

## Public Hospitals

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### Options for Reform through Public-Private Partnerships

**As governments struggle with rising health care costs, public-private partnerships in constructing and managing public hospitals can provide innovative ways to control costs and improve service. Experience shows that such partnerships offer significant benefits as long as policymakers structure the transactions carefully and create sound regulatory arrangements to ensure universal access, quality care, and improvements in efficiency.**

Globally, health expenditures rose from an average of 3 percent of GDP in 1950 to 8 percent (US\$3 trillion) in 1999 (WHO 2000). The increase in spending has been driven by rising income, changing demographic and epidemiological trends, and costly new pharmaceuticals and technology. Although technology is allowing a shift to outpatient care, hospitals still account for 30–50 percent of health expenditures.

Public funding has not kept pace with the growth in spending. Much of the increase has been financed from private sources (out-of-pocket payments and private insurance), while the share funded publicly (by tax revenue and national insurance) declined by 6 percent between 1977 and 1997. Constraints on public funding, combined with rising costs, have forced public hospitals to cut costs wherever possible while still endeavoring to guarantee universal (and often free) access to public patients.<sup>1</sup>

Governments have used different strategies to address these problems, such as shifting financ-

ing from general tax revenue to payroll-financed national health insurance, narrowing the basic package of services available to all citizens, linking hospital funding to outputs and efficiency, amalgamating hospitals into networks, increasing autonomy and incentives for management, and reducing the number of hospital beds. Some governments have also turned to public-private partnerships to bring private sector efficiency into public hospitals.

#### Partnering with the private sector

In Australia federal and state governments have introduced private participation in more than 50 public hospitals through several different mechanisms. They have completed 15 BOO transactions (in which a private firm builds, owns, and operates a public hospital), 4 conversions (in which a hospital is sold to a private operator as a going concern), 4 transactions involving private management of a public hospital that the government continues to own, 3



build-own-leaseback arrangements (in which a private firm constructs a new public hospital, then leases it back to the government), and 30 colocations (in which a private wing is located within or beside a public hospital). These initiatives were driven by a need for new capital, a perceived need to transfer operational risk, and a desire to increase efficiency.

One example from Australia is the Mildura hospital contract, awarded in 1999. The government selected a private operator to design, build, own, and operate a new, 153-bed hospital under a 15-year contract. The existing public hospital was closed, and its employees transferred to the new hospital. The operator must provide appropriate clinical services to all patients who come to the hospital without charging them. The provider receives from the government annual payments based on the forecast mix of clinical patients (with funding capped at a specified number of patients) plus a small block grant to cover such costs as teaching. For quality control purposes, the provider is required to maintain the hospital's accreditation (by an independent agency), provide monthly reports on clinical indicators, and have high-volume treatments reviewed by external peers. The contract includes penalties for non-compliance (including the ultimate sanction, "step-in rights" for the government). And it requires the operator to provide a performance bond of about 5 percent of its annual revenues.

Mildura's results have been impressive. Capital costs for the new hospital came in 20 percent below those for public sector comparators, and the hospital provides clinical services at lower cost than government-operated hospitals. Moreover, all performance targets have been met, patient volumes increased by 30 percent in the first year, and the operator made a profit.

In northeast Brazil the Bahia state government entered into contracts with private firms for the management of 12 new public hospitals, constructed and financed by the government. The government's aim is to increase efficiency, improve quality, and transfer operational risk. The private operators recruit the staff and manage the facilities (including all medical services) under annual funding contracts that can be extended for five years. The operators must treat

all public patients who come to the hospitals. The government pays for the medical services based on a target volume of patients. The operators must achieve 80 percent of the target to receive payment but are not reimbursed for volumes above the target. Nevertheless, they have routinely exceeded the target by 30 percent.

In Sweden the municipality of Stockholm leased a 240-bed public hospital, St. Goran's, to a private provider in 1999 following a series of reforms aimed at introducing competition, improving quality, and lowering costs. The municipality transferred cost risk to the private provider through funding contracts specifying the prices and volumes of services. And it looked to the privatized hospital for performance benchmarks to exert competitive pressure on other public hospitals. Since the reforms were launched in 1994, St. Goran's has cut unit costs by 30 percent and is now able to treat 100,000 more patients annually with the same resources (Hjertqvist 2000).

The U.K. government has used public-private partnerships in financing, construction, and facility management for many public hospitals over the past decade. Under its program a regional health district tenders for a private firm to finance and construct a new hospital, maintain the facility, and provide nonclinical services such as laundry, security, parking, and catering. The operator receives annual payments for 15–25 years as reimbursement for its capital costs and its recurrent costs for maintenance and services. In this model of public-private partnership, unlike those adopted in Australia, Brazil, and Sweden, the public sector remains responsible for all medical services.

### **Which option to choose?**

Public-private partnerships can take many forms, each with a different degree of private sector responsibility and risk (table 1). These are differentiated most critically by whether the private firm manages medical services, owns or leases the facility, employs the staff, and finances and manages capital investments. A government's decision on the most appropriate option will depend on the hospital's needs and circumstances, the government's capacity to regulate and effectively control the quality of care, and the public consensus on the need for reform.

**Table Options for private participation in hospitals**

<b>Option</b>	<b>Private sector responsibility</b>	<b>Public sector responsibility</b>
Colocation of private wing within or beside public hospital	Operates private wing (for private patients). May provide only accommodation services or clinical services as well.	Manages public hospital for public patients and contracts with private wing for sharing joint costs, staff, and equipment.
Outsourcing nonclinical support services	Provides nonclinical services (cleaning, catering, laundry, security, building maintenance) and employs staff for these services.	Provides all clinical services (and staff) and hospital management.
Outsourcing clinical support services	Provides clinical support services such as radiology and laboratory services.	Manages hospital and provides clinical services.
Outsourcing specialized clinical services	Provides specialized clinical services (such as lithotripsy) or routine procedures (cataract removal).	Manages hospital and provides most clinical services.
Private management of public hospital	Manages public hospital under contract with government or public insurance fund and provides clinical and nonclinical services. May employ all staff. May also be responsible for new capital investment, depending on terms of contract.	Contracts with private firm for provision of public hospital services, pays private operator for services provided, and monitors and regulates services and contract compliance.
Private financing, construction, and leaseback of new public hospital	Finances, constructs, and owns new public hospital and leases it back to government.	Manages hospital and makes phased lease payments to private developer.
Private financing, construction, and operation of new public hospital	Finances, constructs, and operates new public hospital and provides nonclinical or clinical services, or both.	Reimburses operator annually for capital costs and recurrent costs for services provided.
Sale of public hospital as going concern	Purchases facility and continues to operate it as public hospital under contract.	Pays operator for clinical services and monitors and regulates services and contract compliance.
Sale of public hospital for alternative use	Purchases facility and converts it for alternative use, depending on sales agreement.	Monitors conversion to ensure adherence to contractual obligations.

While many of the options are well established in infrastructure, hospital services have unique characteristics that allow policymakers a broader menu of options for private participation:

- Governments can pilot private participation in a few small hospitals without having to tackle the entire network.
- Hospitals provide diverse clinical services that can be unbundled for private provision. Governments can outsource sophisticated (and expensive) clinical services while leaving hospital management and standard clinical services under the public sector.
- Hospitals can provide services to both public and private patients. This opens up new possibilities for private participation, such as colocation of a private wing within a public hospital under a contract that governs

how costs, staff, and equipment are shared. The contract can create an integrated public-private hospital that provides choice to patients and improved financial viability while also ensuring universal access and quality care for all patients, public or private.

- Hospital operators include for-profit and not-for-profit firms. Many not-for-profit operators were founded with a charitable mission but are run on commercial principles. Governments often opt to contract with not-for-profit operators because they are more acceptable to the local community.

**The critical policy issues**

While public-private partnerships can be a powerful tool for improving the quality of care and

controlling costs, governments must pay careful attention to key policy issues:

- *Universal access.* To ensure that all public patients, particularly the poor and uninsured, have access to adequate hospital care, most contracts for private management of public hospitals require the provider to continue service to all public patients. In some cases the provider is fully compensated by the government. In other cases the provider may not be, but accepts this financial risk on the assumption that it will be able to introduce cross-subsidies between patients and funding sources.
- *Funding.* Governments generally fund public hospitals through budgetary payments or public health insurance programs. In recent years governments have shifted the basis for payments from historical or input costs to the clinical mix of patients to be treated. With the transition to private management, greater attention must be paid to linking the public funding (whether from the budget or from public insurance) to performance while also rewarding quality care and patient satisfaction.
- *Consolidation.* Many countries, particularly in Eastern Europe, have too many public hospitals and will need to downsize, consolidate, and close some facilities. Public-private partnerships can spur consolidation of services. Governments can tender a group of facilities, allowing the private operator to consolidate them (including closing some) while still being obligated to provide a specified level of clinical services.
- *Competition.* Competition between hospitals stimulates improvements in the quality and efficiency of service. Governments should resist granting privately managed public hospitals exclusivity privileges or otherwise protecting them from market forces. At the same time, where a government continues to own other public hospitals and also purchases care, contracts should include nondiscrimination clauses to prevent the government from providing preferential funding or other unfair advantages to publicly managed hospitals.
- *Regulation.* In many countries the regulatory system for hospitals is limited to an accredi-

tation agency that reviews and certifies their clinical procedures. But public-private partnerships may impose additional public policy obligations that require monitoring, sanctions for noncompliance, and dispute resolution procedures. “Step-in rights” for the government will probably be necessary in the event of significant financial or quality failure. Governments will also need to address the extent to which they will rely on regulation, legislation, self-regulation, external certification, or contractual arrangements in their interaction with private providers. The experience with infrastructure privatization suggests that an independent regulator may be needed to monitor and enforce public-private partnership contracts for hospitals.

### Conclusion

Public hospitals worldwide are facing a financial crisis, squeezed by rising costs and public budget constraints. Public-private partnerships can be a powerful policy tool for improving the viability of public hospitals and the quality of their services. But they are often controversial, and getting them right requires careful attention to the critical policy issues.

### Note

1. Public hospitals, whether publicly or privately owned and managed, are those that provide access to all and are funded from public sources. Public patients are those whose care is publicly funded, from tax revenue or national insurance. Private hospitals include for-profit and not-for-profit entities.

### References

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## viewpoint

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