Public-Private Partnerships in Spanish Health Care System- Lessons for Romania

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Abstract*: In the modern Providence - States, the health became one of major public mechanism , which has leaded to an important rise of public expenditure health -care system. Universal access, high product quality and financial sustainability are key objectives of government health policy in all OECD countries. The funding of health care is one of the greatest challenges facing governments today. This paper addresses issues of public-private partnership in healthcare services, trying to present the example of Spanish regions which have introduced a participation of private capital in healthcare system. This example could be a lesson for Romania , taking into consideration the stipulated decentralization and possible privatization of the healthcare sector.*

Although public-private partnerships have been effective when used in some sectors, the challenges of implementing these forms of collaboration have been greatest when affecting services linked to social or territorial solidarity. Liberalization of the activities that used to be provided as public services does not seem to justify the giving up of the value that public service represents. The introduction of market mechanisms must have as final objective the improvement of the efficiency of the system to the benefit of consumers and users of the public services.

Keywords: *public-private partnerships, private finance initiative, design-finance- operate model, contracting, outsourcing mechanisms,administrative concession*

1. Introduction

The financial sustainability of largely funded health care is a prime concern for policymakers in the EU countries. In addition, the new member states face a different challenge of improving the efficiency and accessibility of their health care system. Most countries try to maintain the financial sustainability of their system by adjusting supply and introducing more market forces[1]in this sector.

The redesigning of administrative structures is in accordance with the principles of the New Public Management in most of the countries of the OECD since the 80's. Nevertheless, in the case of Spain this process reaches its maximum width since the following decade. The participation of private capital in healthcare was not a novelty. In fact, the State civil servants have the possibility to receive medical attention from private companies, and almost all the Spanish regions cover the insufficiency of the public system via collaborations with the private sector. In this sense it can be said that the process of reform of the healthcare sector depends more on the political will of the regional governments since the very moment they begin to receive this competence from the Central government. What is new is that the regional governments of Valencia and Madrid began to introduce, around the end of the 90's (since 2001, in the case of Madrid) liberalization mechanisms and create internal quasi-markets incorporating private actors as providers of health services. These reforms coincide with the neoliberal paradigm being in force (which are reflected in the recommendations of

[1] Social and Cultural Planning Office of the Netherlands – Public Sector Performance – An International Comparison ,SCP publication, Hague, October 2004

international organizations such as the OECD and the WHO) and the concern for the increase of healthcare expenditure and for the quality of public healthcare services, in particular due to the existence of long waiting lists. Thus, the essential principles on which the policy of reform is based are: freedom of choice for the patient, the introduction of competition mechanisms between the service providing institutions and the dissemination of assessment tools.

Influenced by the first regions that assumed all responsibility in healthcare, the new model is adopted in the rest of Spanish regions. The first initiatives of the governments of Catalonia and Andalusia, which consist in achieving more flexible organization, outsourcing in public hospitals or the creation of hospitals with mixed capital are points of reference for other regional governments, including the government of Madrid. The regional Parliament approved the Law for Healthcare Organization in 2001, which creates a healthcare sector model based on agencies as more flexible formulas of organization; it clearly distinguishes administrative functions and the provision of services from assisting functions via instruments for regulating competition between the different actors in the system. A unique healthcare sector is configured, which groups all the actors together – public and private; and favors the principle of free choice of a doctor, hospital and services on behalf of the patient via the signing of "programe-contracts" and outsourcing mechanisms. All new criticism towards this new model were concentrated at first in its determined decision for the liberalization and the introduction of competition mechanisms and the inclusion of private operators in the healthcare network, which have a contract with the regional government for the offering of these services.

In the implementation of this policy of reform there are several factors of influence: on the one hand, the ideological preferences of a conservative government, which is in power for several legislatures consecutively; on the other hand, the favorable international environment for the introduction of reforms, which pressure to improve the efficiency of the administrations and to reduce public deficit; and finally, due to the possibility to make more visible the reforms before the general public, conscious of the serious problem of the waiting lists, which are supposed to be alleviated by the incorporation of the private sector to the healthcare system and giving a leading role to the patient in the election of a hospital of his choice.

The budget limitations imposed by the Treaty of the European Union to the Member-States as conditions for the creation of the single currency a (public expenditure less than 3% of the GDP neither a public debt superior to 60% of the GDP) do not regard as public debt the contracted by public companies managed under private law (even though they are publicly financed, as is the case with healthcare foundations in Spain) or for services contracted by the public system with private enterprises. In consequence of all this, the private sector in Madrid has experienced a spectacular growth in the Madrid region. In the context of restriction of public expenditure public healthcare services end up turning to the private sector for new investments or for the building of new centers and are transformed into public enterprises that use private management. To facilitate these operations, governments have opted in the first phase for the separation between financing and service providing, the substitution of public management of healthcare centers to private management based on the managerial model (increasing the autonomy of each center and introducing management incentives), and for favoring the private presence in the supplying of services financed by the public budget via the public-private partnerships, outsourcing and the turning to private capital for the construction and management of new hospitals.

2. The implementation results of the public-private partnerships in Spanish healthcare sector

As the decision depends on the regional governments we cannot speak about a single healthcare system in Spain. There are great differences between the regions in terms of the healthcare services and the essential healthcare indicators (medical doctors, beds and healthcare expenditure per citizen, remuneration of the personnel, career models...). These differences can sometimes been explained by common problems derived from insufficient financing or their differing funding

capacity depending on the wealth of each region, but the choice of one management model over another depends in principle on the different ideological visions of each government. Thus, it can be seen in table 1 that not all Spanish regions spend the same amount of resources for their healthcare system, and that the waiting lists are not a direct consequence of the amount of public expenditure, from which it can be concluded that these results could only be explained through the combination with other factors of demographic and organizational nature. Nevertheless, in Valencia and Madrid, the regions with the largest private participation in the healthcare sector via direct management, the data concerning the waiting lists are more favorable than in the rest of the regions. Indeed, these are two of the regions with the least healthcare cost per capita, which perfectly coincides with the regions which have opted for the private investment in the management and for construction of hospitals through the "private finance initiative" (PFI) model.

Public expenditure in health care and waiting lists

Table 1

Regions	Public expenditure per inhabitant (in euros)	Waiting lists (in days)
La Rioja	1555.57	29
Cantabria	1471.59	98
Extremadura	1349.44	62
Basque Country	1342.27	47
Navarre	1339.48	63
Aragon	1282.22	70
Castile-La Manche	1249.31	45
Asturias	1235.03	61
Galicia	1224.19	99
Canaries	1212.02	104
Murcia	1176.37	55
Castile and Leon	1160.11	61
Catalonia	1136.00	138
Madrid	1093.68	42
Andalusia	1089.25	61
Balearics	1087.51	51
Valencia	1050.68	31

Source: for public expenditure: Autonomous Communities and Ministry of Health 2007; for the waiting lists: Ministry of Health 2007.

Broadly speaking, there are two kinds of traditional management: those based on public law (public hospitals without independent management; institutional agencies with independent management but without patrimony or own legal personality; and independent administrative organisms with legal personality, own budget and independent management), and those based on private law (public or private non-profit foundations; public companies which deliver public services; and consortiums with civil servants or non-permanent staff). However, the model of the Madrid region is based fundamentally on two models of indirect management: the contracting of private enterprises which receive an administrative concession from the administration in order to manage healthcare services with their own personnel and to outsource secondary activities (cleaning, cafeteria, informatics,...); and the administrative concessions with private management, where the new hospitals are managed by a private consortium that accepts responsibility for the healthcare of a defined population in return for an annual per capita payment. This model of partnership remains highly contentious compared with the traditional delivery models.

In particular, this last technique, known as "private finance initiative" (PFI) has been promoted in the European countries for investments in infrastructures in the healthcare sector and outside of it and in spite of the fact that they have their origin in the United Kingdom for the construction and renovation of hospitals, in Spain this is a novelty. With this formula private enterprises, mainly insurance companies, banks and construction companies finance by their own resources and debt the construction of hospitals for the public healthcare system. These private consortiums construct the infrastructures, install their equipment and maintain the buildings. Besides, the successful contractor can manage and outsource the non-clinical services of the hospital: cleaning, catering, security, logistics, restaurants, clerical tasks, etc. The public administration, on its behalf, pays an annual payment to the enterprises for the use of the hospitals during a limited period of time, typically 30 years. This is a design, build, finance and operate model that has been the primary means of financing major capital investments in the health sector by the region of Madrid. As we can see in the table 2, low levels of public expenditure in the health sector enable the government of the region to remain within targets set for public sector borrowing.

The World Health Organization published a report on privately financed hospitals (McKee et al., 2006). In it the authors are questioning the quality, the facilities suitableness to the new services and their cost. In theory, as we can see in the expenditure index in table 2, the PFI model should contain the cost to the health authority by transferring the risk to the contractors, but in practice the cost of borrowing money is higher than it could be for governments. As consequence in some cases the total cost of constructing these hospitals is much superior to the cost they would have had if they had been constructed publicly. In spite of the fact that this is a method that intends to favor competition in the offering of healthcare services, it seems that a relatively small number of companies are capable of undertaking very large projects and the bidding costs can pose a significant barrier to market entry, what can lead to lack of transparency in these projects. Besides, the dominance of the principal-agent, contractual model of the relationship between regulator and regulatee, coupled with the threat of sanctions, tends towards the production of low-trust compliance rather than a committed engagement with the modernization process. Of course, we have to sum up to this factor the contractors' profit and the possible cases of financial bankruptcy, which ends up remedied by the public administration in order to maintain the supply of services. In fact, The Alzira hospital, opened in the region of Valencia in 1999, achieved high levels on standard measures of performance but was afflicted by finance problems in 2003. The contract was financially unsustainable and in 2003[2] a refinancing deal was arranged providing a substantial financial injection: the regional government gave the contractor 69 million euros as indemnisation for the interruption of the concession, the funding per patient was raised to 379 euros (68% more) and ways were being thought of to make sufficient profit to return to the stakeholders. In particular, it is allowed that a hospital pays additional amounts for patients coming from areas different from the ones where it corresponds them to receive healthcare services. The political opposition accuses the government of Valencia of disregarding the nearby hospitals in order to enhance the choice of the users of the Alzira hospital, while the unions are complaining of the excessive workload and the lack of personnel. Disregarding the truth quality of these statements, it is obvious that the number of births in the whole region of Valencia between 1999 and 2000 was 2.4%, while in the Alzira hospital the increase was of 37% and of 126% for the whole period of its first six years functioning.

Regarding to the region of Madrid, in 2000 all the citizens received health services in the public sector provided by public hospitals, while in 2003, 25% of the whole population (1.500.000 inhabitants)[3] were received in the public sector by eight new hospitals built via the PFI system, one of which is completely private and seven have mixed management where the doctors and nurses are paid

[2] According to the economic newspaper "Cinco Días" the loses were one million euros in the first year of operating; 900.000 in 2000; 450.000 in 2001 and 2.61 millions in 2002.

[3] The region of Madrid has experienced a strong increase of population in recent years due to the arrival of immigrant people. It passes from 5.145.325 inhabitants in 1999 to 6.008.183 in 2005 (growth of 16,76% compared to the growth of 11,12% for the country as a whole).

by the regional government. For all these reasons critics say that "the cost of annual charges for buildings constructed under public-private partnership arrangements may be higher than the cost associated with hospitals built and run using conventional procurement methods. Pollock et al. (1997) suggested making reference to the United Kingdom case that "privately financed initiatives are significantly more expensive than the conventional government funded arrangements for a variety of reasons".

But then, ¿what makes governments decide in favor of this form of partnership? In short-term perspective governments can build hospitals without these investments be regarded as public debt, transferring this expenditure to 30 years in the future. Politically it turns out profitable to build hospitals in little time, in spite of the fact that the annual payment to these companies end up constituting a major part of the public budget for years to come. Moreover, the long periods of administrative concession limit the ability of the hospitals to adapt themselves to rapid changes in the health-care environment. These kinds of contracts could limit considerably the possibility of facing the changes in the technologies applied in medicine and the needs of the population, which in turn supposes changes in the size of the services, the equipment, the number of beds and the overall condition of the health-care service. McKee et al. (2006) say that the "quest to minimize the risk to which the parties to public-private contracts are exposed has meant that the contracts are often specified in very great detail, with large penalties for introducing changes". This lack of flexibility is not exclusive to the public-private partnerships, but the rigidity of contracts makes the solutions to problems more complex and can get difficult to adapt the institutions to unstable or changeable environments.

Other additional problems with these public-private partnerships in the health-care sector have to do with the lack of transparency of the whole system and the quality of the services. The PFI system may hide information since it is the private companies that manage the providing of the service. Public authorities may remain cautious with private operators: they must proceed to economically save bankrupt hospitals (as in the Valencia case) rather than leave great part of the population without medical assistance, and in case they decide to interrupt the concession, they must reimburse the contractors for the damages caused and for the foreseen benefits, which makes it difficult to assume for the public budget to accept a decision of this sort, no matter how convenient it could be for the overall system.

The choice of the PFI model has obliged the political authorities to justify their decision which shows to the public "quick wins" like the reduction of the waiting lists. There was a continued focus on pursuing performance and on the search for business solutions to social and public policy problems. For the regional government, the decision to privatize the management comes not from economic concerns, but from ideological principles. According to the government, it is difficult to overcome the inertias when the services are managed by the administration with its civil servants, and to reach quality standards typical of the private sector. However, it turns out difficult to evaluate the PFI model from the point of view of the quality of the services. It is true that some indicators (customer service, catering, waiting lists) have undergone observable improvements, but the flow of government policies have continued to exert considerable pressure towards a focus on making profitable business rather than on the creation of performance measures based on accessible and ready-made indicators. Los results of table 2 show the level of quality of the different regional systems. The first column shows the opinion of the users expressed in a scale from 1 to 10; the second shows an index which is the resulting sum of 17 variables. Each of the variables used has a minimal punctuation of 1, thus the maximum points a region can obtain is 17.

Quality of the public health sector

Table 2

Regions	Users' opinion on Global quality (from 1 to 10)	Quality survey (minimal mark is 17)
La Rioja	6.97	23
Cantabria	6.70	38
Extremadura	8.19	31
Basque Country	6.83	34
Navarre	6.59	29
Aragon	6.72	40
Castile-La Manche	6.29	31
Asturias	7.35	38
Galicia	5.52	27
Canaries	5.42	20
Murcia	6.27	18
Castile and Leon	6.40	22
Catalonia	6.18	34
Madrid	6.29	21
Andalusia	6.07	31
Balearics	8.19	24
Valencia	6.18	28
Average	6.59	29.76

Source: for the users' opinion: Health Barometer 2007; for the quality survey:
Federación de Asociaciones para la Defensa de la Sanidad Pública (FADSP), 2007.

From consulting the opinion of the users of public services and the meticulous global study of quality it becomes evident that the health-care system in Madrid region, characterized by widespread penetration of the private sector via the described collaboration formula is not positively perceived by the population, and it is situated in both classifications under the national average. It is also easily observed the contrast between the results of both quality surveys and the differences between the basic indicators of the different regional health-care systems (about the offer of basic services, the proportion of professionals per citizen, the access to medical examinations etc.). In any case, it seems the debate about the quality of health-care services has been based more on ideological principles than in the analysis of rigorous assessments with commonly accepted methods.

3. Conclusions and lesson for Romania

The achievement of the public action coherence constitute sone of the major preocupation of the public management. This necessity of public action coherence is felt either în the countries where healthcare services are delivered by governments, also in the countries like U.S.A, where the delivery of healthcare services is the result, in great partie, of the private agents. The actual debates regarding to the healthcare system reform from EU countries and U.S.A, suggest us three possibilities of relization, such as:

- Reform coordination by the private market
- Reform coordination based on hierarchie
- Reform coordination by the decentralization to regional level.

The changes undergone under the public-private partnerships formula that we have seen here are only acceptable if they do not imply the giving up of the achievements of the Social State. It would be a considerable backward movement that the competence incentive does not guarantee citizens, as final consumers of these activities a better level of delivery in terms of quality and price.

Apart from a reduction of the role of the State, the case analyzed shows us new ways of establishing the relations between the public administrations and the private sector. This conception of governance doubtlessly offers opportunities for symbiosis, alliances and negotiation, but can also be a source of conflict in the unstable context of administrative modernization and it is charged with conflicting values and ideologies. In all the cases seen above, the private sector plays a leading role in the production of services, while public authorities seem to tend to situate themselves in a favorable position to engage as actors and draw them into the government's agenda. Only this leadership position in the management of essential services could compensate the dispersion of the power of the State, which is the result of the collapse of the old bureaucratic hierarchies. The turning to the public-private partnerships can relegate the State in a secondary position for the delivering of the public policies in favor of private operators or, on the contrary, these partnerships can be instruments that end up guaranteeing a strengthened position for the public authorities in the shared production of essential services. In any case, as the case analyzed here shows, the public-private partnerships do not guarantee neither quality of the services, neither solidarity in the system as a whole. Only a strengthened position of the State in the heart of these essential services can be a guarantee in this sense.

In Romania, The Law regarding the hospitals was one of the controversial of package law of the healthcare- economic stake focusing on political customers. That's why, the hospitals are responsible for about 20% of population health condition, in exchange its spend about 70% of healthcare budget. It is easy to understand that for the 420 Romanian hospitals have been invented over night very short training on management and have been taken out on the rolling tape hundreds of incompetent managers, but who had to be rewarded and were direct subordinated to the Health Ministry by the new law, since 2 years and half. That's why the National Pact for the Health have to contain compulsory a strategy for the health sector decentralization (regarding preeminently to the hospitals), an administrative and financial decentralization (not methodological one) Local authorities are able to understand better the basic needs of health care of the owns communities and could give more attention for personalized care. Local authorities have a better possibility to facilitate the inter-sectorial cooperation, which is crucial to the humane dimension improvement and primary prevention services efficiency and pre- and post hospitalization services which are under-represented in the actual health system, which is centralized, birocratic and focused on the hospital.

Local public authorities could offer basic health care packages for the disadvantageous persons. The primary assistance for the disadvantageous persons needs an intersectorial approach and the local public authority represents the most adequately level to integrate the health assistance with social one for the disadvantageous persons, its represents the most adequately level to integrate financing for basic health services, social benefices and social assistance services. Local public authorities can offer a large scale of focused services (for example, through social-medical organizations, residence care) for different segment of poor population.

In addition, due of unperforment management and waste of resources utilization which didn't lead to remarkable outcomes as the result of very discussant reform of the health system , in the next years , the introduction of private management in public hospitals or the public financing of private hospitals could be possible alternative for the improvement of health services quality.

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