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EUROPEAN CENTRE FOR HEALTH ASSETS AND ARCHITECTURE

How to, & who will, pay for new healthcare infrastructure?

(or PPP redux…)

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- ECHAA's aim is, by means of comprehensive & rigorous analysis, to:
  - support & promote evidence-based policy decisions on contribution of built environment to European health sector
  - focus on long-term issues of sustainability & appropriateness of estate
  - cover service planning, architecture/design, finance, construction & operation of hospitals & other healthcare facilities
- Founding Partners:
  - DuCHA: within TNO, state Netherlands Organisation for Applied Scientific Research, www.tno.nl/ducha
  - HaCIRIC: collaboration of British universities research centres – Imperial College, Loughborough, Reading & Salford (www.haciric.org)
  - [Karlsruhe University of Technology]

Scope of my presentation

- **What are PPPs, really? Some theory**
- The state of the UK health estate
- Alternative European PPP models
- And finance markets?

Purported rationales – what PPP is not

"Private sector is more efficient"	↔	**Often, but not always** (Megginson & Netter, 2001)
"Private finance is cheaper"	↔	**No**, because of risk premium (a government (almost) always borrows cheaper than a private firm in jurisdiction)
"Borrowing is off-balance sheet"	↔	**No**, illusory anyway, plus Eurostat rules now formally discourage this

PPP is best understood through the lens of economic contract theory

Features that distinguish a PPP from pure public or private provision:

- **Bundling** especially of project phases (including notably the "**O**" in DBFO)
- **Pay for performance** via an output (not input) specification
- **Long-term** contracts (25-50 years)
- **Private finance** ("skin in the game…")

Done well, these bring about the 3 real objectives of choosing a PPP route: **management of risk,** & **incentivisation of long-term quality**, subject to **minimisation of transaction cost**

Risk transfer in PPPs (not just health)

- Risk transfer in PPPs is principally either:
  - **Demand or volume risk** - for 'economic' infrastructure delivering market or pseudo-market services i.e. priced, where user fees or shadow fees (such as shadow tolls in a road) can apply, or
  - **Performance & Availability risk** – for most 'social' infrastructure & services, where demand is a function of government decision & not reasonably transferable to a private sector partner
- These two have very different risk profiles, for all parties (public sector, firms, finance markets)

Health is normally in the second type, but note capitation fits the category of a "user fee" (see later)

How to transfer risk?

"Risk transfer" is better thought of as "risk management", of two kinds:

- Minimisation of risk premium – risks must be passed to the party with the least risk-aversity
- Management of performance – risks must be passed to the party which can best manage it

(These may not be the same thing, thus there could be a trade-off here)

"Bundling" of FM with construction is key to increasing the incentive power of risk transfer, & makes concrete issue of specifying *output* rather than *input*. Use the same principle beyond building services?

Quality & cost

- Once the contract is under way, the private sector has an incentive to control **costs** – the benefit is captured & flows immediately through to the bottom line:
  - Most of this is conventional & unarguable – quality of construction minimises long-term maintenance cost (again, the phenomenon of *bundling*) - but it can be pernicious & damage quality
- The public sector wants to maximise long-term primary service delivery **quality**:
  - Often the key quality concept is not an amorphous concept of "quality" but rather **through-life flexibility** of the capital asset
  - There is usually no incentive on the SPV to provide it since it is often non-contractible (because there is "incompleteness of contract")
  - Real ownership (=power) of the asset rests with the party committing most capital – the private sector

Therefore, the contract needs as far as possible to specify & control the quality/cost trade-off, to align incentives on the parties

Transaction costs

Transaction costs are the friction – deadweight losses – between parties to an activity:

- Setting the project envelope wider internalises & thus reduces transaction costs (only in those circumstances where whole-life costing is valuable or there are externalities across different functions) - but at the cost of concentrating control inside the project entity
- Conflict resolution procedures (e.g. specifying detailed contingencies in the contract) in the contract have an impact on the magnitude of transaction costs

Again, trade-offs - in this case extending the project scope to reduce transaction costs can lessen public control, & increasing the completeness of contract specifications can raise transaction costs

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UK Investment in healthcare

The **target** was 100 new hospitals, 500 new "one-stop" primary care centres, 3000 GP premises modernised & 200 new scanners

Delivery:	Public	PFI	TOTAL
Operational	29	87	116
Under construction	5	14	19
In procurement	-	1	1
TOTAL	34	102	136

Plus 47 LIFTCOs, 1 eLIFT (based on framework procurement) & >250 buildings – for a total investment of £2bn

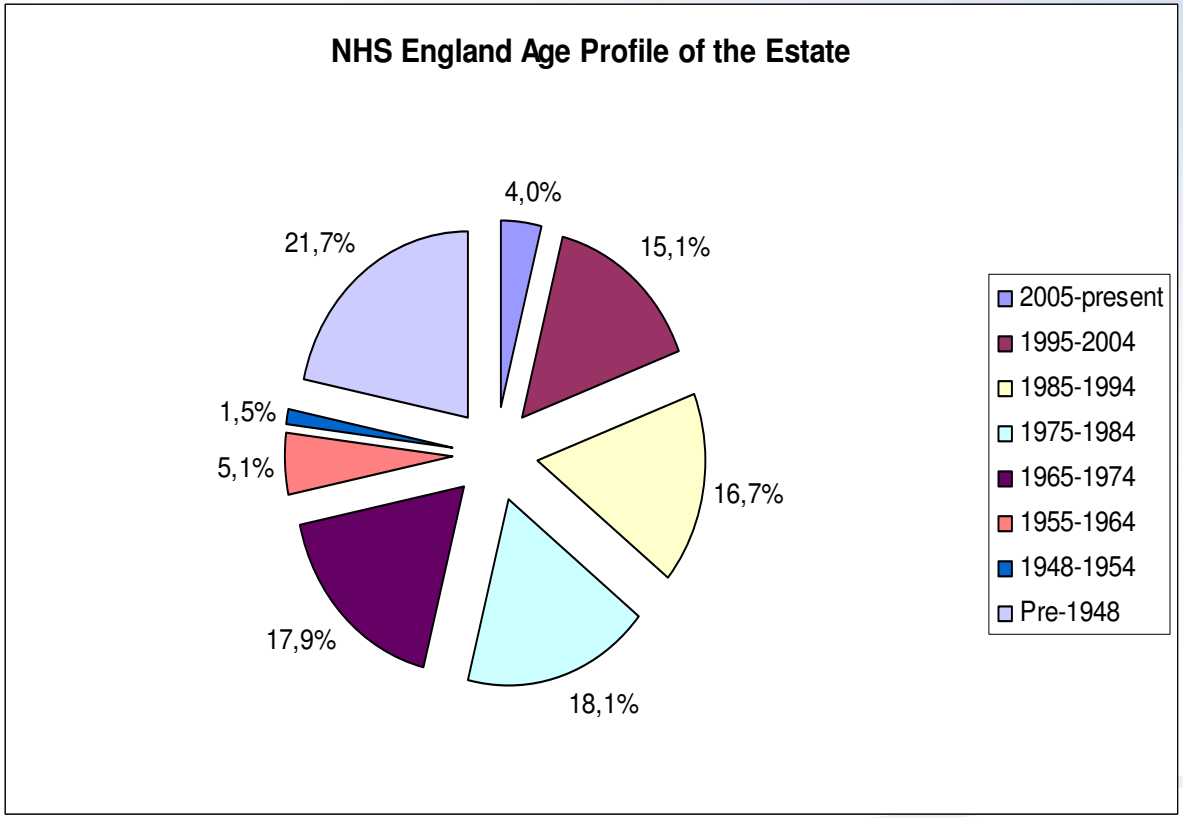
In the original terms set out, the PFI & PPP programmes fully delivered (including improvement of quality of the healthcare environment & reduction of backlog maintenance)

What next in England?

- DH is projecting only 7-8 new PFIs now
  - Balance sheet issue
  - Compatibility with Foundation Trust rules not sure
  - There are thought to be few neglected areas left – except, say, mental health & some regional spots
- ISTC – no new (existing ones being bought out)
  - The waiting list problem has diminished
  - Perceived unfair competition because of the take-or-pay contracts
  - Quality of service?
- More eLIFT

But judged by conventional standards, the estate is still very old

- Over a fifth of English NHS estate is >60 years old – but still somehow used
- The capital stock concerned must be fully depreciated
- Few other industries have (or want) capital stock this old



Source: DH, Statistics & Analysis, NHS England 1999-00 to 2005-06, August 2007

Assuming UK's fiscal issues don't prevent doing anything at all about the estate, & bearing in mind the theoretical arguments, would PFI be right choice to pursue modernisation?

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Alternative PPP models

1. Public-Public Partnership
2. Accommodation PPP (i.e. PFI)
3. Hospital infrastructure-clinical joint ventures
4. Licensed hospital privatisation
5. Population full-service PPP

I have arranged this list in ascending order of “private-sector” involvement; in other words, the envelope around the private sector project partner becomes wider (i.e. not just construction-FM bundling)

These are not theoretical examples - they exist in the wild, & arguably work well in their contexts

1.Public-Public Partnership (e.g. *Hospital Universitario Central de Asturias, Spain*)

- In many respects, it's like an accommodation-only PPP
- *Principado de Asturias* (one of 17 regional governments) controls the health services
- Non-profit SPV called Gestion de Infraestructuras del PdA SA (100% owned by PdA) is contracted to deliver a new 1000-bed hospital
- GISPASA financed mostly by debt
- 30 year building operating lease, subcontracted rolling 6 year FM contracts with market-testing
- Annual fee PdA to GISPASA has a fixed (invariant) component to cover debt service, & variable one to cover other costs subject to performance penalties
- Construction contract is separate from hard FM
- Contract specifies periodic renegotiation between HUCA and GISPASA to achieve through-life asset flexibility
- Major productivity changes being achieved compared to existing buildings

2.Accommodation PPP (*PFI; France, Spain, Portugal Wave 2, Australia…)*

- Always construction bundled with hard FM; soft FM & medical equipment optional
- 20-35 year duration
- Nowadays, EU procurement procedures ‘competitive dialogue’
- Monthly Unitary Charge composed of Performance & Availability fees offset by deductions for failure
- No demand risk (apart from incidentals like car park etc.)
- …

The simple option that everyone looks at first

3.Hospital infrastructure-clinical JV (*Portugal 1st Wave, Australia*)

- Within an NHS system, an InfraCo (~PFI) with 30-year contract coupled with a ClinCo with rolling 10-year
- InfraCo covers construction & hard FM, has unitary charge based on performance/availability
- ClinCo covers clinical services, soft FM & medical equipment procurement & operation. It has demand-linked payments (episode*price) except for A&E (availability), subject to caps
- Variable-geometry shareholdings between the two companies, to align incentives through life
- A failure of ClinCo does not pull down InfraCo
- 2 hospitals under construction, 2 being negotiated
- "Value for Money" gain of 8-33% versus Public Sector Comparator (almost all in medical services rather than building costs)

Being treated as **pilots**; 2nd Wave are conventional PFIs

4. Privatised hospital concession (*Germany – Rhön, Helios…; Finland - Coxa*)

- For-profits are a recognised – & fast growing - part of hospital provision in what is the classic Social Health Insurance (Bismarckian!) system
- *Duales System* – capex nominally from the state, recurrent costs from the social insurers
- Significant system excess capacity (30-40%?), many municipal/state hospitals stressed
- Private companies buy municipal hospitals to get the license to operate (no cream-skimming); uninterested in the buildings
- State capex funds too limited for serious investments, & carry restrictions on operating flexibility
- State investment costs 50-100% above private, so private can raise own-funds for investment & still be profitable
- Alignment of clinical & business models
- Some attempts to operate polyclinics on secondary hospital sites

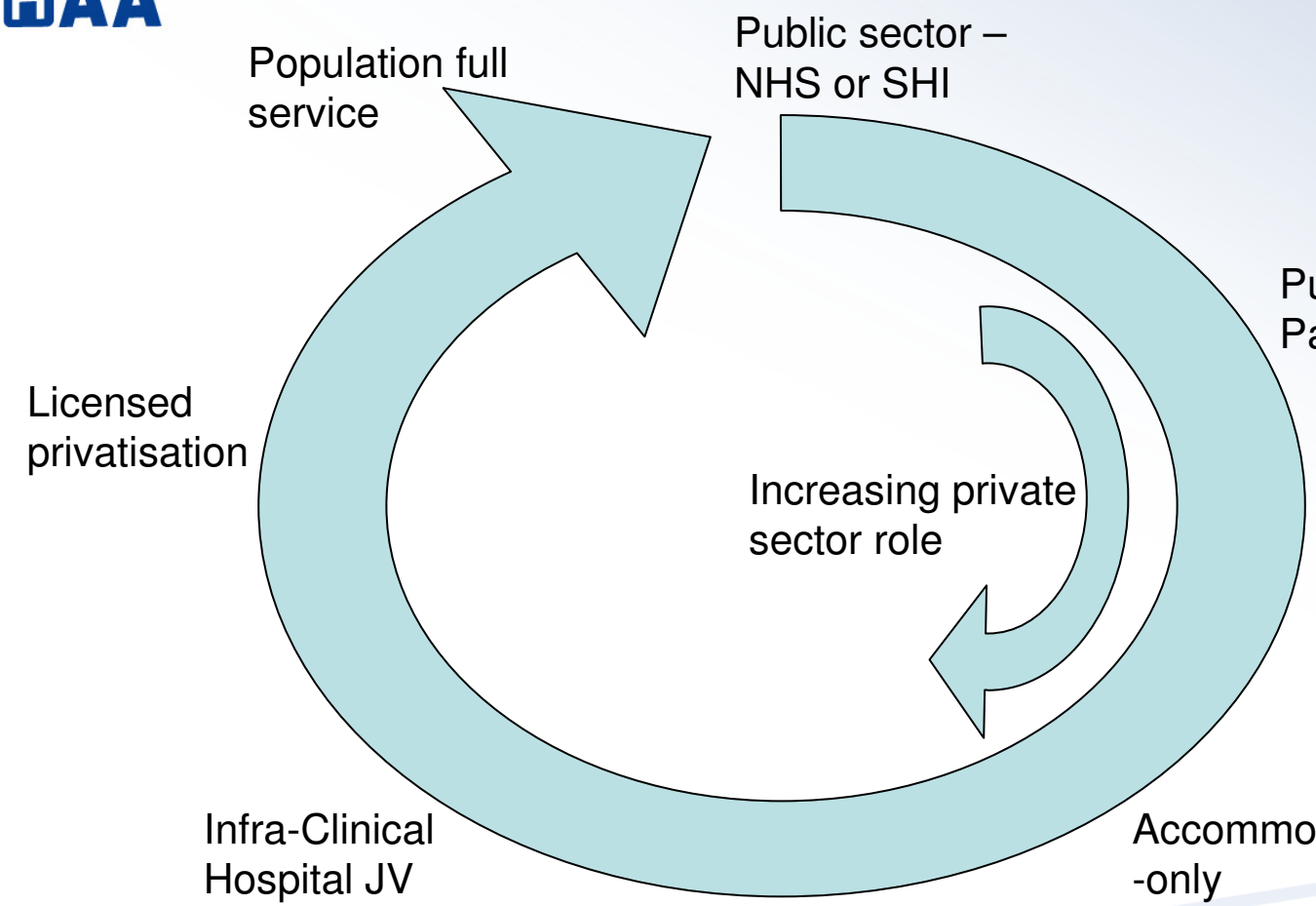
This is **effectively** a PPP because of the license/concession

5. Population full-service PPP (*Spain – Hospital de la Ribera, Valencia*)

- Alzira Model I (Hospital Care): 1999/2003
  - Concession for 10-15 years for management of secondary medical care of a Health Area
  - Building of a new district general hospital: Hospital de la Ribera (capex €61M)
  - Capitation fee: €204 per head of regional population, inflated by CPI (1999)
  - Financial issues caused reconsideration in 2002
- Alzira Model II (Integrated Care): 2003/2018
  - Concession for 15 years, extendable to 20, for the **management of both secondary care & primary care** in the Health Area
  - Investment: €78M mostly in community facilities in the Health Area during the 15 year period
  - Capitation fee: €379 + % yearly increase in the region's health budget
  - "Money follows the patient" - company pays 100% of cost of a patient who travels to another area, only receives 80% reimbursement for one who comes in

The (integrated primary/secondary + capitation) model is now also being used in 4 other Spanish Health Areas

Back to the future…



You should judge how this stacks up against my assertion that the **real** reasons for doing PPP should be **risk management**, **long-term quality/flexibility** & **transaction cost minimisation**

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Today - finance markets & the recession

- Banks are charging a higher rate of interest than in the fevered days of 2007-8; equity bridge loans more difficult to obtain
- Wrapped bond market is comatose
- Governments advance finance for projects – TIFU etc (paradoxical?)
- Banking industry temporary responses:
  - "Club & hold" - syndication in advance; but further reduces competitiveness of financing markets
  - "Mini-perms" (refinancing)
    - Hard (basically, enforced default at about 7 years)
    - Soft (gradually increasing incentives for refinancing)
      - Cash sweeps (but problematic for the equity and sub-debt)
      - Margin ratchets (but affordability for public sector?)
- **Liquidity** is the problem today, not the fundamental credit-worthiness of current PPPs for economic or social infrastructure

We've learnt that banks are **not** the right vehicle for most long-term lending – inherently unstable because of liquidity mismatch

Longer term issues: the evolution of PPPs

Currently, it is a seller's market for money, but:

- Infrastructure is a huge market demanding capital expenditure, both economic (e.g, transport) & social (e.g. health & education), & offering **stable returns**
- Many institutions need to invest in assets that will generate long-term income to **match their liabilities** (insurance companies, but above all pension funds)
- PPP is a way of bringing these together
  - Clean, dedicated debt structures (helps governments under budgetary restraint, even if the reality is just substituting one sort of debt commitment for another)
  - Efficient procurement tool

The financial crisis as a catalyst

- Everything depends on when Western economies exit reliably from the crisis
- What will be the impact of governments as major shareholders in banks?
- What role should rating agencies have?
- Will new monolines enter the market?
- Should there be an expanded role for centralised government PPP agencies (PUK+)?
- & one or several government debt-financed central funding agencies?
- Multilaterals (EIB, KfW…) will need to take a more central position
- Equity proportions of project financing will have to rise
- Still, different mezzanine instruments can be carved out for those institutions with an appetite for slightly greater levels of risk (given that economic/social infrastructure starts as plain-vanilla anyway)

The finance industry believes there is a strong future for PPP

Conclusions

- **PPPs** are best regarded as a **contract** mechanism for which the real criteria of success are:
  - Appropriate management of risk
  - Long-term quality & flexibility of the estate
    - Subject to minimised transaction costs
- Recent PFI & other **investment** in UK health estate:
  - Has delivered a very big fleet of large acute hospitals, & some primary
  - Not many more large projects planned
  - But it's still a relatively old estate so shouldn't more be done
- There are many **alternative** PPP models:
  - Covering some combination of infrastructure, hard FM, soft FM, equipment, medical services, primary care
  - To some extent, culturally-bound
- In the background radiation of the **economic crisis**:
  - Some band-aids being used to keep PPP lending going
  - PPP has a long-term future, but not with banks as the major investors

Thank you!

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