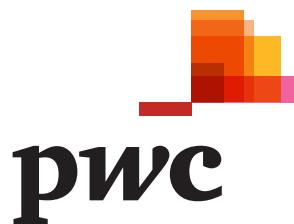


Lessons from Latin America:

The early landscape of healthcare
public-private partnerships

*Healthcare public-private partnerships series, No. 2
Executive Summary*



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UCSF/PwC report series on public-private partnerships

About the report series

This market landscape study of current and planned healthcare public-private partnership (PPPs) projects in Latin America (excluding Brazil, the Caribbean and Suriname) is the second in a series of publications on PPPs jointly authored by the UCSF Global Health Group and PwC.

This series aims to document and raise awareness of innovative PPP models in health globally and to disseminate lessons learned to inform current and future healthcare partnerships.

About public-private partnerships

PPPs are a form of long-term contract between a government and a private entity through which the government and private party jointly invest in the provision of public services. PPPs are distinguished from other government private contracts by: the long-term nature of the contract (typically 15+ years); the shared nature of the investment or asset contribution; and the transfer of risk from the public to the private sector.

Under a PPP arrangement, the private sector takes on significant financial, technical and operational risks and is held accountable for defined outcomes. PPPs provide governments with alternative methods of financing, infrastructure development and service delivery. By making capital investment more attractive to the private sector, PPPs can reduce the risk for private investment in new markets and ease barriers to entry.

In the past three decades, governments from low- to high-income countries have increasingly sought long-term partnerships with the private sector to deliver services in sectors such as transportation, infrastructure and energy. Healthcare partnerships have emerged more cautiously but have rapidly expanded in the last 10 years. The emerging partnerships have tackled a range of healthcare system needs—from construction of facilities, to provision of medical equipment or supplies, to delivery of healthcare services.

Most PPPs operate under a “DBOT” model (design, build, operate and transfer), under which the private

partner is responsible for the infrastructure throughout the life of the contract. The private partner then transfers this responsibility back to the government upon expiration of the contract. The private partner is responsible for operating the hospital, including services such as laundry and cafeteria. However, the government retains responsibility for the delivery of healthcare services throughout. The most common form of PPPs in health has been the private finance initiative (PFI) model used to build many hospitals in the United Kingdom¹.

Recently, however, an increasing number of governments are exploring more ambitious models such as public-private integrated partnerships (PPIPs), under which the private partner is additionally responsible for delivering all clinical services in one or more health facilities, often including an acute care hospital, as well as one or more primary care facilities. The private partner designs, builds, operates and delivers clinical care, including recruitment and staffing of healthcare professionals.^{1,2} This model is commonly called “DBOD” (Design, Build, Operate and Deliver) model.

Scope and methodology

This study reviewed the healthcare PPP landscape across 17 countries located in Central, North and South America (excluding Brazil, the Caribbean and Suriname). With more than 18 healthcare PPP projects in the pipeline in 2014, the scale and scope of Brazil's infrastructure needs creates a rich environment for PPPs and warrants further future research to uncover lessons learned in recent years.

Desk research was conducted on each of the 17 countries to gain an overview of the different healthcare systems (including recent reforms), summarize existing PPP legislation and identify current and planned facility-based PPP healthcare projects. Five countries—Chile, Colombia, Honduras, Mexico and Peru—were identified as having current or planned projects. In early 2013, more than 50 key stakeholders were interviewed in four of these five countries (excluding Honduras).

Interviewees included senior leaders in government ministries, private consortia, financing institutions and nongovernmental organizations (NGOs) as well as academic thought leaders, and financial, legal and technical advisors.

Audience

The primary audiences for this report are Latin American governments that have undertaken or are considering healthcare PPP projects, international donors and policy makers involved in health in Latin America, as well as private sector investors, insurers and healthcare organizations, each of which seek to capitalize on the experience and lessons learned from countries within the region.

This report may also be helpful to other countries that are exploring private sector roles in their health systems, as well as to private sector investors looking to enter this emerging market.

Introduction

Across Latin America, demand for health services has outpaced supply. Many countries lack the adequate clinical and technological resources and infrastructure to address this increased demand. Significant investments are needed in healthcare infrastructure to replace aging facilities and/or construct new facilities to address current access gaps. Governments are also seeking innovative ways to quickly expand their networks of partners. Healthcare PPPs have become an attractive option for expanding healthcare services while requiring only limited up-front capital investment from the public sector.

PPP projects in Latin America have traditionally focused on transportation, telecommunications, and energy; however, in the last decade, governments have started to use PPPs to address social infrastructure needs, including healthcare. A nascent market for healthcare PPPs has emerged, driven by the following:

- **Changing demographics:** Most countries in Latin America are experiencing an aging population driven by lower birth rates and longer life expectancy. Meanwhile, the overall population continues to grow, though at a slower pace than in the past. In addition, increased employment and an overall reduction in poverty rates, as a result of improving economies, have contributed to a wealthier and healthier population.

- **Changing epidemiology:** The distribution of causes of death in most Latin American countries is moving away from communicable diseases and accidents to noncommunicable and chronic diseases. Treatment of chronic diseases requires additional healthcare resources and an increase in expenditure.
- **Growing economy:** Over the last 10 years, the economies of many Latin American countries have demonstrated strong performance and have continued to show gains, despite the global financial crisis affecting other regions of the world. Gross domestic product (GDP) has grown on average 4% per year since 2003 and is projected to grow at an annual rate of 3.25% through 2017.³ Interest from the private sector is strong in these emerging markets and continues to grow.
- **Expanding healthcare coverage:** Healthcare coverage in many Latin American countries is tied to employment. Strongly performing economies have driven increases in formal employment and, consequently, access to healthcare. In addition, countries such as Chile, Colombia and Mexico have passed initial healthcare reform measures with the aim of achieving universal healthcare coverage.

- **PPP legislation:** Within the last decade, several governments across Latin America have passed, or are in the process of passing, PPP legislation that encourages and incentivizes the participation of the private sector. The formality and structure of these PPP tender processes facilitates the execution of PPP contracts.

The full “Lessons from Latin America” report provides an overview of the healthcare PPP markets in each of the 17 countries, as well as an in-depth analysis of the five countries studied—Chile, Colombia, Honduras, Mexico and Peru. Topics covered within the country profiles include: summary of key factors of mature healthcare PPP markets, and an overview of healthcare PPP projects tendered to date, including their tender processes, financing schemes, key performance indicators, supervision and monitoring, as well as country specific successes and challenges with the PPP projects underway at the time of the study.

Regional summary

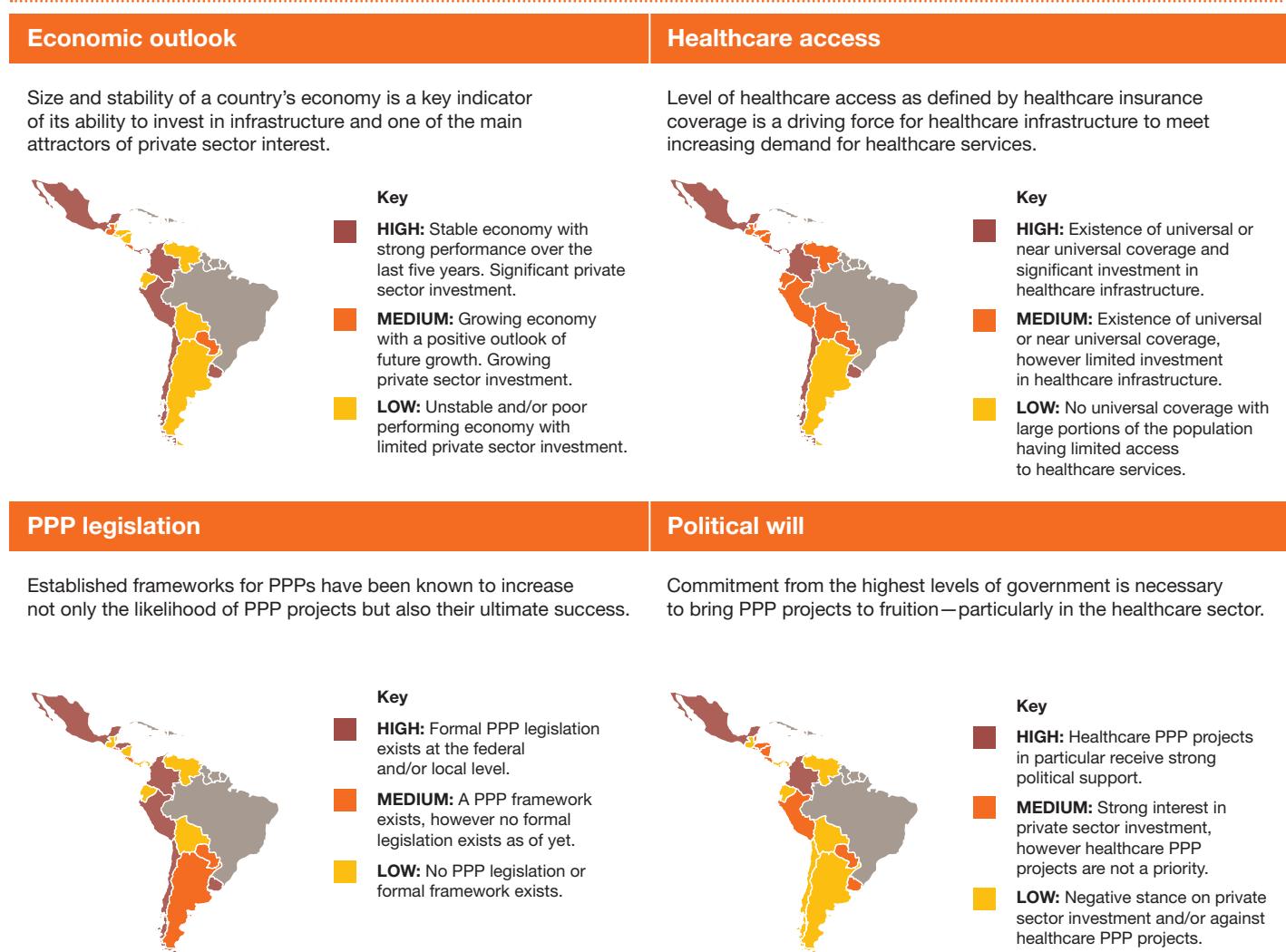
The maturity of the healthcare PPP markets varied across the 17 countries within the scope of this study, with some countries having more favorable markets than others. For example, Colombia and Mexico each have a stable economy, expanding healthcare coverage and infrastructure investment, formal PPP legislation and a favorable political environment (see Figure 1).

Market maturity was evaluated based on four main criteria that were identified as key indicators of healthcare PPP opportunities. Three criteria—economic outlook, PPP legislation and political will—were obtained from the 2012 Infrascope PPP readiness assessment published by the Economist Intelligence Unit.⁴ Healthcare access was added as an additional reference point to reflect the healthcare PPP market. Each country

was given a rating of high, medium or low for each criterion.

In 2013, three countries led the pack in healthcare PPP maturity: Chile, Mexico and Peru. However, a change in administration in Chile in 2014 has resulted in a hold on healthcare PPPs for the next four years. This 180-degree shift highlights the importance of political will and is discussed in further detail in Chile's country profile.

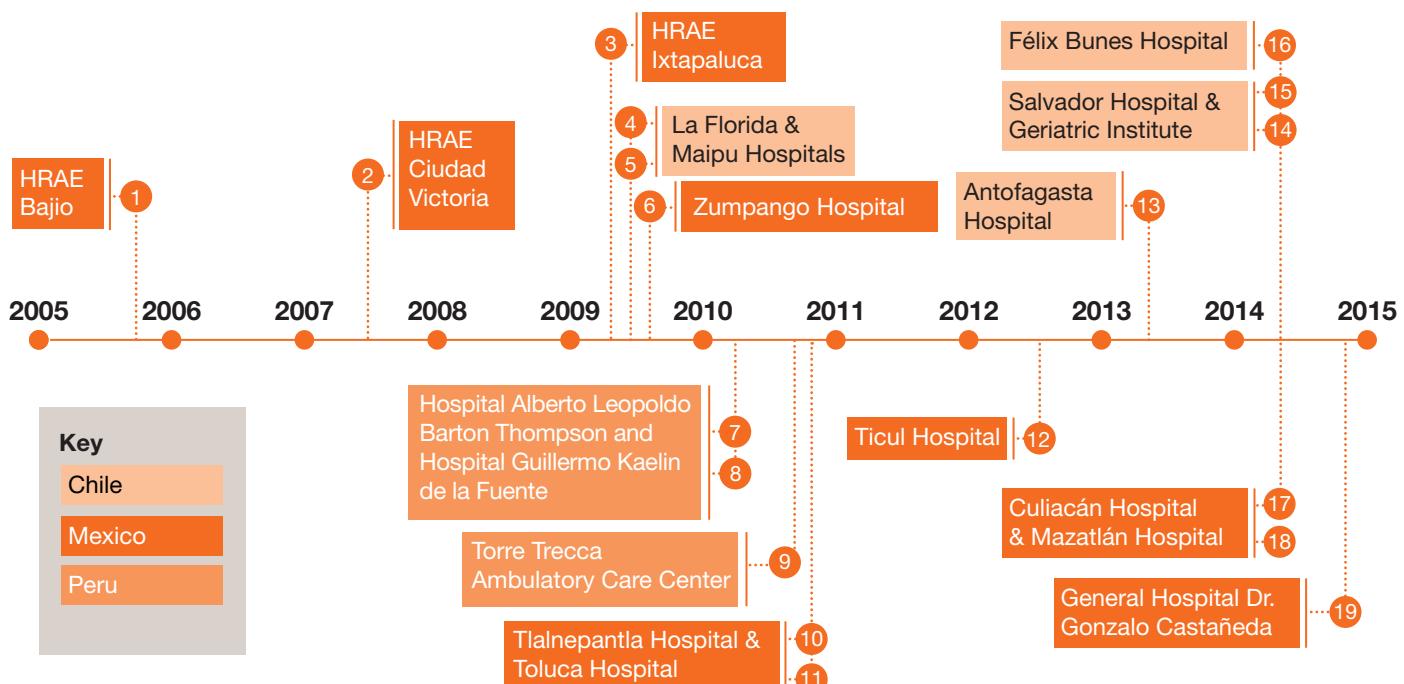
Figure 1: Summary of healthcare PPP market maturity factors



A summary of ratings by country is included in Appendix B.

Source: Economic Intelligence Unit, "Evaluating the environment for public-private partnerships in Latin America and the Caribbean: the 2012 Infrascope," 2012

Figure 2: Healthcare PPP projects tendered to date



As of April 2015, 19 projects had been carried out across these three countries, including the first PPIPs in the region in Peru, which will help Peru to move beyond infrastructure toward population health management (see Figure 2).

Countries with active PPPs

Chile

At the time of research for this report, Chile had committed to a robust PPP strategy to take forward a number of health infrastructure projects. Chile had tendered five PPP hospitals and announced plans to tender an additional nine hospitals in 2014. However, the change in administration in 2014 closed the PPP pipeline for the next four years and the country

withdrew the tenders for seven of the remaining nine hospitals.

Two hospitals—La Florida and Maipú, located in the Santiago metropolitan region—were bundled together and tendered in 2009, comprising Chile's healthcare PPP pilot program. Construction of both hospitals was completed in the last quarter of 2013. The La Florida Hospital was inaugurated in November 2013; the Hospital El Carmen de Maipú was inaugurated a month later. The second project was tendered in late 2012— a replacement hospital in the northern mining region of Antofagasta. The timing between the pilot program and the subsequent tenders allowed the government to incorporate lessons learned from the pilot program into subsequent contracts. Two additional

hospitals—Salvador Hospital and Geriatric Institute and Félix Bunes Hospital—were tendered in early 2014.

As a result of the government's comprehensive and transparent bidding process, each tender announcement received multiple bids, both domestic and international. All six hospital PPPs fall under the traditional DBOT scheme and are of 15 years' duration from the initiation of operations. In addition to infrastructure maintenance, the contracts include nonclinical services such as housekeeping, laundry, security, parking and cafeteria. Replacement hospitals also included change management services to facilitate staff transition.

Table 1: Snapshot of PPP activity in the five focus countries (most recently available data)

Measurement	Countries with healthcare PPPs			Countries to watch	
	Chile	Mexico	Peru	Colombia	Honduras
Economic outlook	GDP (USD)*	\$277.2B	\$1,261.0B	\$202.3B	\$378.4B
	Health expenditure (% of GDP) ²	7.4%	6.1%	5.1%	6.8%
Healthcare access	Hospital beds/1,000**	2.2	1.6	1.5	1.0
	Healthcare coverage	Defined robust benefits package	Universal coverage	Fragmented—35% uninsured	Defined minimum benefits package
PPP activity	Current healthcare PPP projects	2 in operation; 4 in construction	6 in operation; 4 in contracting	2 in operation; 1 on hold	None
	Future outlook	On hold	More projects expected	7 hospitals	2 hospitals

Sources: *CIA The World Factbook, **World Bank

While medical equipment and information technology (IT) were excluded from the pilot program contracts to reduce complexity, Chile has bundled these services into subsequent PPP contracts, starting with the Antofagasta tender. Experience from the pilot program demonstrated that these services were too integral to effective hospital operations to be managed separately.

Mexico

Mexico was the first country in this study to launch healthcare PPP projects, tendering its first pilot program in 2005. It is also the only country in the study to have hospitals with several years of operating experience. The country aggressively implemented PPP projects, tendering 10 PPP projects over the course of 10 years—six of which are currently operating and four that are in the contracting phase. Four of the projects were sponsored at the federal level and six at the state level.

Three of the federal hospital projects, as well as the state hospital of Zumpango, are regional tertiary care hospitals (*hospital regional de alta especialidad—HRAE*); the other six are general hospitals. All of Mexico's projects fall under the traditional DBOT scheme and include medical equipment. Two of the hospitals are also LEED-certified “green hospitals.” All contracts are of 25 years’ duration and include nonclinical services such as housekeeping, laundry, security, parking and cafeteria. Later contracts incorporated additional patient care services such as laboratory, hemodialysis and medical gases; these services are traditionally outsourced to third-party vendors, but were included in the PPP contracts to be managed by the private partner.

Since opening, some of the Mexican PPP hospitals have faced challenges with low occupancy rates, and recruitment and retention of healthcare professionals. A key lesson learned was to better

match healthcare resources with infrastructure expansion.

Peru

Peru is a more recent entrant into the healthcare PPP market but is applying the PPP model in innovative ways, experimenting with different models to meet its growing healthcare needs. Peru is the first country in Latin America to undertake the more ambitious PPIP model and is also the first country to include nonacute care facilities within the scope of a PPP project.

To date, the country has awarded three projects—all at the federal level and carried out by EsSalud, an autonomous, decentralized government agency that provides coverage to the formally employed and retired sector of the population and their families. EsSalud’s unique status allowed it to bypass the country’s formal PPP tender process, though it did consult with the country’s PPP

The Alzira model

The La Ribera hospital and clinics comprised the first PPIP, established in Spain between the Government of Valencia and Ribera Salud Temporary Union of Businesses (UTE-Ribera). The model focuses on a four-pronged approach—public control, public property, public funding and private management. The government provides the private partner a capitated payment per inhabitant and is required to provide a package of clinical services that complies with pre-agreed quality standards.⁷ The third paper of this healthcare public-private partnerships series—*Innovation Rollout: Valencia's experience with public-private integrated partnerships*—provides further details on this model and subsequent variations.

agency, *ProInversión*, throughout the process. Two projects, modeled after the Alzira PPIP model in Spain (see text box—*The Alzira model*), involve the building and operation of new hospitals in the Lima metropolitan region (Hospital Alberto Leopoldo Barton Thompson and Hospital Guillermo Kaelin de la Fuente), each with corresponding primary and urgent care centers. A third project (Torre Trecca in Lima) involves the renovation of an existing abandoned high-rise building into an ambulatory care center.

All three projects follow the DBOD (PPIP) scheme and have adopted an innovative financing model that decouples the risk of construction from that of operations, and minimizes risk to EsSalud by tying payment to specific project milestones. Although the projects were adjudicated in 2010, they faced significant setbacks during a change in administration that occurred within EsSalud in 2011. The two hospital projects were completed

and went into operation in April 2014; however, the ambulatory care center project was still stalled, and as of this publication it is unclear when construction will commence.

Countries to watch

Two additional countries—Colombia and Honduras—were identified through this study as “countries to watch.” Both countries exhibited strong performance in the market maturity assessment and have announced plans to tender healthcare PPPs within the next one-to-two years. Their economic outlooks and levels of national healthcare access point to ripe environments to explore partnerships between the government and private entities.

Overall lessons learned

Although many of the healthcare PPP projects in Latin America outside of Mexico are still in their infancy, several overall lessons have emerged from these early experiences, particularly around project design, project management, aligned incentives and communications.

Project design

Transparency boosts public perception and private sector confidence

In all five countries studied, transparency stood out as a key component of PPP legislation. In Chile, Honduras and Peru, information on all PPP projects, including tender announcements, contracts and progress reports, can be easily found on a public website.

Transparency is a critical requirement for PPP projects, as it helps to assure the public that their tax dollars are being well spent. This is particularly important for healthcare PPP projects, which can be highly politicized.

Transparency also boosts private sector confidence and encourages participation. Responding to public bids is an expensive endeavor; in most cases, private sector partners will only consider making an investment if they are assured that the tender process is fair and free of corruption. This can be an important hurdle to overcome, especially for low- and middle-income countries whose economies are less than stable. Greater private sector participation also leads to increased competition and the potential for higher-quality and more cost-efficient bids.

Pilot programs allow for fine-tuning of PPP contracts

Healthcare PPP contracts are complex and challenging to implement, especially for the first time in a country. Pilot programs allow countries to experiment and gain experience with PPP structures and determine the best model to meet their needs before embarking on

more complex arrangements or more widespread adoption.

Chile and Mexico each employed different approaches to healthcare PPP pilots. Chile started with a pilot program comprised of two general acute care hospitals bundled together as one contract. Mexico, on the other hand, planned to tender eight tertiary care facilities in various regions across the country. Due to limited resources, only three were ultimately tendered.

While both countries incorporated lessons learned into subsequent contracts, each did so at different rates. For instance, Chile was able to address several of the challenges faced with the hospitals of La Florida and Maipu, particularly around IT and medical equipment, in its second PPP contract. Mexico had to wait to incorporate many changes, as the subsequent tender processes were already too far underway: contract changes around medical equipment did not occur until the third and fourth projects were tendered.

Figure 3: Summary of overall lessons learned

Project design	Project management	Aligned incentives	Communications
<ul style="list-style-type: none">Transparency boosts public perception and private sector confidencePilot programs allow for fine-tuning of PPP contractsSocial need and availability of resources should drive project design decisions	<ul style="list-style-type: none">Knowledgeable and skilled supervisors are critical to project successEngage hospital management as early in the process as possibleChange management and capacity building should be incorporated into the process	<ul style="list-style-type: none">Risk transfer of medical equipment and IT must be properly managedPayment mechanisms should balance operating and financial riskFinancial incentives based on performance metrics can drive outstanding performance	<ul style="list-style-type: none">Maintain an open dialogue when managing contract termsKnowledge sharing mechanisms across the region should be formalized

Social need and availability of resources should drive project design decisions

Design decisions such as size, location and facility type should be driven not only by social need but also by availability of healthcare resources to staff and operate a facility, as this ultimately impacts a project's success or failure. Chile and Peru set up their pilot programs for success by starting with general acute care hospitals in attractive, well-established cities. In contrast, Mexico's initial projects involved tertiary facilities located outside of the capital region, where social need was high but availability of resources was low. Consequently, these hospitals have struggled with physician recruitment and low occupancy rates during their initial years of operation.

Healthcare PPP projects are inherently risky to both the government entity and private partner. It is critical that governments clearly define their project goals and carefully evaluate their available resources and healthcare network interdependencies prior to embarking on a PPP path. Although PPP legislation outlined prerequisite analyses such as cost-benefit, social impact, financial effectiveness and value for money, these studies were not always completed with the required level of rigor—and in some cases were susceptible to political influence.

Project management

Knowledgeable and skilled supervisors are critical to project success

Supervision and monitoring, during both construction and operation phases, ensure that PPP projects adhere to contract terms. Given the complexity of PPP contract terms and the uniqueness of the healthcare sector, the individuals or organizations charged with supervision and monitoring should be highly skilled professionals with specific healthcare experience, in order to assure all parties that monitoring is fair and accurate.

Jointly selecting supervisors and addressing conflicts of interest caused by method of payment are critical factors to be addressed during tender design. As PPP projects become more widespread, it will also be important for countries to invest in developing a robust pool of well-trained supervisors to provide appropriate and independent oversight.

Engage hospital management as early in the process as possible

Early engagement of hospital management enables a smoother transition from construction to operations. Key benefits include:

1. Management understands the contract details, roles and responsibilities prior to kick-off of hospital operations;
2. Management is able to provide end-user input on hospital design decisions up front;

3. Engagement allows development of working relationships with the private partner; and

4. Engagement helps to create buy-in and investment in the ultimate success of the PPP project.

For example, Mexico engaged multidisciplinary teams at the beginning of its projects, which gave the management team time to fully prepare for operations. Chile's approach of engaging hospital management in the final stages of construction contributed to a four-month delay in the opening of La Florida and Maipu hospitals.

Change management and capacity building should be incorporated into the process

Under PPP arrangements, hospital management teams must shift from an “owner’s” mentality (where they make all key decisions related to hospital infrastructure and nonclinical operations) to a “renter’s” mentality (where they report issues to the private partner, who is then responsible for resolving them in accordance with contract terms). Most hospital management teams have not had exposure to this style of management and could benefit from training and capacity building. Chile was the only country within the scope of this study to incorporate change management into its PPP contracts, starting with the Antofagasta tender. Since the Antofagasta project is still in the construction phase, it is too soon to know whether this will provide significant benefits to workers and management teams; however, it is a start.

Aligned incentives

Risk transfer of medical equipment and IT must be properly managed

One of the most important lessons learned from the experience in Latin America was that medical equipment and IT should be bundled into the PPP contracts for the life of the contract. Although this transitions additional risk and consequently increases cost, the inherent interdependencies between infrastructure, IT and equipment outweigh the minimal gains of excluding both from the contract. This transition of risk must be closely managed and the roles and responsibilities of both parties clearly delineated in the contract. Medical equipment and IT fall into a grey area where the distinction between clinical and nonclinical services is blurred. It is important that both parties have an active role in the procurement and management process, and that they maintain an open dialogue throughout.

Chile and Mexico both faced challenges related to medical equipment and IT during their pilot programs and made adjustments to future contracts based on these early experiences. Chile excluded both IT and equipment altogether from its initial PPP contract, and subsequently had to procure IT and medical equipment via a parallel tender process. The government thus faced managing two contracts with two different partners, as well as managing the relationship between both entities due to the inherent interdependencies between infrastructure, IT and medical

equipment. In the case of Mexico, early contracts included medical equipment and IT for a limited amount of time. The contract terms were unclear, and the private partner and government found themselves at odds over the type and quality of equipment, not only during the procurement phase, but also during the transition of responsibility from the private partner to the government.

Payment mechanisms should balance operating and financial risk

The PPP projects assessed during this study employ a wide range of approaches to balance operating and financial risk. Both Chile and Peru separate payments for construction from those of operations, whereas Mexico bundles both together in one payment. In the case of Chile and Peru, when the lower risk of construction is separated from the higher risk of operations, private partners are able to obtain financing at more favorable rates. This was particularly important for Peru where clinical services were included within the scope of the PPIP contract. Mexico transferred full risk to the private partner, since poor performance during operations can impact payments related to construction.

There are pros and cons to both methods of financing and contracting; governments will need to weigh the benefits of additional risk transfer with that of increased cost. If governments choose to limit risk transfer, they will need to build strong financial incentives and penalties

into the contract to ensure high-quality performance during the operations phase.

Financial incentives based on performance metrics can drive outstanding performance

Financial incentives can be used to drive performance results that go beyond contract compliance. For example, Chile offers incentives to private partners for procuring medical equipment at prices below budget, and Peru incorporates patient satisfaction as part of its performance bonuses. Contracting government agencies should take into consideration their desired outcomes for the PPP contract and build incentives based on performance metrics that reward private partners for achieving and exceeding these goals.

Communications

Maintain an open dialogue when managing contract terms

While defined contract terms and conditions are imperative to a PPP contract's success, open lines of communications are equally important to resolve common issues unforeseen at the time of contracting. These may be operations-related, or derive from changing technology, evolving medical practices and/or epidemiologic shifts.

Contract changes are often difficult and time-consuming to implement as they require several levels of approval. Flexibility and an open dialogue help address concerns in a more timely fashion. Management of PPP

contracts should focus on obtaining optimal results for both parties and not on imposing penalties or deductions in payment. For example, during the first year of operations, the Zumpango Hospital's public and private partner management teams struggled to find a way to effectively work together. Initially, the government team reported all issues directly to the contract supervisor, rather than first alerting the private partner. This proved to be ineffective in dealing with minor issues that could have been easily resolved without such escalation.

The government and private partner management teams therefore began to hold regular meetings to discuss and address ongoing concerns. By working collaboratively, both public and private partners will be able to achieve the ultimate goal of the PPP project—to provide increased access and high-quality care to patients.

Knowledge sharing mechanisms across the region should be formalized

Lessons from early PPP experiences in Latin America will continue to emerge as additional hospitals begin operations. New and existing players in the region could benefit from formal exchanges on PPP project successes and challenges. Although this is done on a global scale for healthcare PPPs by organizations such as the World Bank and for general PPPs in Latin America by the Interamerican Development Bank, there is currently no forum for discussion of healthcare PPPs in Latin America.

Given the size of the region, the unique nature of healthcare projects compared to other construction projects and regional similarities in demographics and health system structure, formalizing knowledge sharing could enable strong business and operating models to emerge as leading practices for the region.

Conclusion

Latin America is still a relatively new market for healthcare PPPs, but holds a promising future for innovation in public and private partnerships. Of the seventeen countries studied, three have carried out PPP projects and an additional two are identified as “countries to watch.” As of April 2015, 19 hospital PPPs have been tendered and there are over ten additional healthcare projects in the pipeline across four of the five countries.

The decision to pursue a traditional PPP or a PPIP is highly dependent on political support. PPIPs are an interesting option for Latin American countries that are seeking to expand infrastructure, yet struggle with scarcity of healthcare professionals. The inclusion of clinical services, however, increases the risk, and therefore price, which public entities need to consider in their risk/reward calculations. The region’s first PPIP projects in Peru are now in operation and their success could pave the way for additional projects under this scheme.

The catalyst for continued growth across the region lies in a combination of the economic and political environment, healthcare reform and private companies’ appetite to participate in social infrastructure programs. Further research should be conducted once nascent projects have had a chance to operate and generate lessons and insights around PPP and PPIP implementation.

About the Global Health Group

The Global Health Group at the University of California, San Francisco (UCSF), Global Health Sciences is an “action tank” dedicated to translating major new paradigms and approaches into large-scale action to positively impact the lives of millions of people. The Global Health Group works across a spectrum, from research and analysis, through policy formulation and consensus building, to catalyzing large-scale implementation of programs in collaborating low-and middle-income countries.

One of the Global Health Group’s programmatic focus areas is the role of the private sector in strengthening health systems. The Group studies a variety of innovative delivery platforms that utilize the strengths of the private sector to achieve public health goals. The Global Health Group has identified public-private partnerships (PPPs) in general, and public-private integrated partnerships (PPIPs) in particular, as promising models to improve health systems globally, including in developing countries.

For more information, visit: www.globalhealthsciences.ucsf.edu/global-health-group.

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