source: author's own summary
Note: NIE stands for New Institutional Economics

APPENDICES 2

United Kingdom Supplementary Information

1. NATIONAL HEALTH SERVICE OF THE UNITED KINGDOM

Figure 49: England's National Health Service



Source: (Hellowell and Pollock 2010, 32)

2. SPECTRUM OF THE PUBLIC INTEREST COMPANY

Figure 50: The Public Enterprise Scale

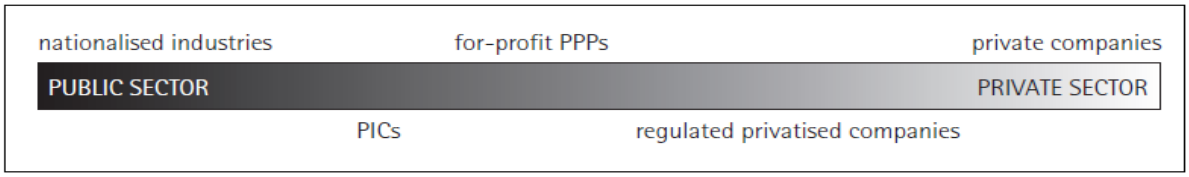
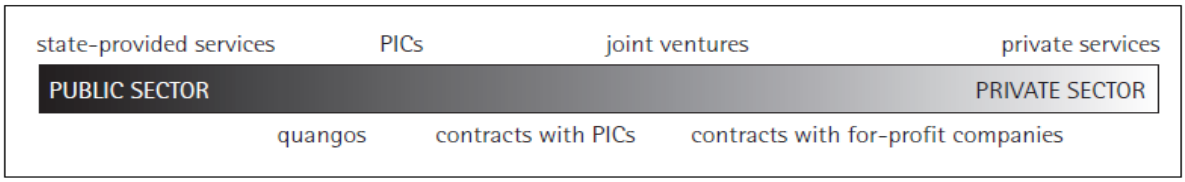


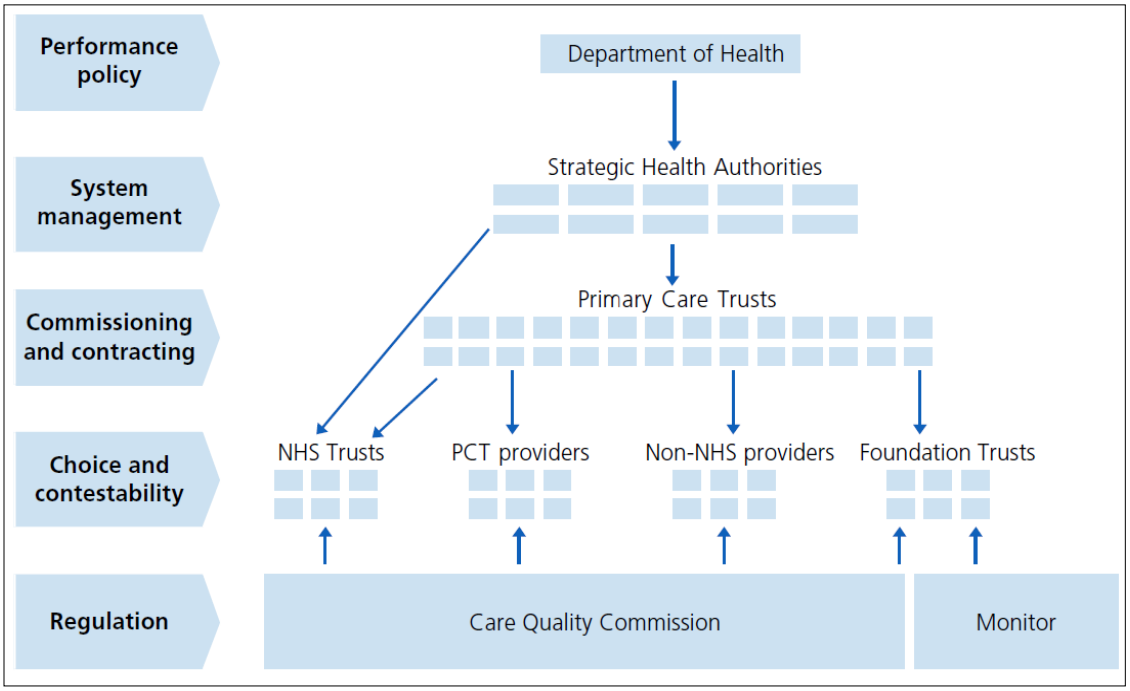
Figure 51: The General Public Services Scale



Source: (Maltby 2003), IPPR

3. THE UK NHS'S PERFORMANCE REGIME

Figure 52: Roles and responsibilities within the NHS Performance Regime



Source: (Department of Health 2012)

APPENDICES 3 :

Philippines Supplementary Doing Business Indicators & PPP Typologies

Figure 53:Doing Business Indicators of starting a business, construction permit approval in the Philippines

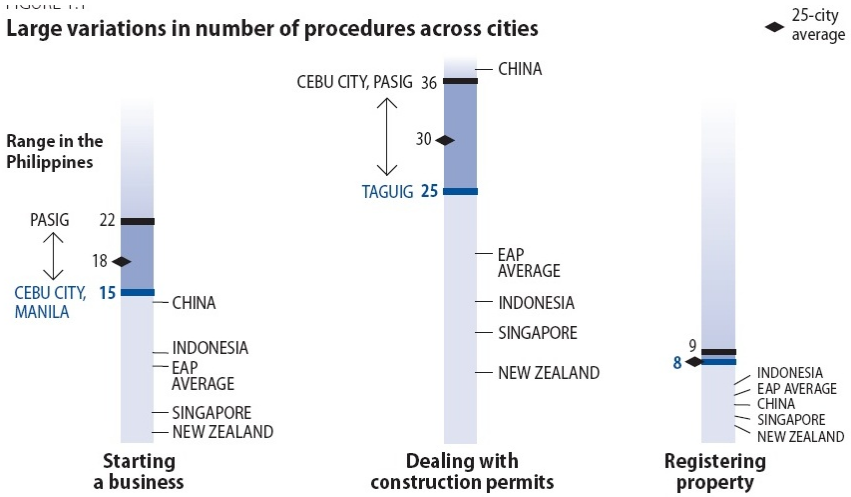


Figure 54:

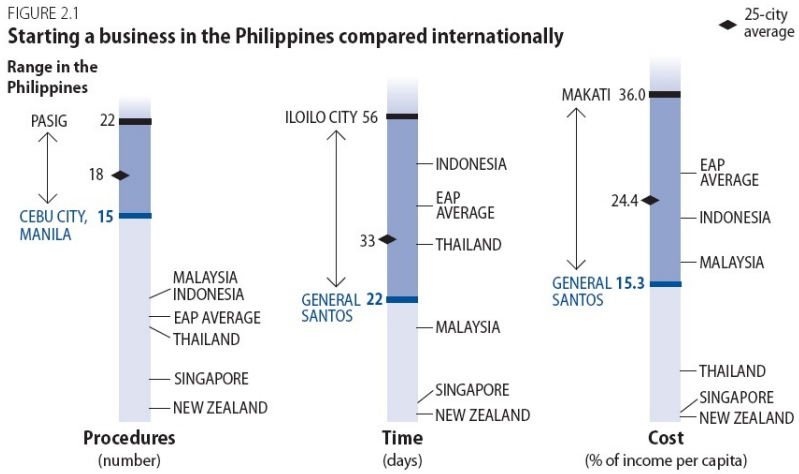
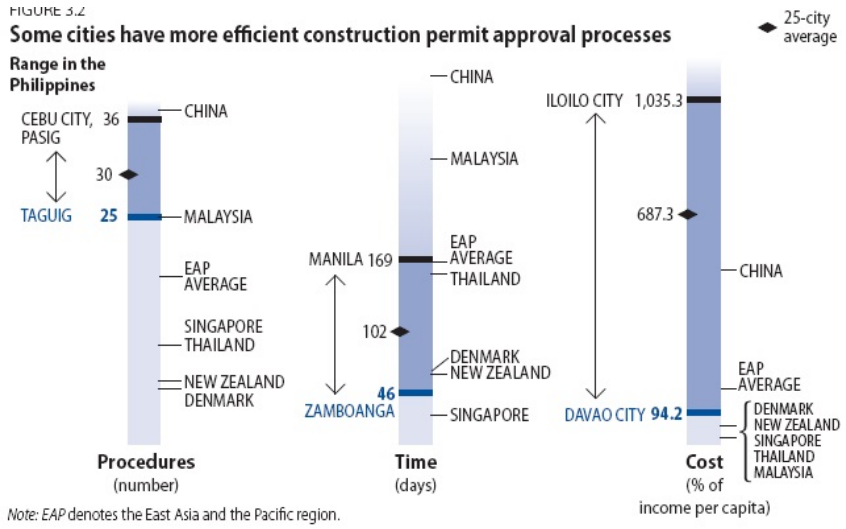


Figure 55:



Source: (The International Bank for Reconstruction and Development / The World Bank 2010)

DEFINITIONS OF 9 PHILIPPINES PPP TYPOLOGIES

i. **Build-and-transfer (BT)** - A contractual arrangement whereby the Project Proponent undertakes the financing and Construction of a given infrastructure or development facility and after its completion turns it over to the Agency or LGU concerned, which shall pay the Project Proponent on an agreed schedule its total investment expended on the project, plus a Reasonable Rate of Return thereon.

ii. **Build-lease-and-transfer (BLT)** - A contractual arrangement whereby a Project Proponent is authorized to finance and construct an infrastructure or development facility and upon its completion turns it over to the Agency/Local Government Units (LGU) concerned on a lease arrangement for a fixed period, after which ownership of the facility is automatically transferred to the Agency/LGU concerned.

iii. **Build-operate-and-transfer (BOT)** - A contractual arrangement whereby the Project Proponent undertakes the Construction, including financing, of a given infrastructure facility, and the operation and maintenance thereof. The Project Proponent operates the facility over a fixed term during which it is allowed to charge facility users appropriate tolls, fees, rentals, and charges not exceeding those proposed in its bid or as negotiated and incorporated in the contract to enable the Project Proponent to recover its investment, and operating and maintenance expenses in the project. The Project Proponent transfers the facility to the Agency/LGU concerned at the end of the fixed term that shall not exceed fifty (50) years.

iv. **Build-own-and-operate (BOO)** - A contractual arrangement whereby a Project Proponent I authorized to finance, construct, own, operate and maintain an infrastructure or development facility from which the Project Proponent is allowed to recover its total investment, operating and maintenance costs plus a reasonable return thereon by collecting tolls, fees, rentals or other charges from facility users; provided, That all such projects upon recommendation of the Investment Coordination Committee (ICC) of the National Economic and Development Authority (NEDA), shall be approved by the President of the Philippines. Under this project, the proponent who owns the assets of the facility may assign its operation and maintenance to a Facility operator.

v. **Build-transfer-and-operate (BTO)** - A contractual arrangement whereby the Agency/LGU contracts out the Construction of an infrastructure facility to a private entity such that the Contractor builds the facility on a turnkey basis, assuming cost overruns, delays, and specified performance risks. Once the facility is commissioned satisfactorily, title is transferred to the implementing Agency/LGU. The private entity however operates the facility on behalf of the implementing Agency/LGU under an agreement.

vi. **Contract-add-and-operate (CAO)** - A contractual arrangement whereby the Project Proponent adds to an existing infrastructure facility which it is renting from the Government and operates the expanded project over an agreed Franchise period. There may or may not be a transfer arrangement with regard to the added facility provided by the Project Proponent.

vii. **Develop-operate-and-transfer (DOT)** - A contractual arrangement whereby favorable conditions external to a new infrastructure project which is to be built by a Project Proponent are integrated into the arrangement by giving that entity the right to develop adjoining property, and thus, enjoy some of the benefits the investment creates such as higher property or rent values.

viii. **Rehabilitate-operate-and-transfer (ROT)** - A contractual arrangement whereby an existing facility is turned over to the Project Proponent to refurbish, operate and maintain for a Franchise period, at the expiry of which the legal title to the facility is turned over to the Government. The term is also used to describe the purchase of an existing facility from abroad, importing, refurbishing, erecting and consuming it within the host country.

ix. **Rehabilitate-own-and-operate (ROO)** - A contractual arrangement whereby an existing facility is turned over to the Project Proponent to refurbish and operate with no time limitation imposed on ownership. As long as the operator is not in violation of its Franchise, it can continue to operate the facility in perpetuity. (Revised Implementing Rules and Regulations of R.A. No. 6957, "An Act Authorizing the Financing, Construction, Operation and Maintenance of Infrastructure Projects by the Private Sector and for Other Purposes", as Amended by R.A. No. 7718 2006)

APPENDICES 4 :

Research Questionnaires

QUESTIONNAIRE On Public-Private Partnerships in the Health Sector

The United Nations Economic Commission for Europe (UNECE) in collaboration with a group of graduate students from the Paris Institute of Political Sciences (Sciences Po Paris) is carrying out a research project on Public-Private Partnerships (PPPs) in the Health sector with a focus on health facilities. This research will look into the best practices in Turkey and the Philippines and will derive success factors learnt from international PPP experiences.

Main Objectives:

1. Identify specific models that have been successful and which could be replicated elsewhere adapting to countries' specificities
2. Show the differences between low income countries and wealthier countries as it concerns the feasibility of doing PPPs in the health sector
3. Highlight the advantages and disadvantages of PPPs applied to the development of health facilities in Developing Countries for the purpose of improving trade in services

Structure of the questionnaire:

To reflect various views of different stakeholders such as the private sector, public sector, and the third sector, three different questionnaires, which include key successful factors drawn from guidelines, principles and lessons from the UN, World Bank, WHO, OECD, Asian Development Bank and European Commission, independent scholars, are designed and tailor-made to address the health-related PPPs in different countries.

The questionnaire is divided into main thematic parts*:*

- For all sectors, the common parts: *Main Features of PPPs, Regulatory & Institutional Framework, Trade & Development in Turkey and the Philippines*
- For the public and private sector, sector-specific part: *Risk Transfer & Assessment, Main Constraints*
- For the 3rd sector, sector-specific part: *Involvement of Civil Society Organizations (CSOs)*

Results:

All data gathered will be aggregated and analyzed through statistical software and be used only for research purpose. Upon request, your information remains strictly confidential and anonymous.

We greatly appreciate the fact that you will be dedicating part of your busy schedule to filling in the questionnaire, and wish to thank you in advance for doing so. Following our receipt of the questionnaire, we would appreciate if we could also be able to contact you, should there be a need for any additional clarifications

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QUESTIONNAIRE (Public Sector Module)

On Public-Private Partnerships in the Health Sector

Name of Respondent			
Organisation Name			
Country		City	
Category (please tick box ✔)	☐ Department of Health ☐ Other ministries ( ) ☐ Provincial government ☐ Municipal government ☐ A national agency ☐ Other ( )		
Position (Title)			
Health PPP Involvement	☐ Yes ☐ No		
Your main duties	*Please write briefly what he or she is in charge of*		
Date	*DD / MM / YY*		
Code Number	**PB XXX** *(ex: PB001) used only for statistical coding*		

Part I: Main Features of PPPs

1. If the government is interested in venturing into a health PPP, what are the motivations in the country? (Please tick box □)

☐ To better manage resources through better efficiency from the private sector
☐ To achieve better quality of service compared to traditional procurement forms
☐ To leverage private sector financing and investment due to financial shortages
☐ To innovate through access to improved technology and management expertise
☐ To provide a sector reform agenda and accelerate socio-economic development
☐ Other (if possible, specify one:_____)

1-1. Are the Health PPP projects considered a national PRIORITY in comparison with traditional procurement?

☐ YES ☐ NO

2. Have PPPs ever been an EFFECTIVE way to meet public health demand?

☐ YES ☐ NO

2-1. If YES, how beneficial have PPPs been to the public interest? Please select based on a scale of 1-5 (1 being the most beneficial, 5 being the least beneficial)

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

PART II: Regulatory & Institutional Framework

3. Is there a designated body or unit in your government that coordinates and manages PPP projects?

☐ YES ☐ NO

If YES, please name the body and specify its functions, where is it located?

3-1. Is the PPP unit charged BOTH with coordinating and promoting PPPs in terms of identifying projects and courting investors, and scrutinizing them?

☐ YES ☐ NO

3-2. If NO, how are the responsibilities divided? Which institution performs what?

4. How does the government see its main role after a PPP is established?
(Please tick box □)

☐ To offer more incentives to the private sector
☐ To provide financial support and project revenue streams
☐ To strengthen regulatory and institutional capacities with checks and balances
☐ To play a consultative role by setting up a PPP unit and publishing guidance
☐ Other (if possible, specify one:_____)

5. How does the government address specific institutional issues on PPP project coordination?
(Please tick box □)

☐ By allocating more resources to counter the risk of an internal brain drain
☐ By training public sector staff
☐ By recruiting an experienced project manager from the private sector
☐ By consulting skilled external advisors
☐ Other (if possible, specify one:_____)

6. Are there HEALTH-specific polices or legal frameworks in relation with PPP?

☐ YES ☐ NO

6-1. If YES, could you please enlist all of them?

6-2. Are SAFEGUARD measures in favor of the socially and economically disadvantaged put in place to make accessible essential services to the poor?

☐ YES ☐ NO

PART III: Risk Transfer & Assessment

7. How are risks allocated in your signed PPP contracts? (Please tick ONE box □)

- ☐ Nothing done
- ☐ By compensating profit potential in return for greater risk exposure
- ☐ By sharing the risks borne by those that manage them best
- ☐ Other (if possible, specify one:_____)

8. What are the main policy instruments in place against potential risks?
(Please tick box □)

- ☐ Defining output-based specifications
- ☐ Performance measurement and incentives
- ☐ Encouraging competition in and for the market
- ☐ Introducing private sector management expertise into the public sector
- ☐ Assessing quantitative (ex: Public Sector Comparator) and qualitative evaluation (ex: Value-for-Money)
- ☐ Focusing more on monitoring and enforcement to prevent ex-post risks
- ☐ Other (if possible, specify one :_____)

9. How do you manage risk transfer in terms of PPP on hospital and clinic facilities?

10. How does the government strike a balance between budget baseline and profitability of private partners?

PART IV: Main Constraints

11. In pursuing existing Health PPPs, could you rank the main binding constraints in your country? (Please rank them in order of importance: 1 HIGH ~ 7 LOW)

___ Lack of political will and commitment
___ Lack of human capital and expertise (public servants and skilled experts)
___ Non-coordination and conflict of interest between the public and private sector
___ Frequent political shifts from administration to administration
___ Lack of long-term vision of PPPs
___ Migration of professionals such as doctor and nurse to foreign countries
___ Other (if possible, specify one:_____)

12. When reforming a regulatory framework to introduce PPP, there can be a number of difficulties.

In your view, what are the main obstacles to overcome?
(Please rank them in order of importance: 1 HIGH ~ 5 LOW)

___ Lack of awareness and consensus within the country (public acceptance)
___ Falsely preconceived notions about the benefits and risks of PPP
___ Political ideological conflicts
___ Resistance from workers in the public sector for fear of losing their jobs
___ Other (if possible, specify one:_____)

PART V: Trade & Development

13. In the health sector GATS regarding commercial presence, "foreigners may establish private hospitals with the permission of the Ministry of Health". What are the key factors in opening foreign hospitals? How do foreign hospitals work in the country's public health system? Substitute or supplement?

14. Some PPP projects are intended to attract foreign patients. What is the government view on this? Making more profit out of health service or brain drainage in public hospitals?

You are welcome to share any other information on your country's experiences with Public-Private Partnerships in the Health sector:

Thank You!

QUESTIONNAIRE (Private Sector Module)

On Public-Private Partnerships in the Health Sector

Name of Respondent			
Organisation Name			
Country		City	
Category (please tick ✔)	☐ a national corporation ☐ an international corporation ☐ a joint venture ☐ a corporate philanthropic foundations ☐ an Official Development Aid agency ☐ a financial institution ☐ other ( )		
Position (Title)			
Health PPP involvement	☐ Yes ☐ No		
Your main duties	*Please write briefly what he or she is in charge of*		
Date	*DD / MM / YY*		
Code Number	**PR XXX** *(ex: PR001) used only for statistical coding*		

Part I: Main Features of PPPs

1. What are the main motivations of joining a PPP project? (Please tick box □)

- ☐ Being as part of Corporate Social Responsibility (CSR)
- ☐ Networking opportunities
- ☐ Market entry advantage and access to new markets
- ☐ Exposure to knowledge and best practices
- ☐ Return on investment and profit-oriented
- ☐ Financial benefits such as tax breaks
- ☐ Increasing corporate influence in policy-making at the national level
- ☐ Other (if possible, specify one:_____)

2. What are the preparations the private sector does before getting involved in a PPP? (Please tick one box □)

- ☐ Start networking and dialogue with the public sector
- ☐ Identifying risks in the project
- ☐ Assessing costs & benefits analysis and project feasibility
- ☐ Enhancing Negotiation skills
- ☐ Clarifying the objectives and expectations of the public sector
- ☐ Enhancing capacities and expertise
- ☐ Other (if possible, specify one:_____)

Part II: Regulatory & Institutional Framework

3. How is the process of a PPP project procurement throughout the bidding process? Please select based on a scale of 1-5 (1 being the most open and transparent, 5 being the least open and transparent)

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

4. What factors are most influential in your decision-making of PPPs?
(Please tick box □)

- ☐ Ensuring flexibility into the process and procedures
- ☐ Providing government guarantees such as committed financial support & subsidy, etc.
- ☐ Project feasibility and financial viability over the long term
- ☐ A solid legal framework that provides judicial enforcement of contractual rights
- ☐ Other (if possible, specify one:_____)

5. Do you think the government provides a favorable environment in which the private sector can contribute to health service delivery?

☐ YES ☐ NO

5-1. If YES, what is the government doing to support a better performance of health PPPs for the private sector?

5-2. If NO, what hinders most the delivery of PPPs? (Please tick box □)

- ☐ Bad governance (corruption, no respect for the rule of law, etc.)
- ☐ Red tape and bureaucratic process
- ☐ No policy consistency and public discretionary actions
- ☐ Multiple layers of regulations either one or different levels of government (central/federal, sub-national/state and local)
- ☐ Unforeseen risks such as sudden changes in circumstances
- ☐ Other (if possible, specify one:_____)

6. Can you have easy access to information and decision-making process concerning PPP projects?

☐ YES ☐ NO

Part III: Risk Transfer & Assessment

7. Are you satisfied with the degree of risk transfer in your signed PPP contracts?
Please select based on a scale of 1-5 (1 being the most satisfactory, 5 being the least satisfactory)

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

8. Do you think political risks such as power shift (presidential election, etc.) hinder your business

and financial viability? If yes, to what extent? Please select based on a scale of 1-5 (1 being the most disturbing, 5 being the least disturbing)

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

8-1. if you answered "1" and "2", what were the responses from the government and how did you mitigate this risk?

9. Is the private sector ready to bear the risks involved in a PPP project? How does transfer of risk work?

Part IV: Main Constraints

10. In pursuing existing Health PPPs, could you rank the main binding constraints in your country? (Please rank them in order of importance: 1 HIGH ~ 7 LOW)

___ Low market demand and low profitability
___ Lack of human capital and expertise
___ Non-coordination and conflict of interest between the public and private sector
___ Instability due to frequent political shifts from administration to administration
___ Lack of an enabling regulatory and institutional framework
___ Other (if possible, specify one:_____)

11. BEFORE embarking on health PPPs, what are the main binding bottlenecks? (Please rank them in order of importance: 1 HIGH ~ 8 LOW)

___ High transaction costs such as lengthy negotiations and long bid times
___ Complexity of legal procedures and processes
___ Lack of flexibility in terms of legal and institutional frameworks
___ Unpredictable rules and instability
___ Focusing on more formality than informality such as forums and dialogues
___ Lack of public sector expertise
___ Non-coordination and non-cooperation between government entities
___ Other (if possible, specify one:_____)

PART V: Trade & Development

12. Do you face foreign investors' competition in PPP projects bidding? If yes, what are the local company's advantages and disadvantages?

13. . Do you find difficulties in hiring local health professional staffs? Does your company affected by brain drainage in health sector?

You are welcome to share any other information on your country's experiences with Public-Private Partnerships in the Health sector:

Thank You!

QUESTIONNAIRE (Third Sector Module)

On Public-Private Partnerships in the Health Sector

Name of Respondent			
Organisation Name			
Country		City	
Category (please tick ✔)	☐ an academic institution including research center ☐ a private consulting firm ☐ a hospital & clinic ☐ a community association ☐ a professional association (labour trade union, etc.) ☐ an international organisation ☐ a national NGO ☐ an international NGO ☐ a religious organization ☐ other ( )		
Position (Title)			
Health PPP Involvement	☐ Yes ☐ No		
Your main duties	*Please write briefly what he or she is in charge of*		
Date	*DD / MM / YY*		
Code Number	**TR XXX** *(ex: TR001) used only for statistical coding*		

Part I: Main Features of PPPs

1. Are you satisfied with the health service quality of PPP hospitals and clinics?
Please select based on a scale of 1-5 (1 being the most satisfactory, 5 being the least satisfactory)

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

2. Do PPP hospitals and clinics generate better societal benefits for the pro-poor, compared to the traditional hospitals?

☐ YES ☐ NO

2-1. If YES, what are the main benefits of health PPPs? (Please tick box ☐)

- ☐ New hospital facilities are well-located and convenient
- ☐ New hospital facilities are in better quality
- ☐ New health care services are less expensive

☐ New health care services are in better quality
☐ None of them

3. Infrastructure provision such as hospitals was within the domain of the public sector. Are you satisfied with PPP hospitals and clinics provided by FOREIGN investors? Please select based on a scale of 1-5 (1 being the most satisfactory, 5 being the least satisfactory)

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Part II: Regulatory & Institutional Framework

4. Can you have easy access to information and decision-making process concerning PPP projects?

☐ YES ☐ NO

5. Are you involved in monitoring health PPP projects to evaluate service quality?

☐ YES ☐ NO

6. Do PPP projects monitored and evaluated by *the government* ensure better accountability and credibility of health services?

☐ YES ☐ NO

7. Do PPP projects monitored and evaluated by *an independent third party* ensure better accountability and credibility of health services?

☐ YES ☐ NO

8. Are there are gaps between the formal legal arrangements and practices in terms of health PPPs?

☐ YES ☐ NO

If YES, provide details?

9. Are government supports in favor of the socially and economically disadvantaged put in place to make accessible essential services to the poor?

☐ YES ☐ NO

If YES, provide details?

Part III: Involvement of CSOs

10. Is the public informed about the PPP project throughout the project life-cycle?

☐ YES ☐ NO

11. Are your social and public needs concerning on-going PPP projects reflected well during or after the consultation process?

☐ YES ☐ NO

12. When designing PPP policies or rules, have you (your institution) been consulted by the government?

☐ YES ☐ NO

13. Through health PPPs, is the PUBLIC INTEREST well-safeguarded, rather than private interest? Please select based on a scale of 1-5 (1 being the most protected, 5 being the least protected)

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Part IV: Trade & Development

14. How does foreign health provider affect the health service provision to the public? What are their main roles in public health?

15. What is your view of PPP projects targeting at foreign patients? Should the government focus more on providing sufficient health service to the countries local citizens?

You are welcome to share any other information on your country's experiences with Public-Private Partnerships in the Health sector

Thank You!