

Public-Private Partnership Options toward Achieving Universal Health Coverage in the Philippine Setting

EDUARDO P. BANZON, JOSEPHINE ANNE C. LUCERO,
BEVERLY LORRAINE C. HO, MARIA ELIZABETH D. PUYAT,
EMMAE JUNE A. QUIBOD, AND PATRICIA ANN A. FACTOR¹

ABSTRACT

The World Health Organization advocates universal health coverage so that all people can obtain the needed health services without suffering financial hardships. In the Philippines, the government has included public-private partnerships (PPPs) as among its strategies in pursuit of universal health coverage, as PPPs can help fund the immediate repair, rehabilitation, and construction of selected priority health facilities. It also encourages local government units to tap PPPs in improving their service delivery.

Given all these, it is important to define PPPs and distinguish them from all other forms of public-private interactions. Public-private investment partnerships (PPIPs) have been described as health-related PPPs that are potentially transformative for underperforming government-run health systems. These comprise of long-term, highly structured relationships between the public and private sectors designed to achieve significant and sustainable improvements to health-care systems at national or subnational levels. They expressly address public policy objective/s and usually following the Design-Build-Operate-Deliver model (or a minimal variation). In PPIPs' delivery of quality health service, government retains ownership of assets. There is government review and independent monitoring, and

¹ Consultants, Philippine Institute for Development Studies. Email for correspondence: epbanzon@gmail.com.

the investment is long term. There is risk transfer to the private sector and predictable government payments while ensuring cost neutrality to patients. Finally, PPIPs aim for equity of access for all and system-wide efficiency gains. They, therefore, address all components of a system, and not just its parts.

PPPs that do not meet most of the characteristics of PPIPs are construed to be public-private interactions (PPIs). These may be considered minor PPPs as they attend to singular portions of the health-care service delivery—infrastructure, service, management, or concession-type contracts, serving as stopgap measures instead of addressing the bigger problem.

Thirty-nine foreign health PPPs and 24 local health PPPs were reviewed. Most of the health PPPs were not determined to be PPIPs. Only six foreign and one local health PPPs qualified as PPIPs. Since PPIPs are the type of PPPs that appropriately support the pursuit of universal health coverage, it is important that the country prioritizes PPIPs and consider the three PPIP options—namely, health-care delivery in the settings of primary care; hospital care; and an integrated system—as it moves ahead with implementing health PPPs.

A decision algorithm is proposed to help decide on the PPIP option to be considered and developed. Proposed partnerships must be need based with accompanying evidence and statistics, and long term in nature with a goal of achieving universal health coverage by improving access to health care and reducing the financial burden of out-of-pocket expenses. Both the public and private sectors must share risks and benefits, and hold open dialogues on the design, scope, and details of the partnership.

Although both PPIPs and PPIs are intended to improve the country's health outcomes, the former must be prioritized as it can improve the overall efficiency of the system. Ultimately, PPIPs must be integrated within the health system to demonstrate the country's commitment to the pursuit of universal health coverage.

OVERVIEW

Public-private partnerships (PPPs) are increasingly being utilized to meet development goals of many countries. Inherent issues on the public sector's inability to meet social needs stem from the sector's lack of resources, administrative roadblocks, and management issues. Thus, arrangements such as PPPs bring in the efficiency and expertise of the private sector to facilitate the attainment of social needs (Nishtar 2004).

This paper aims to define what PPPs are and their application in the health sector. It presents representative case studies or models of PPP practices in health. Furthermore, it aims to provide decisionmakers and stakeholders a methodology in developing health PPPs.

Specifically, the study shall:

- discuss the rationale of health PPPs
- define PPPs in health
- differentiate PPPs from other public-private interactions
- provide representative case studies of PPP options in health
- propose mechanisms in approaching PPP development in health in various levels of care.

METHODOLOGY

A literature search was undertaken, focusing on PPPs rather than on private sector participation or privatization. The following search tools were used: academic databases (PubMed, Science Direct, and Google Scholar), search engines (Google and Yahoo), and sources of gray literature (government, educational and other institutional reports, research organization sites, conference papers, and other topic-specific databases). Global and local examples and experiences pertained to PPPs under the following categories: design and construction, nonclinical services, primary care, clinical support services, specialized clinical services, and hospitals/health facility management. The PPP contract types included, but were not limited to, the following: service contract, management contract, affermage/lease, build-operate-transfer (BOT) and its variations, concessions, joint ventures, and hybrid arrangements.

Although a thorough search was done, not all PPP examples were reviewed as the focus was on three scenarios: primary care, hospital setting, and an integrated health-care system. Selected case studies looked into these three scenarios' systems and locations of their health provision (Barr 2007). For the evaluation of these scenarios, proposed assessment criteria on eight aspects of the research protocol were used; namely, (1) the relationship between the public and private sectors; (2) the nature of the partnership; (3) the financial arrangements; (4) the structure, scope, and functions of the services; (5) the government policies that promote the partnership; (6) the proposed and actual measured outcomes of effectiveness; (7) the improvement of equity as a separate distinct outcome; and (8) the identification of potential weaknesses in analysis.

PUBLIC-PRIVATE PARTNERSHIPS

PPP is a broad term describing a range of relationships between the public

and the private sector. Other similar terms include private sector participation, privatization, and public-private interactions. There are also several basic PPP contract types such as service contracts, management contracts, lease contracts, concessions, and BOT (ADB 2008).

Under a *service contract*, the government hires a private company to carry out specific tasks or services for a period. Only a portion of the operation is contracted out to a private partner. In *management contracts*, services to be contracted out include the management and operation of the public service. In a *lease contract*, the entirety of a service, including obligations to quality and service, are contracted out. The operator provides the service at his expense and risk. Leases are longer in duration, typically 10 or more years. A *concession* gives the full delivery of services in a specified area to the private sector operator. This includes operation, maintenance, collection, management, construction, rehabilitation, and financing of the system, with no transfer of assets. The public sector's role is that of establishing performance standards and as a regulator of price and quality of service. Contracts are long term in order for the operator to have sufficient time to recover the capital invested and earn an appropriate return. In *BOT contracts*, the private partner provides the capital to build the facility and operate it for a sufficient time set by the contract so as to recover investment costs, with a temporary transfer of assets. The public sector may purchase a minimum level of output produced by the facility or may pay a capacity and consumption charge. At the end of the contract, the public sector assumes ownership but has several options for the transfer of responsibilities. BOT schemes generally involve large "greenfield" investments requiring substantial outside finance.

Aside from the definition and characteristics of PPPs, its motivations must also be understood. The main reason for pursuing PPPs is to improve service delivery through increased efficiency and lower cost, in comparison to traditional procurement methods. Even if the traditional public procurement is effective, there are instances when the process or the service delivered may be inefficient and costly. During these instances, government can consider partnering with the private sector to increase efficiency (Espigares and Torres 2009).

PPPs IN HEALTH: MOVING TOWARD PPIPs

The World Health Organization (WHO) advocates universal health coverage so that all peoples can obtain the needed health services without suffering financial hardship. A universal health coverage has financial risk protection as an important aspect. Without such protection, the sick will be pushed into poverty to pay for health services.

Universal health coverage is critical in the development of a community and in reducing its poverties and social inequities. Described by WHO as the

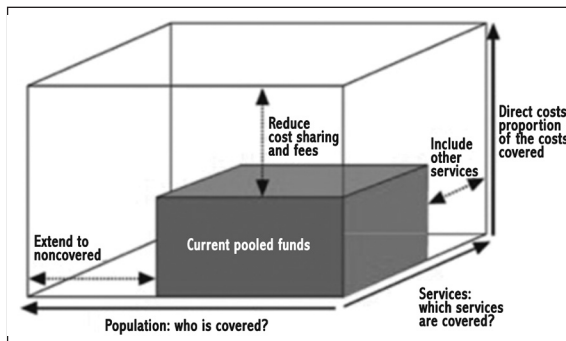
“hallmark of a government’s commitment to improve the wellbeing of all its citizens (WHO 2012),” a universal health coverage calls for improving the three dimensions: population coverage, quality of services, and cost of services (WHO 2010). Figure 1 shows WHO’s universal health coverage cube.

The Department of Health (DOH), in line with the mandate of President Aquino to achieve universal health care for all Filipinos, provided in its Administrative Order 2010-0036 the guidelines, approaches, and resources needed to affect and influence PPPs (DOH 2010). It further states the use of PPPs, especially in services needing heavy capital investments such as the immediate repair, rehabilitation, and construction of selected priority health facilities. It also encourages local government units to use PPPs in organizing community health teams and service delivery networks and when appropriate, in supplementing services that cannot be delivered by existing public providers (DOH 2010).

Because PPPs are commonly viewed as a middle ground between traditional procurement and privatization, it is important to define PPPs and distinguish them from all other forms of public-private interactions that encompass outsourcing and other interactions involving the private sector.

Worldwide, there is no single accepted definition of PPP (Marin 2009). Loosely defined, it involves the collaboration between public and nonpublic entities, including private and nongovernment organizations, to achieve a commonly agreed social goal through pooling of resources—e.g., financial, human, technical, or information (Itika et al. 2011). This collaboration spans a spectrum of nonformal to formal arrangements ranging from simple grants to elaborate contractual relationships. PPPs have been extensively used in transportation, communication, and utilities sectors, but have seen limited application in the health sector given that health has always been considered as a complex social good.

Figure 1. The universal health coverage cube



Source: World Health Organization (WHO) 2010

The Global Health Group from University of California San Francisco coined the term public-private investment partnerships (PPIPs) to set apart a category of health-related PPPs that are potentially transformative for underperforming government-run health systems. PPIPs refer to a “special form of PPPs that comprise long-term, highly structured relationships between the public and private sectors designed to achieve significant and sustainable improvements to healthcare systems at national or sub-national levels.”

The PPIP mechanism

- allows a private entity or a consortium of private partners to cofinance, design, build, and operate public health-care facilities;
- enables the government to utilize private sector expertise and investment to achieve public policy goals while maintaining ownership of the assets throughout the duration of the partnership; and
- ensures high-quality and affordable preventive and curative care for the citizenry, who should incur the same, minimal, or zero out-of-pocket payment, as they did in previous poorly run public facilities.

As such, there is a transfer of substantial and financial risk to a private entity, which is bound by a contract to deliver a bundled package of services that includes construction, maintenance, clinical care, preventive, and supplementary services such as procurement and training (GHG 2010). By describing a PPIP, The Global Health Group sets the bar for a quality PPP that would impact health outcomes.

Although PPPs are now a strategy in the Philippines to achieve universal health coverage, there is no clear description of what it is and how it can be utilized to better health outcomes. Taking the cue from The Global Health Group, the following definition of PPPs in health is proposed to end confusion on the matter. The proposed definition is as follows:

"A **health public-private partnership** is a contract between the public sector and one or more private sectors, organized as a legal entity, with a common goal to provide a public health service, while sharing substantial financial and operational risk. The private entity employs their expertise in innovating, building, maintaining, and/or managing delivery of agreed-upon services over a specified contract period. The government provides the purchasing power and may serve to oversee and monitor the project. The potential of shared cost savings and the achievement of a public good are mutual goals and benefits for both sectors."

There are four main elements in this definition. First, the life span of a health PPP is lengthy in nature to provide adequate time for health goals and the return on investments to be attained. Second, the sharing and transfer of risk highlight the contrast between PPPs and traditional procurement methods. Risks must be explicit and understood by all sectors involved. Third, the stakeholders understand their strengths and their responsibilities in relation to the project and

work within those limits. Fourth, the explicit goal of providing a publicly needed health service must be the motivation of a health PPP.

Health PPPs can be classified into two: PPIPs and public-private interactions (PPIs). The PPIPs have a larger scale and a greater impact compared to PPIs. In a way, PPIPs are major PPPs and PPIs are minor PPPs. The distinguishing characteristics between the two will be elaborated on later in this paper.

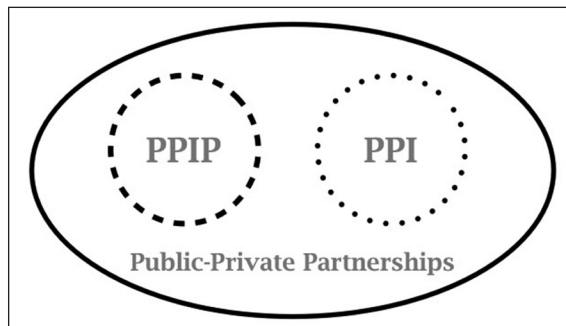
From this point on, the appropriate terminology will be utilized. A PPP is the broad term indicating an interaction between the public and private sectors, and PPIPs and PPIs are kinds of PPPs. The relationship among the three is depicted in Figure 2.

Review of foreign and local health PPPs

Ten vital characteristics qualify what a PPIP should be (Table 1). These characteristics distinguish the PPIP from a simple public and private sector interaction.

- *Public policy objective: Universal health coverage*
The success of a PPP requires that the population be covered under a financing scheme, whether a social health insurance (i.e., the Philippine Health Insurance Corporation, or PhilHealth for short) or another scheme, so as to receive the needed services with minimal or no financial risk. Although the private sector will deliver these services, the initiative to cover the population must come from the public sector, as it is its mandate to provide health insurance or similar health financing schemes to its constituents.
- *Design-Build-Operate-Deliver model*
This model provides the most complete approach to delivering health outcomes as compared to contract types that are smaller in scale and serve as mere stopgap measures. In this setup, the private partner designs, cofinances, builds, operates, and delivers clinical care throughout a health system.

Figure 2. Relationship between PPPs, PPIPs, and PPIs



Source: Authors

Table 1. Summary of vital characteristics in public-private partnerships

Vital Characteristics of PPIPs
1) Addresses public policy objective
2) Follows the Design-Build-Operate-Deliver model (or a minimal variation)
3) Delivers quality: <ol style="list-style-type: none"> a. Integrated clinical services b. Nonclinical services
4) Government has ownership of assets
5) Presence of the following: <ol style="list-style-type: none"> a. Government review b. Independent monitoring
6) Investment is: <ol style="list-style-type: none"> a. Long term b. A combination of public and private funding
7) Risk transfer to the private sector
8) Expenditures <ol style="list-style-type: none"> a. Cost neutrality to patients b. Predictable government health expenditures
9) Equity of access for all
10) System-wide efficiency gains

Source: The Global Health Group (GHG), 2010

- *Delivery of quality integrated clinical and nonclinical services*
 Similar to PPIs, PPIPs must deliver a service whose quality is at par or exceeds that of traditional public procurement and service delivery models. An integrated model is seen as the way forward due to rising chronic, noncommunicable diseases and need for efficiency in savings (Barlow et al. 2012).
- *Government ownership of assets*
 An important characteristic of PPIPs is the absence of a sale of public assets. “PPIPs are carefully designed vehicles for achieving public healthcare policy goals; they do not relinquish control or ownership of assets to the private sector” (GHG 2010).
- *Government review and independent monitoring*
 The government is tasked to provide a public social need and must take it upon itself to monitor and ensure that the goal is met. Third-party monitors and evaluators may also be employed if agreed upon by both sectors. The presence of third-party monitors preserves the integrity of the project evaluation and creates room for growth and improvement.
- *Long-term and shared investment*
 A PPIP requires both the government and the private partners to have a long-

term commitment to provide health services. Investing significant resources into the project helps to ensure dedication and shared interest in producing successful outcomes. Additionally, its long-term nature gives the partners time to develop sustainable processes and to improve using feedback loops (GHG 2010).

- *Risk transfer*
The risk of meeting service quality benchmarks is transferred to private partners. The private sector also assumes risks for infrastructure delays, human resource issues, and failures in efficiency. However, the government is not completely devoid of risk for it is responsible for meeting the social needs of the public and for making sure that the financial commitments to the private sector are met.
- *Cost neutrality to patients and predictable government expenditures*
Cost neutrality means that PPIPs must not bring any additional cost to patients utilizing health services. Such is the universal health coverage's goal of financial risk protection. Also, PPIPs must be as cost neutral as possible to the government by ensuring that expenditures remain within predictable limits.
- *Equity of access for all*
All PPIP facilities must provide access to all and should not discriminate based on a patient's income level or social status. This assumes that the health facility has adequate resources to serve all those who wish to avail of the services.
- *System-wide efficiency gains*
PPIPs are designed to "operate within, and improve, existing systems" (GHG 2010). Contracting completion of the Design-Build-Operate-Deliver model may be helpful to ensure that high and transparent standards for service delivery and outcomes are met. A consistent attainment of these standards will raise the bar for the entire health-care system. The PPIPs are likewise able to address the challenges proposed by Barlow et al. (2012)—i.e., for PPPs to have an integrated service approach and a community-centered approach—since these follow a Design-Build-Operate-Deliver model that sees through the whole project with a mandate for quality, integrated clinical and nonclinical services.

The PPPs that do not meet the above characteristics can be called PPIs or minor PPPs since they attend to smaller portions of the health-care service delivery—that is, those that are infrastructure-, service-, management-, or concession-type contracts. Similar to PPIPs, PPIs may be long term, do not engage in any sale of assets, allocate risk appropriately, and maintain the government's role of reviewer and monitor. The difference lies in the overall impact that PPIs

make. Unlike the systemic impact of PPIPs, PPIs may likely be stopgap measures that address fragments of the real problem due to their small-scale nature. Given this, the paper will focus only on PPIP options, as these have greater impact on the health outcome.

Review of foreign and local health PPPs

An extensive literature review using filter and manual search strategies on various Internet search engines yielded a total of 63 health PPPs. Of the 63, the 39 were foreign while 24 were local initiatives. These partnerships involved outsourcing of clinical, technical, or support services to private enterprises or organizations; contracting the direct provision of a health facility or certain health services with a private provider; collaborating with the private sector to develop or deliver health services for a specific disease or to a specific group of areas; and contracting or integrating private insurance schemes to cover specific populations. Different types of health PPPs were clustered under either design and construction, nonclinical services, primary care, clinical support services, specialized clinical services, hospital management, or combination types.

Majority of those reviewed were from South Asia (12), and Europe and Central Asia (9). The PPPs can be observed in low-income, lower middle-income, upper middle-income, or high-income countries.

From the 39 foreign cases reviewed, seven were PPPs for design and construction, four for nonclinical services, six for primary care, nine for clinical support services, seven for specialized clinical services, four for hospital management, and two combination models.

Health PPPs under design and construction varied in contract types and were large in scale requiring substantial investments. All projects involved either the construction or management of a hospital. Lessons gathered from these studies stressed the importance of feasibility studies, creating standardized guidelines, and establishing success indicators for monitoring performance. On the other hand, PPPs for hospital management harnessed the expertise of the private sector in management and efficiency to better serve social needs. This was seen in hospitals in California-USA, India, and Brazil.

For nonclinical services, the projects ranged from waste treatment and disposal (Bihar, India) to robotic automatic guided vehicles that will aid service delivery (Royal Adelaide Hospital in Australia). The Inkosi Albert Luthuli Hospital in South Africa, however, was the only one in this review and the first in its country, to enter into a PPP for all its nonclinical services.

In the area of primary care, PPPs were employed to improve primary care centers such as those in Costa Rica and the Belo Horizonte primary care centers in Brazil; to contract out primary care to nongovernmental organizations in

Cambodia; and to outsource urban health centers in Bihar, India. Also, there were nutrition services contracts in Bangladesh and a community-based pain clinic established in the United Kingdom.

Clinical support services are services that lead to comprehensive, efficient, and improved care for the patient. The PPP projects for these may be in the form of laboratories, such as the one in Colentina, Romania, or diagnostic centers such as the ones in Andhra Pradesh and Bihar, India. In Gambia, medical transport issues were addressed through a partnership with Riders for Health, wherein transportation was made available for all health-related needs. For specialized clinical services that require field specialists for certain diseases and disorders, PPPs improved the access at an affordable cost. Examples of these were the dialysis centers in Romania; neurosurgery, urology, and nephrology services in Mowassat, Kuwait; obstetrics and gynecology services in Smouha, Egypt; a radiotherapy center in Moldova; eye units in Bihar, India; and a center for translational molecular medicine in the Netherlands.

There are instances when a partnership involved a combination of services and a number of facilities. For the Alzira Model in Spain and the Lesotho health system, the contracts covered not only the construction of health facilities but the overall management of the health system as well. This ensured efficient operations and a seamless referral mechanism within the system. In these two examples, integration was a key aspect in guaranteeing the projects' success, relevance, and consistency.

Of the 24 local PPPs studied, majority fell under primary care (10 cases) and clinical support services (4 cases). However, unlike in the global cases, the local primary care projects did not involve primary care centers but rather focused on the access to services. The rest of the projects pertained to nonclinical services (4 cases), hospital management (3 cases), specialized clinical services (2 cases), and design and construction (1 case).

Most programs were conducted locally as the initiatives came from either the provincial/municipal government or private entities in the community. There were also a few—such as the Private Sector Mobilization for Family Health and *Lakbay Buhay Kalusugan* Caravan—that were financed by donor agencies (CHMI 2011). These projects mainly addressed maternal and child health problems.

In general, the reviewed health PPPs were either in the start-up/pilot phase or existing/expansion stage. However, those projects that involved the construction or management of a health facility were still in the preliminary stage: either in the planning, bidding, or construction phase. Examples are the Philippine Orthopedic Center (PPP Center n.d.), Sarangani Medical Center (Sarangani Information Office 2011), and the Research Institute for Tropical Medicine Vaccine Production Project (RITM n.d.), among others.

This paper then evaluated both foreign and local health PPPs using the PPIP characteristics earlier enumerated here to determine whether or not each initiative could fall under the PPIP definition. Of the 10 criteria enumerated in Table 1, the following were considered the more important characteristics when classifying case studies as PPIPs: Design-Build-Operate-Deliver model, delivery of integrated clinical services, government as the owner of assets, risk transfer, cost neutrality, and equity of access.

Of the foreign PPPs reviewed, only six out of 39 qualify as PPIPs. On the other hand, only one (i.e., that of the Northern Samar public health-care project, which is still in its initial phase) out of 24 local PPPs has the potential to be classified as PPIP. While many local projects were in the start-up phase, a number of small-scale projects such as BlueStar Pilipinas: Social Franchising for Health and *Botika ng Bayan* have expanded.

Among the local PPPs reviewed, the largest PPP thus far is that on the Hemodialysis Center of the National Kidney and Transplant Institute (NKTI). The initiative is a lease contract with the government as the lessee and one recognized as a top PPP in emerging markets. It featured an innovative way of procuring equipment to address the annual budget deficit that hindered a proper service delivery for a rising need. As a result of the lease contract, NKTI provides the highest level of hemodialysis service, serving more than 120 patients per day while being relieved of the responsibility of acquiring new equipment. However, based on the definition proposed by this paper, this project is still deemed a PPI.

As the existing projects only partially fulfill the stated criteria for a PPIP, it seems that there has yet to be a PPP in the Philippines that qualifies as a PPIP. Note though that the Philippine Orthopedic Center project was not included in this evaluation as it is still in the preliminary (bidding) stage at the time of the study. This initiative, which is a BOT project wherein the hospitals are to be transferred to the DOH after 25 years, may well be the first real PPP to fit the description proposed by this paper. However, its impact—including the implications of the requirement to allocate 30 percent, or 210 beds, as private beds—has yet to be determined.

PPIP OPTIONS FOR THE PHILIPPINES

Based on the review of the global and local PPPs, three approaches in terms of focus and scale—health-care delivery in (1) primary care; (2) hospital care; and (3) an integrated system—are proposed to serve as models.

The primary care model: Cambodia and Costa Rica

An increasing number of developing countries have looked into or have implemented contracting-out schemes to provide and improve health services

through nongovernmental providers. Proposed benefits from this approach include its ability to scale up health initiatives, bypass limited quality and efficiencies of centralized services, and address the shortage of public health-care personnel and facilities. This approach, however, remains controversial; it is being criticized that it may not reach its objectives; that it presents an unrealistic administrative cost; and that the government has weaknesses in its stewardship (Liu et al. 2007). To understand the approach further, two case studies on primary health-care delivery are discussed and analyzed below.

The first case is that of Cambodia, where it contracted primary health-care services for over four years (1999–2003) to cover about 1.26 million people. The short-term nature of the setup was an experiment designed to determine the effectiveness of contracting in and contracting out of health services. *Contract-out* models involved the government tendering management of government health services to private bidders. These private contractors were required to provide all preventive, promotional, and simple curative health-care services mandated by the Ministry of Health. *Contract-in* models maintained government-managed health systems in their district. The two designs aimed to test the two variants of the contracting approach in terms of control, budget process, and effectiveness. Eight health service indicators were set, mostly related to maternal and child health.

The experiment showed that all districts monitored with the contract-out model performed better than the contract-in model (Bhushan et al. 2002). Improvements in efficiency led to similar improvements in accessibility, with Bhushan et al. (2002) notably concluding that “efficiency gains in the provision of health services do not come at the expense of equity.” Although short term, the experimental nature of the setup in Cambodia can still be classified as a genuine PPIP: There is the presence of private sector investment in increasing access and expanding health services in remote areas and the proper sharing of roles and risks between the public and private partners. Furthermore, it enhanced health-care services of the districts involved, improved access for the lower socioeconomic classes, reduced disability time, and decreased out-of-pocket expenses.

On the other hand, Costa Rica partnered with the private sector via performance contracts. Contracts proposed to cover nearly 110,000 people and set 23 indicators related to primary health care. These positively drove contracting parties to reach the improvement targets in the quality and efficiency of health services delivery. Such contracts required that at least 85 percent of the targets have to be achieved; otherwise, the bond would be forfeited and private providers duly penalized. Existing service providers were not exempt from these new performance indicators. Contracted providers showed more general practitioner visits per capita, conducted fewer lab tests, and dispensed less medication, all

translating to lower expenditures. Whether this translated to actual better health outcome and improved equity was not stated.

Costa Rica's performance contracts for primary health care are true PPIPs since these involve active investment and management from the private sector, and regulation from the public sector.

The impact of the contracted model on access was significant in terms of raising general practitioner visits per capita and in reducing unnecessary diagnostic and therapeutic costs. No sale of assets was made, and the private sector executed a public function, while the government is the one that regulates and finances such public function. Services were available to all free of charge. More impressively, Cercone in the Bulletin for the World Health Organization (De Bertodano 2003) said, "for every dollar invested, US\$1.50 has been returned to the population in terms of improved health status, greater productivity and better quality."

The hospital model: São Paulo and Bloemfontein

In the late 1990s, São Paulo in Brazil finished constructing new hospitals in underserved neighborhoods. An open competition was held to identify the best operators that would then enter a "five-year renewable operating contract with performance specifications, which in turn were linked to payments" (La Forgia and Harding 2009). The 16 facilities opened for bidding were all general hospitals, averaging 200 beds and located in low-income neighborhoods in heavily urbanized municipalities. The contract specified services to be rendered and targets to be attained, including volume targets, quality processes and benchmarks, and reporting requirements on daily operations. A performance-based global budget was given in two parts: 90 percent linked to service provision targets, and 10 percent linked to compliance with reporting and quality indicators. La Forgia and Harding (2009) concluded that "from a value-for-money perspective, the results demonstrate that PPP hospitals represent major improvements over traditional public hospitals in Brazil. The PPP hospitals are performing much better on efficiency and productivity, with no evidence of quality shortfalls."

Overall, the case of São Paulo demonstrated how the public mission of providing quality and efficient health care in a hospital setup is preserved in a radically altered system of governing and financing the delivery of health services. Although there was no large investments or capital outlay, the long-term nature of the contract and the risk undertaken, as well as the shared responsibilities, prove this project to be a true PPP.

In South Africa, another hospital partnership with the private sector has been undertaken in the state of Bloemfontein. This is a collaboration of public and private sectors to operate a similar service for a win-win situation. That is,

the public sector receives revenue and the private sector generates profit. This setup can occur when the public sector “has redundant assets and the private sector has sound commercial reasons for the utilization of these excess state assets.” This colocation PPP scheme is long term, carries substantial capital and operational costs.

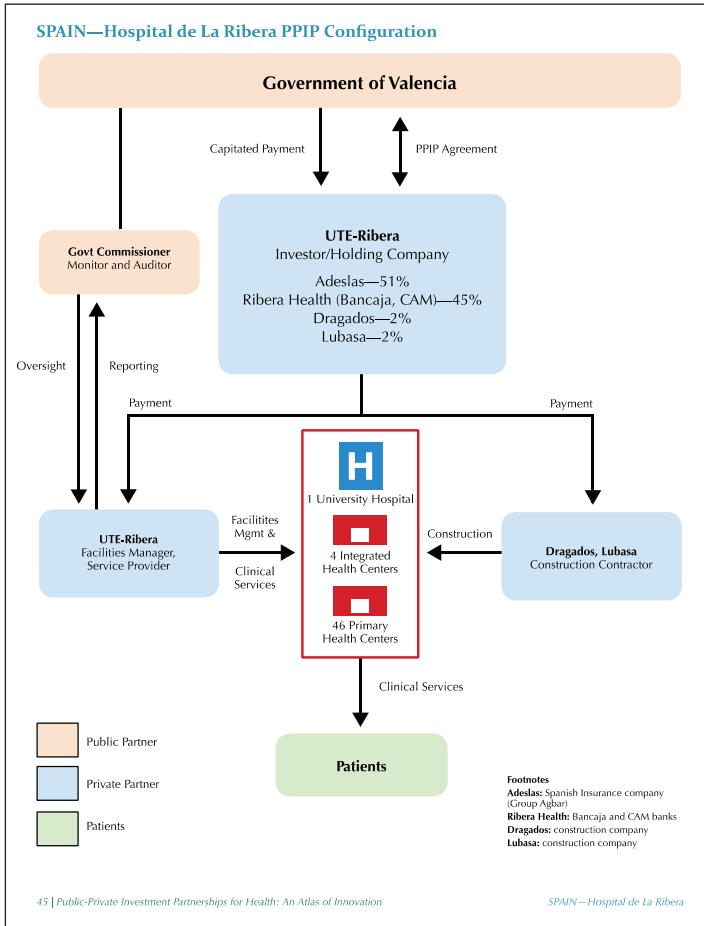
In this scheme, the government wanted to resolve problems of duplication, inefficiency, and inequity. Three Bloemfontein hospitals were realigned by assigning National Hospital as the district-level hospital, Pelonomi as a regional-level hospital, and Universitas Hospital as a tertiary-level provincial hospital. This reassignment reduced the number of beds but left the government with excess, underutilized infrastructure. The private and public sectors thus entered into a 20-year concession to operate a private hospital in Universitas Hospital and inject capital toward the upgrade of a public ward, theater, and intensive care unit block of the Pelonomi Hospital. The state retains ownership, and also gains revenue from a percentage of the turnover generated by the private hospital. Overall, this type of colocation partnership may be considered a PPIP due to its long-term nature, magnitude of capital outlay, improvement in efficiency and access, and control of user fees. There are also noted gains in new employment and transfers of knowledge and skills.

The integrated health-care model: Alzira and Lesotho

In the late 1990s, the health management company Ribera Salud proposed an integrated health-care model in Alzira in the region of Valencia, Spain (Figure 3). An integrated system has many benefits. For patients, this provides a higher level of privacy and comfort, greater accessibility, a choice in treatment providers, and up-to-date technology. For professionals, the integrated system provides stable employment, opportunities for career development, teaching and research, and a good working environment. For the regional government, this model has value for money, allows for investments throughout the concession period, and provides for financial risk transfer and innovation in technology and systems (NHS Confederation 2011).

Through a management concession contract, this partnership provided a health system for Alzira that is integrated with the existing National Health System that covers a university hospital, four integrated health centers, and 46 primary health centers. A unified information system was set in place to ensure that a comprehensive clinical and drug history and diagnostic data would always be available to all physicians, reducing any duplications and having a trail of accountability. Its professional management approach features a delegated responsibility and external performance targets. Ownership remains with the government, and clauses in the contract must be complied with. Otherwise, the

Figure 3. Alzira health system model



Source: GHG (2010)

government can pose sanctions. The private provider commits itself to ensuring the proper delivery of service.

The payment system is a capitation model where there is a fixed price per person for the duration of the contract. The payment model also includes a percentage of the yearly increase in health budget. This fee covers for all expenses including service, amortizations, payroll, consumables, and utilities. Physicians receive incentives for target outcomes and patient volumes reached. A four-pronged approach—public control, public property, public funding, and private management—coupled with the “money follows the patient” incentive, ensures quality and patient satisfaction.

The success of this arrangement led the government of Valencia to establish PPIPs for four other hospitals: Hospital de Torrevieja (a paperless and technologically advanced hospital, where patients can SMS the hospital to obtain real-time waiting times and doctors have remote electronic access to records at all times), Hospital Dénia Marina Salud, Hospital de Manises (where specialist units are included in the system), and Hospital del Vinalopó (a hospital providing both primary and specialist care, and is labeled as one of the most technologically advanced hospitals in Europe). This model for an integrated health-care system is a true PPIP. The long-term nature of its contract; the shared roles, risks, and benefits; the increase in coverage, health-care quality; and the security of a no-user fee policy point to one that supports universal health coverage.

In 2006, Kingdom of Lesotho, Africa constructed an integrated health service delivery model to replace its main public hospital. The model consisted of a new hospital, adjacent gateway clinic, three filter clinics, and the management and operations of all of these services for at least 18 years (Figure 4). The scope of services ranges from complete health-care service delivery from health professionals, to medical equipment and pharmaceuticals. Furthermore, as part of the integrated model, the contracting parties also refurbished, re-equipped, and operated primary health-care clinics in the area. The private operator agrees to treat up to 20,000 inpatients and 310,000 outpatients per annum at the hospital and filter clinics regardless of condition. There is an annual fixed service payment for delivery of all services that may escalate with inflation. The agreement includes typical monitoring of payment and penalties related to facilities management, equipment, and other nonclinical outcomes. Also, there is a detailed list of clinical and facility performance indicators that must be met before receiving payment. This PPP can be considered a true PPIP because of the substantial risk and complex contract arrangement entered by both the public and private sectors. It is long term in nature, involves a large capital outlay, and requires a systems approach to ensuring better access and improved quality of services, while guaranteeing that there is no extra cost to patients.

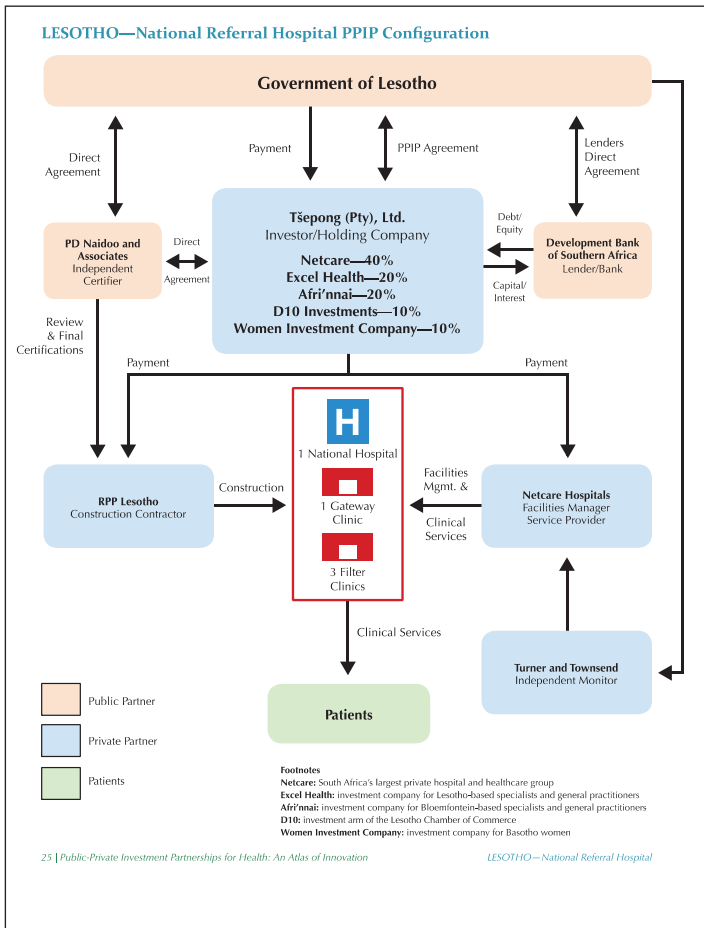
Key lessons

Table 2 lists the key lessons that can be gathered from the six case studies presented.

PPIP OPTIONS APPRAISAL

Although the six cases presented are successful PPPs in their home countries, these are just models that must still be modified according to local knowledge and experience in a country. Furthermore, PPPs must be contextualized to the political landscape, economic situation, private sector interest, and commitment

Figure 4. Lesotho's integrated health system



level of the stakeholders involved. They must be consistent and coherent with the national health mandate and strategy so as to avoid scattered initiatives that clutter the landscape and confuse the key players in health care. As Widdus (2001) says, PPPs “show promise but are not panaceas.” The following questionnaire will help stakeholders determine whether or not PPPs are the right solution for the problem at hand (Table 3).

In the Philippine health landscape, where there are many existing health-care providers, an integrated and system approach to PPIP may not always be the best solution. In spite of this, it is still important to keep the ideal PPIP in perspective and consider that this may be achieved in increments.

Table 2. Key lessons from the representative case studies

Primary Care	Cambodia	Setting explicit health service indicators allowed proper evaluation. Efficiency gains in the provision of health services through PPPs did not come at the expense of equity. Contracted-out models yielded better outcomes.
	Costa Rica	Under performance contracts, contracted providers were driven to meet the standards for coverage and quality while lowering the cost of care. The project experienced improvements in access through increased general practitioner visits per capita and reduction in unnecessary diagnostic and therapeutic costs.
Hospital	São Paulo	The PPP hospitals are performing much better in terms of efficiency and productivity, and there is no evidence of quality shortfalls. Innovative use of PPPs preserved the public mission of providing quality and efficient health care.
	Bloemfontein	PPP can be pursued when the public sector has redundant assets and the private sector has sound commercial reasons for utilizing these excess state assets.
Integrated Health Care	Alzira	An integrated health-care system reduces duplications and establishes a trail of accountability. A per-capita payment approach with an incentive for target outcomes and patient volume is effective in ensuring that citizens' health needs are attended to, and in keeping physicians committed to service delivery.
	Lesotho	An annual fixed service payment for delivery of all services, with room for escalation with inflation, can work. A long-term systems approach to health care ensures better access and improved quality of services at no extra cost to the patient.

Source: Authors' compilation

To further aid these stakeholders, a decision tree toward PPPs is presented in Figure 5. Prerequisites before applying this algorithm are that proposed partnerships must be need based with accompanying evidence and statistics, and the scheme should be long term in nature and aim for achieving universal health coverage by improving access to health care and reducing the financial burden of out-of-pocket expenses. Furthermore, both the public and private sectors must share risks and benefits and engage in an open dialogue regarding the design, scope, and details of the partnership, all throughout the lifetime of the project.

The first question policy- and decisionmakers should ask is: What aspect of their health-care system do they want to create a PPP? In the Philippine setting, the two choice answers may be primary care services and hospital services.

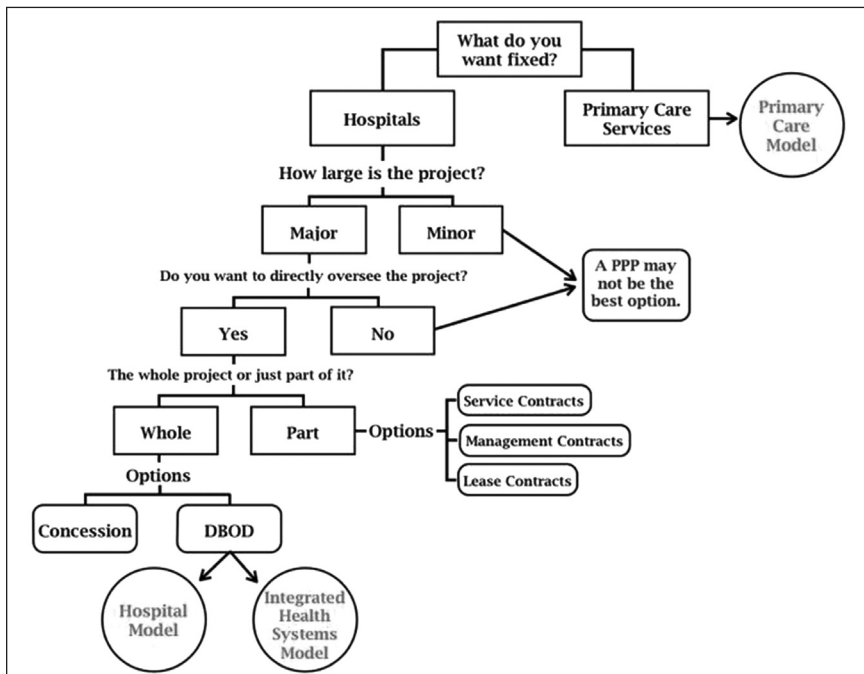
For hospital services, the decisionmakers must next decide if the project or partnership is large in scale or not. Small-scale projects do not strictly fall under PPIPs. They may be PPIs, as most bids and contracts are, but are not health PPIPs in the strictest definition. These smaller-scale projects may push through and need less coordination than larger projects. Furthermore, public sectors that do not wish to directly administer their partnerships must look into the possibility of entering

Table 3. Inception questionnaire for interested stakeholders in PPPs

Questionnaire	
1.	For which aspect of your health system are you interested in creating a PPP? <input type="checkbox"/> Primary care services <input type="checkbox"/> Hospital-based services (If this is your option, proceed to No. 2.)
2.	Is your project large in scale? <input type="checkbox"/> Yes (Proceed to No. 3.) <input type="checkbox"/> No (PPIPs may not be for you.)
3.	Are you interested in playing an active role in the project? <input type="checkbox"/> Yes (Proceed to No. 4.) <input type="checkbox"/> No (Consider sale of assets or outsourcing.)
4.	Is the project comprehensive for the hospital? <input type="checkbox"/> Yes (Proceed to No. 5.) <input type="checkbox"/> No (Proceed to No. 6.)
5a.	Are you interested in a greenfield project? <input type="checkbox"/> Yes (Design-Build-Operate-Deliver contract variations may be suitable.) <input type="checkbox"/> No (Consider concession contract variations.)
5b.	Are you interested in integrating the health care provided and gain value for money? <input type="checkbox"/> Yes (Consider integration with primary care facilities in the community.) <input type="checkbox"/> No
6.	Which aspect of hospital-based services will you focus on? <input type="checkbox"/> Infrastructure (Build-transfer-operate contract variations may be suitable.) <input type="checkbox"/> Clinical services (Service, management contract variations may be suitable.) <input type="checkbox"/> Nonclinical services (Service, management contract variations may be suitable.)

Source: Authors

Figure 5. PPP decision tree for stakeholders



Source: Authors

a different contract type. Active participation between both the public and private sector is essential in a PPP.

Large projects can be administered either in part or in whole. Comprehensive administration of partnerships is seen in concession or BOT-type contracts. These contract types allow for greater systems change within the hospital. Those administered in part are usually partnerships for particular portions of hospital operations such as infrastructure, clinical services, or nonclinical services. These smaller partnerships may improve efficiency, leading to better quality of care.

Additionally, taking into account the three approaches presented earlier—primary care, hospital-based care, and an integrated health-care system—one must look at the relevance and success factors that will help stakeholders choose one model over another as summarized in Table 3.

Primary health-care PPIPs flourish in an environment where there is a lack of supply in a community of high demand. Demand may be measured based on untreated morbidities and/or overcrowding of secondary and tertiary care facilities. It is not measured by political will. The Declaration of Alma Ata (WHO 1978) includes at least the following eight goals in primary health care that need to be measured regularly: “education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child healthcare, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs.”

Only when the goals and criteria of universal health coverage (such as the availability and equitable accessibility of quality services, improved efficiency, and cost neutrality) are met can it be said that primary health-care PPIPs have succeeded.

Hospital-based health-care PPIPs are appropriate when there are redundant public facilities wherein potential income can be generated, or when inefficient operations are detrimental to the sustainability of a public hospital. They may also be applied in situations where a public hospital is needed in a community but will be difficult and expensive for the government to set up. These PPIPs are flexible and can work as greenfield projects or as renovation and concession projects. Key factors to their success include improving employees’ accountability, obtaining a more efficient staff mix, and including certain incentives for good performance.

Integrated health-care systems are an ideal setup for any community. They lessen duplicity of visits and laboratory examinations. They provide seamless care appropriate to the needs of the patient. They may be approached as PPIPs in a community that is amenable to make major changes. However, in the Philippines

Table 4. Relevance and success factors of PPIP models

	Primary Health Care	Hospital-based Health Care	Integrated Health-care Systems
When is it appropriate	High demand, low supply; High morbidities	Redundant hospital facilities Inefficient hospital operations	Presence of strong political will and cooperation of local leaders and innovative investors; Sound national health insurance program
Success factors	Meet the criteria of universal health coverage: accessibility, availability, efficiency, and cost neutrality	Improve employees' accountability; obtain a more efficient staff mix; and include certain incentives for good performance	Unify health information systems; provide seamless services across different levels of care; communicate the integration to constituents

Source: Authors' analysis

where there is a large private health-care presence and citizens have autonomy in choosing their providers, this may be difficult.

These PPIPs unify information systems, deliver services in all levels of care, and ensure both horizontal and vertical integrations. Key factors to the success of these PPIPs include a sound national health insurance program, political cooperation among local leaders, and innovative investors (Table 4).

CONCLUSIONS AND NEXT STEPS

Revised definition of health PPPs

In its Administrative Order 2010-0036, the DOH called for greater partnership with the private sector to meet the Aquino administration's health agenda on universal health care for all Filipinos. The administrative order used the term PPP, defined as "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. This partnership may range from healthcare provision to logistics management, information and communication technology to capacity building of health providers" and indicated that a large capital investment is required. The definition is general and does not contextualize its relationship to health. Adopting the terms PPIPs and PPIs may delineate the scale and requirements of various projects, highlighting their relevance and importance.

The proposed definition of a health PPP provides a clearer description of its components and goals.

"A **health public-private partnership** is a contract between the public sector and one or more private sectors, organized as a legal entity, with a

common goal to provide a public health service, while sharing substantial financial and operational risk."

The three types of PPIPs should also be defined and described in terms of the settings or scenario where they are most appropriate to be considered. The decision tree and questionnaire can be incorporated in the revised administrative order.

It must be noted that primary health-care PPIPs flourish in local governments where there is a lack of supply in a community of high demand. Hospital-based health-care PPIPs are appropriate when there are redundant government health facilities. They are also applicable in situations where a public hospital is needed in a community but will be difficult and expensive for the government to set up. Integrated health-care systems are ideal arrangements for the devolved systems of the country as they provide seamless care to the patients and address the fragmentation brought about by devolution. These PPIPs unify information systems and the delivery of health-care services in all levels of care, and ensure both horizontal and vertical integrations of health-care providers.

Enabling PPPs

The success of a PPP is not only measured at the project's culmination; rather, it is also determined by the preparation leading up to it. As such, there are certain elements that must be present for a PPP to thrive in.

- **Comprehensive health plan.** A comprehensive health plan should clarify the role of PPPs in the health system and in attaining universal health coverage. If there is a long-term plan in place, government will be guided as to what projects they should be prioritizing and who they should be collaborating with. This ensures that projects are accounted for, thus avoiding duplication, and integrated within the system for sustainability. Moreover, this will also help the private sector understand how they can contribute to improving health outcomes.
- **Legal framework.** A legal framework is necessary to protect the interests of both the public and private sector and to make them liable if the objective of the PPP is not attained. Policies should be in place to serve as guidelines on how to go about the partnership, ensuring that there is enough incentive for private investors. Additionally, the legal framework should define health financing arrangements that minimize the financial risk of the population, but at the same time are suitable for a PPP. Political will is necessary for this to come into fruition.
- **Regulatory framework.** A regulatory framework—specifically a controlling body—is essential to keep track of projects, to police partners, and to assist in technical aspects of the partnership, among others. An independent body

is also needed for unbiased and consistent monitoring and evaluation of projects.

- **Readiness of public and private sectors.** Both public and private sectors must be ready and willing to enter into the partnership. This means that the public sector must have the capacity to handle the technical requirements of the project, including regulation and enforcement, and the private sector is able to meet the quality standards required to achieve better health outcomes. Moreover, as the essence of a partnership is collaboration, the partners must build on each other's skills, expertise, and resources to reach the goal that, ultimately, cannot be done alone (Widdus 2003). Constant and clear communication must occur between the two sectors. Finally, there must be trust, accountability, and transparency in the partnership throughout the project duration.

PPIPs AND UNIVERSAL HEALTH COVERAGE

PPIPs provide a concrete option toward achieving universal health coverage. Their integrated approach works within the system of health-care delivery, therefore improving overall efficiency instead of simply bridging gaps. Such approach further brings about private sector participation and accountability under the usual PPIP's Design-Build-Operate-Deliver model with risk transfer to the private sector. Because ownership of assets remains with the government during the life of the PPIP, the presence of robust government reviews and independent monitoring is ensured.

With the expanding population coverage of PhilHealth, charity patients are converted into insured patients with third-party payors. Thus, maintaining government ownership of the assets no longer automatically translates into a lack of financial viability that was brought about by the old Hospital Law (Republic Act 1939), which required that 90 percent of government hospital beds be maintained as charity beds. The PPIPs clearly aim for system-wide efficiency gains and the delivery of integrated clinical services and nonclinical services without putting the patient at risk of financial hardship while providing predictable costs to government. Properly implemented, PPIPs may responsively address the three dimensions of the universal health coverage.

REFERENCES

- Asian Development Bank (ADB). 2008. *Public-private partnership handbook*. Manila: ADB. <http://www.adb.org/sites/default/files/pub/2008/Public-Private-Partnership.pdf>
- Barlow, J., S. Wright, and J. Roehrich. 2012. New generation PPPs: What they need to deliver to meet the emerging health-care challenges. Paper

- presented at the 15th European Health Forum Gastein, 6 October. <http://www.ehfg.org/intranet/app/webroot/uploads/presentations/files/uploads/6b4ba4b7bca35dcf9ed756256beb9b.pdf>.
- Barr, D. 2007. Ethics in public health research: A research protocol to evaluate the effectiveness of public-private partnerships as a means to improve health and welfare systems worldwide. *American Journal of Public Health* 97(1):19–25. doi: 10.2105/AJPH.2005.075614.
- Bhushan, I., S. Keller, and B. Schwartz. 2002. Achieving the twin objectives of efficiency and equity: Contracting health services in Cambodia. ERD Policy Brief No. 6. Manila: Asian Development Bank. <http://www.adb.org/sites/default/files/pub/2002/PB006.pdf>.
- Center for Health Market Innovations (CHMI). 2011. *Lakbay Buhay Kalusugan* (LBK) caravan. Washington, D.C.: <http://healthmarketinnovations.org/program/lakbay-buhay-kalusugan-lbk-caravan>.
- De Bertodano, I. 2003. The Costa Rican health system: Low cost, high value. *Bulletin of the World Health Organization* 81(8). <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2572522/pdf/14576897.pdf>.
- Department of Health (DOH). 2010. The Aquino health agenda: Achieving universal health care for all Filipinos (Administrative Order No. 2010-0036). Manila: DOH. <http://www.scribd.com/doc/45621892/The-Aquino-Health-Agenda-Achieving-Universal-Health-Care-for-All-Filipinos>.
- Espigares, J. and E. Torres. 2009. Public-private partnership as a new way to deliver health-care services. <http://dialnet.unirioja.es/descarga/articulo/2942101.pdf>.
- Itika, J., O. Mashindano, and F. Kessy. 2011. Success and constraints for improving public private partnership in health services delivery in Tanzania. ESRF Discussion Paper No. 36. Dar es Salaam, Tanzania: The Economic and Social Research Foundation. <http://esrf.or.tz/docs/ESRFDiscussionPaper36.pdf>.
- La Forgia, G. and A. Harding. 2009. Public-private partnerships and public hospital performance in São Paulo, Brazil. *Health Affairs* 28(4):1114–1126. doi: 10.1377/hlthaff.28.4.1114.
- Liu, X., D. Hotchkiss, and S. Bose 2007. The effectiveness of contracting-out primary health-care services in developing countries: A review of the evidence. *Health Policy and Planning* 2008(23):1–13. doi: 10.1093/heapol/czm042.
- Marin, P. 2009. Public-private partnerships in transport, trends and policy options. Washington, D.C.: The World Bank. <https://openknowledge.worldbank>

- .org/bitstream/handle/10986/2703/530170PUB0Tren101Official0Use0Only1.pdf?sequence=6.
- NHS Confederation. 2011. *The search for low-cost integrated health care: The Alzira model – from the region of Valencia*. [http://www.nhsconfed.org/Publications/Documents/ Integrated_healthcare_141211.pdf](http://www.nhsconfed.org/Publications/Documents/Integrated_healthcare_141211.pdf).
- Nishtar, S. 2004. Public-private ‘partnerships’ in health – a global call to action. *Health Research Policy and Systems* 2(5). doi: 10.1186/1478-4505-2-5.
- Public Private Partnership (PPP) Center. n.d. Modernization of Philippine Orthopedic Center. Quezon City: PPP Center. <http://ppp.gov.ph/?p=7686>.
- Research Institute for Tropical Medicine (RITM). n.d. Vaccine self-sufficiency project. Muntinlupa City: RITM. <http://www.ritm.gov.ph/report.htm>.
- Sarangani Information Office. 2011. Sarangani Medical Center groundbreaking on August 1. <http://www.maitum.gov.ph/maitum-news/440-sarangani-medical-center-groundbreaking-on-august-1>.
- The Global Health Group (GHG). 2010. Public-private investment partnerships for health: An atlas of innovation. San Francisco: GHG. <http://globalhealthsciences.ucsf.edu/ghg>.
- Widdus, R. 2001. Public-private partnerships for health: Their main targets, their diversity, and their future directions. *Bulletin of the World Health Organization* 79(8):713–720. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2566486/pdf/11545327.pdf>.
- . 2003. Public-private partnerships for health require thoughtful evaluation. *Bulletin of the World Health Organization* 81(4):235. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2572433/pdf/12764487.pdf>.
- World Health Organization (WHO). 1978. Declaration of Alma Ata. http://www.who.int/publications/almaata_declaration_en.pdf.
- . 2010. Three dimensions to consider when moving towards universal coverage. http://www.who.int/whr/2010/10_chap1_fig02_en.pdf.
- . 2012. What is universal health coverage? [Online Q&A]. http://www.who.int/features/qa/universal_health_coverage/en/index.html.