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Developing sustainable healthcare governance mechanisms to manage public-private partnerships

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Background: Despite a growing body of research literature focused on public-private partnerships (PPPs) in healthcare, some critical issues still seem to be insufficiently investigated, especially due to the frequent lack of clarity in defining the goals for healthcare management and to an oversimplified framework for analysing PPPs. Resolving conflicts of interest between diverse PPP stakeholders in healthcare requires special attention. Effective solutions in this area are not well known in Central and Eastern Europe countries, which are trying to modernise their healthcare systems.

Aims: The purpose of this article is threefold. Firstly, it is to establish an appropriate understanding of healthcare sustainability, currently understood as the ultimate goal for healthcare management. Secondly, it is to shift the context for analysing the performance of PPPs from a purely financial to a wider and well-framed one, comprising the pillars of healthcare sustainability. Thirdly, it is to identify the governance mechanisms intended to improve the impact of PPPs on healthcare sustainability.

Methods: The methods employed include a broad conceptual analysis of the international literature as well as external online desk research of the materials published by PPP consortia, financial institutions and public authorities engaged in managing PPPs for healthcare in Europe.

Results: Healthcare sustainability is a complex, multifaceted and multi-pillar problem. PPPs can enhance, or damage, all healthcare sustainability pillars due to a complex conflict of interest between the parties involved. Embedding certain governance mechanisms in PPP contracting and management is necessary to foster both financial and non-financial sustainability in healthcare provided via PPPs. Some countries and some PPPs have managed to develop suitable mechanisms to govern the conflicting goals in healthcare management.

Conclusions: The mechanisms governing PPPs can be programmed as sustainability drivers to improve the resilience of healthcare to the benefit of all stakeholder groups, including capital providers, society and the government. The experiences of PPPs in healthcare operating in the European context may inspire an appropriate design of the PPP framework and PPP contracts.

Keywords: healthcare project management, healthcare stakeholders, healthcare durability

1. Introduction

During the last decades, there has been a sharp rise, predominantly in Europe, in PPPs delivering healthcare infrastructure and facility management. However, although the increase in the number and scope of PPPs for healthcare is mirrored by an increasing number of publications, some important questions remain unanswered. One

compelling issue is the number of tensions between the goals and conflicts of interest between diverse stakeholders. Approaching the issue requires understanding of a problem, which is at stake. Discussion on the benefits of PPPs is atomized and not enough attention is paid to the benefits for the healthcare itself since the focus on PPPs' performance is usually very narrow. This paper discusses PPPs for healthcare, shifting the context for the analysis of PPPs' performance from purely financial to a wider and well-framed one comprising healthcare sustainability pillars. This allows escaping overreliance on financial metrics such as e.g. value for money in the evaluation of PPPs for healthcare, which may produce imbalanced results

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for different types of the stakeholders involved. Another important underinvestigated issue is how the partners' goals conflict or are mutually reinforced, thus affecting the project outcomes. The purpose-based framework is adopted to analyse how PPPs may affect the financial and social pillars of healthcare sustainability pillars. The governance mechanisms in PPPs for healthcare are then examined to identify best practices to support PPPs for healthcare sustainability. The examples of best practices provided in the paper include legal and institutional frameworks as well as specific PPP projects.

2. Sustainability in healthcare

The desirable healthcare system is often referred to as “sustainable”, and “sustainability” is contemporarily the key word to describe the goal of reforms, policies and innovations in healthcare management (e.g. ESG, 2015). The review of the literature shows three main trends in which “sustainability in healthcare” is defined.

The first trend is strictly connected with the classic definition of “sustainable development” provided in the Brundtland Report (UN, 1987), which states that sustainable development is the “development which meets the needs of the present without compromising the ability of future generations to meet their own needs”. It is generally accepted that sustainable development requires convergence between the three pillars: economic development, social equity and environmental protection. For this reason, the studies by Capolongo et al. (2015) or Boone (2012) and many others examine **healthcare sustainability** in the context of **balancing three goals: natural environment conservation, social responsibility and economic efficiency**. The goals are explicit for healthcare since the social outcomes (health) are the priority, the healthcare environmental footprint is heavier than that of many other industries (Rodriguez-Mozaz et al. 2015), and healthcare financial efficiency gains extraordinary attention in the times of budgetary constraints. Some studies reduce the problem of sustainable healthcare management to sustainable healthcare infrastructure management, that is an appropriate

design and construction of hospitals, which ensures a balance between the three pillars mentioned above (e.g. Phiri, Chen 2014, Buffoli et al. 2015).

The described strand of healthcare management literature is definitely underpinned not only by the Brundtland report, but also by a vast body of literature on corporate sustainability. The literature provides a set of significant advancements in the analysis of sustainability on the micro-scale (organisations), including: well-developed terminology, expanded theoretical frames (the stakeholder theory, corporate governance, corporate social responsibility and risk management) and well-tested tools and procedures (e.g. life cycle assessment, sustainability reporting, social and environmental accounting, balanced scorecard, etc.).

Nevertheless, despite its incontestable achievements, the advancements in organisational sustainability literature are not massively translated into **healthcare management literature**, and the representatives of the former trend remain relatively rare.

In the healthcare management literature, the concept of “healthcare sustainability” has been developed based on the specificity of the sector, which is characterised by a strong requirement for the certainty of healthcare provision rather than on the general prerequisites for sustainability. The well-developed strand of the healthcare management literature defines “sustainability in healthcare” as continuation (durability) of programmes or innovations introduced into the system (Pluye et al. 2004; Stirman et al. 2012; Proctor et al. 2015). In this context, **sustainability in healthcare is understood as persistence, routinisation, survival and viability**. Importantly, such an understanding of “healthcare sustainability” coincides to some extent with the classic definition of sustainable development. Since there is a need to protect the interests of the future generations, the viability of healthcare provision in the long term is crucial.

The studies examined by Pluye et al. (2004) and Stirman et al. (2012) analyse a wide range of factors which affect healthcare sustainability (understood as viability, persistence) including leadership, social structures, governance, stakeholder engagement, staff, policies, etc. However,

there is a noticeable separate strand in the literature which concentrates almost solely on the financial aspects of healthcare sustainability, whereas other factors are neglected as practically irrelevant in that regard (Kaplan and Porter 2011; Maarse et al. 2013, Bauzon 2015). In this research avenue, the term **“healthcare sustainability” is used interchangeably with “healthcare financial sustainability”**.

It has been noticed that problems with funding contribute most to de-adoption of programmes and innovations in healthcare (Marty et al. 2008). This explains the focus on financial conditions to ensure healthcare sustainability. Contemporarily, the problem of financial sustainability of healthcare occurs on the macro-scale, also because of the 2008+ crisis which generated financial austerity. The ageing populations, the shift in morbidity patterns towards chronic diseases, expensive technologies, the increasing demands and expectations all increase the costs of healthcare and create political concerns (Borgonovi and Compagni 2013; OECD 2010). Considering the fact that healthcare can be financed by the government or privately (via insurance or out-of-pocket payments), the problem of financial sustainability of healthcare is multifaceted, and tensions between the facets are apparent.

The first facet of healthcare financial sustainability (and the first perspective) is connected with the crowding-out effect. The healthcare financing mechanism is described as unsustainable when it is unable to deliver universal publicly funded healthcare services without compromising other government programmes (CMA 2010). The use of the term “unsustainable” is justified because population ageing will reduce the tax base, and the expected growth in expenditures will defy manageable tax rates and increase government debt loads, with the health spending already outpacing economic growth (OECD 2015). Therefore, it could lead to adverse redistribution among the present generations as well as among the present and future generations.

The second perspective on healthcare financial sustainability focuses on the affordability of healthcare. Unequal access to healthcare services generally results from the necessity to bear the costs of services by individuals, which can be

the case when the system is based on out-of-pocket payments or on private insurance, where the insurance premiums reflect the individual risk profiles and costs of services. If such inequalities occur, the system is called “unsustainable” (e.g. Samad et al. 2015). The decreased ability of the future generations to pay for healthcare services due to increased government debt loads, ascribed to the first facet of financial sustainability in healthcare, is seen as a dimension of the issue of “sustainability as affordability” (CMA 2010).

The third perspective is connected with attributing unsustainable health costs to “failed governance”. In the absence of market discipline, administrators may fail to innovate, providers lack sufficient accountability, and consumers do not have financial incentives to use the system judiciously (Birch et al. 2015; Laba et al. 2015). Policies aimed at reducing this type of unsustainability focus on reinterpreting the role of the private sector or on developing sound pricing and reimbursement assessments as well as evidence-based funding mechanisms. Such an approach to sustainability in healthcare is translated into policy: *The European White Paper on Sustainable Healthcare* states that sustainability is equal to cost-efficiency, which means that every euro spent must bring the greatest possible effect (ESG 2015).

The focus on financial sustainability observable in the literature expresses a widespread belief that financial issues are the main threat to the viability of healthcare services. However, other factors, even if to a lesser extent, also have a bearing on the sustainability of healthcare. Additionally, the classic approach to organisational sustainability, based on the concurrence of three pillars of sustainability: environment, society, economy, broadens the perspective on healthcare provision as situated in a macro-system whose components are indispensable for the well-being of societies. Therefore, all these perspectives on healthcare sustainability are valuable and useful in identifying its underpinning factors.

The complexity of the attributes of healthcare sustainability arises from the compound context of healthcare system ability to endure and withstand the changing circumstances. The principal tensions which characterise this context are the following: present-future, public-private, input-output,

economy-environment-society, affordability-quality. Therefore, the definition of “sustainability in healthcare” should be developed on a general level. **The proposed definition of sustainability in healthcare is the viability of healthcare provision balanced with the need for natural environment protection and desirable social goals. It is assumed that healthcare viability depends on financial and non-financial factors and that financial factors include efficiency, which is a prerequisite for economic viability.** Such a definition embraces all the classic pillars of sustainability and the concern for healthcare sustainability in terms of financial austerity prompted by the increasing costs of healthcare and funding constraints.

3. The impact of public-private partnerships on the pillars of healthcare sustainability – a purpose-based perspective

Since public-private partnerships are mixes of standards and rules for different value regimes, the author analyses PPPs in the frameworks appropriate for both the public sector and the private sector. This analysis aims to provide a sound foundation for the identification of factors within PPPs which can enhance or impair healthcare sustainability. As the name implies, PPPs involve actors from the public and private sectors who agree to cooperate and to share different types of resources in order to achieve a particular public task. The main characteristic of a PPP, compared with the traditional approach to the provision of infrastructure, is that it bundles investment and service provision in a single long-term contract (Peters et al. 2014). The European Commission (2004) listed the following elements that typically characterise a PPP:

- the relatively long duration of the relationship between the public and the private partner;
- partial contribution of the private sector to the project’s funding;
- an important role of the private operator at different stages of the project (design, completion, implementation, funding, etc.);

- the allocation of risks between the public and the private partner.

Privatised procurement is nationalised at the end of the concession when the licence expires, even if a new tender opens up space for some renegotiated agreements with private partners.

In the context of the structure and content of individual PPPs and their operation at the inter-organisational and interpersonal levels, there are research gaps in the study of PPPs concerning their effectiveness. This knowledge is crucial for understanding the impact of PPPs on healthcare systems, and thus their role in policymaking.

The central idea of PPPs is that added value can be achieved through greater cooperation between public and private actors. The rationale of a public-private partnership rests on the combined assumption that the project is a legitimate collective project, which justifies political involvement, and that it has market potential which creates incentives for corporate investment (Peters, Pierre 2010). If so, public private partnerships have a significant potential to enhance sustainability in healthcare. Such potential is driven by legitimised public authorities that safeguard public interest (appropriate quality and accessibility of healthcare, natural environment protection, acceptable social outcomes) and willingness of the private partner to invest capital, technologies and expertise in profitable projects. This assumption, however, not always holds, and distortions are observable. Therefore, a deeper reflection on PPPs is needed. It is not possible to capture the complexity of PPPs using a single analytical framework. Here, a purpose-based framework is adopted for the examination and expression of the defining features of such partnerships as they relate to achieving specific goals. The paper’s contribution is discussing PPPs’ features and performance in the theoretical framework based on the theories which explain the goals of the entities participating in the PPP. These theories are: public choice theory, neoclassical firm theory, agency theory and the corporate social responsibility concept. They represent a positive and complementary approach towards analysing goals of the public and private partners.

Two approaches govern the research on public sector issues: the normative approach and the positive approach (public choice theory). In the normative theory of public finance, projects are examined, selected and executed with a view to producing the best social outcome. The assumptions mentioned above are reiterated in an overwhelming majority of studies on PPPs. This, however, shows the way in which ideal institutions are hoped to act, whereas the public choice theory is useful for explaining less ideal reality. In the public choice theory, the question on the determinants of the public partner's involvement in the PPP can be answered by analysing the interactions and interdependencies between rational and self-interested voters, politicians, bureaucrats and lobbyists in non-market institutions.

The motivation of the abovementioned actors is rather complex and intricate. If public service is the prevalent factor, officials act for public interest, which helps to improve the achieved outcomes, i.e. welfare (Leisink, Steijn 2009). Nevertheless, self-interested officials can engage in rent-seeking behaviours. Corruption, negligence, collusion and inefficiency can damage welfare. The public-choice model fostered a noticeable shift towards privatisation and hybrid forms of public service provision (Grimshaw et al. 2002), by focusing on efficiency improvements available under market-driven management (escaping state failure by privatisation, insistence on PPPs as an infrastructure provision path).

The market-driven private partners of PPP contracts provide several types of efficiency gains. The first type includes efficiency gains resulting from the focus of the private partner on maximising the firm's value, which is considered as the firm's ultimate goal in the neoclassical firm theory. Such gains may result from reduced costs, increased incomes and lower cost of capital, and can therefore help to increase the efficiency of projects fostered by PPPs. It should be stressed that costs, benefits and risks are balanced throughout the project life cycle (the second type of efficiency gains), because maximising the firm's value is a long-term goal, and PPPs are based on long-term contracts. Therefore, the PPP as a procurement method offers opportunities

to reduce project risks and inefficiency risks connected with the traditional public procurement path, which is sensitive to the election cycle, the annual budget cycle and administrative short-termism. By contrast, a well-structured PPP can introduce clear lines of accountability, transparency of outcomes and performance, clarity as to the roles and responsibilities of the contracting parties. Therefore, fostering healthcare through PPPs can help reduce public sector inefficiency resulting from rent seeking and annual management. The third type of efficiency gains is the appropriate size of the project. PPP projects can sometimes be downsized compared to what the government initially plans without sacrificing capacity or quality of service. Ugarte et al. (2012) provide evidence of achieving cost savings from downsizing reaching billions of dollars. The fourth type of efficiency gains is reduction of transaction costs. Private partners can provide technical expertise, management know-how, access to specialised assets, innovation and funding. The costs of access are lowered through PPPs. Additionally, PPPs can provide economies of scale, efficient risk sharing and possibility to engage underexploited assets. The specific healthcare achievements of PPPs include significantly reduced delays in waiting for treatment, reduced average hospital stays, lower readmission rates and increased rates of inpatient and outpatient surgery. It means that PPPs can produce benefits for the following pillars of sustainability in healthcare: accessibility of a service, efficiency and quality.

The categories of efficiency gains mentioned above should, however, be seen as a potential which can be well used or mismanaged. In some cases, significant efficiency gains were observable and in other cases PPPs resulted in huge cost overruns, savings being offset by transferring the revenue flows to the private sector (Engel et al. 2013) or in lower value for money when compared to non-PPP hospitals.

The reason for not meeting efficiency goals seems to be twofold. First, the profitability of PPP projects is subject to considerable uncertainty concerning exogenous demand, which is often not properly provided for when designing the contracts. Second, poorly designed PPPs can result in an expropriation of public wealth. A wider

explanation of the second consideration is provided below.

Research provides evidence that PPPs may lead to the construction of inefficient infrastructures, long-term indebtedness of municipalities, unequal access to services because of high user tariffs, poor quality of services, postponement of investments in less profitable project parts, contract renegotiation in favour of private providers and so on (Koppenjan and Enserink 2009, Broadbent et al. 2009). The costs of such partnerships are ultimately paid by taxpayers, users of services or other stakeholders who feed the private partner, allowing him to generate return exceeding the average returns in the sector.

Poor efficiency outcomes of PPPs for healthcare are related mostly to serious practical difficulties in harnessing private striving for profit for the purpose of public interest. This striving, which theoretically provides with a number of efficiency gains discussed above, can easily turn against public interest. It is especially easy for private companies to take advantage of the PPP at the expense of the society at large in the case of an uncompetitive market for the provided services. An uncompetitive market scheme can comprise: inclusion of exclusivity agreements within PPP contracts, providing subsidies in order to realise full recovery costs, giving financial guarantees with regard to operation and currency risks, granting tax exemptions, providing soft loans and formulating regulations that grant the private provider a local monopoly (Marchegiani et al. 2012) – all these can be named “worst practices”.

Such “worst practices” are driven by the private partner’s focus on financial performance, combined with the limited managerial talent, negligence or self-interest oriented behaviour of the public officials (this problem is usually ignored in studies on PPPs). For example, politicians may enter a PPP for a project producing a utility with a limited collective value in order to foster a good relationship with the local business community (Peters, Pierre 2010). Another example is that, as Engel et al. (2008) suggest, spending authorities use PPPs to get around oversight by the legislature that constrains public spending in order to increase their chances for re-election. Thirdly, public administrative staff,

following the New Public Management style and focused on financial efficiency, may not be ideally suited for representing and safeguarding public interest (Peters, Pierre 2010). Fourthly, officials and administrative staff may be susceptible to the “white hat bias” – a tendency to disregard facts and distort the truth to serve desirable purposes (where the PPP is a desirable purpose, considering how strongly it is advertised). Fifthly, in the case of complex and long-term relationships, transparency and control are much weaker than is the case in more routine political processes (Peters, Pierre 2010).

The negative picture of PPPs provided above is only partially true. Firstly, because many public officials are motivated by public service, and public management tools are constantly improved and enhance the public sector’s transparency and accountability. Secondly, because contemporarily businesses change their views on their role in the society. The neoclassical firm theory is challenged by a wider perspective on norms which govern business, that is corporate social responsibility (CSR). The majority of current CSR theories focus on four main aspects: (1) meeting objectives that produce long-term profits, (2) using business power in a responsible way, (3) integrating social demands, and (4) contributing to a good society by doing what is ethically correct. Socially responsible firms introduce firm-wide CSR management and report on their social and environmental performance.

In reality, firms, especially those operating globally, are held accountable for an ever wider range of issues and are expected to fill new roles, including more political ones (Scherer, Palazzo 2012). It is argued that the corporate response to PPP opportunities can be driven by a CSR agenda (Alexander, Brown 2006). This is the case also in healthcare (Leenaars et al. 2013).

Since ethics and social welfare are the core values driving the actions of socially responsible firms, CSR can be used to alleviate conflicts of interest between the partners. Nevertheless, CSR is not a simple answer to all problems related to PPPs due to the fact that it is a heterogeneous concept. This can result in conflicts of interest in other fields. Additionally, if both partners see their role in protecting public interest, their

function within the PPP is doubled instead of being complementary so as to bring about synergy effects. Eventually, it is not clear which partner is accountable for safeguarding the project's financial efficiency.

4. Mechanisms of governing PPPs for healthcare sustainability

In PPPs for the healthcare sector, a number of agency relationships can be identified: society-officials, shareholders-managers, managers-stakeholders, public partners-private partners. Unavoidable conflicts of interest which can undermine healthcare sustainability should be managed carefully. This part of the study focuses on the identification of PPP governance mechanisms and instruments aimed to improve the multi-pillar sustainability in healthcare, done by external online desk research of PPPs for healthcare in 2017. The desk research covered a number of publicly available materials produced by private consortia participating in PPPs for healthcare, governments and local governments, financial institutions supporting PPPs for healthcare as well as consulting firms. Only the most pertinent findings are cited here, with the focus being placed on the developed economies of Western Europe.

Governance mechanisms influence the partners' behaviour by increasing the cost of opportunistic behaviours and by aligning the interests of each partner with the success of the alliance. They include policy-wide (legislation, practices) as well as project-specific mechanisms (e.g. contract, stakeholder engagement). Governance mechanisms can be relational or contractual, both producing the desired outcomes (Luo et al. 2013). Here, the focus is on contractual mechanisms because of their transparency. Contractual mechanisms are embedded in the legislation and/or in the PPP contract. The main identified governance mechanisms for the support of healthcare sustainability are briefly presented below.

A. Pro-competitive measures

Some instruments used to govern public sector administration in order to mitigate rent-seeking behaviour among public officials and administrative staff are already well established. Public procurement legal schemes, which are usually applied for PPPs arrangements, include complex and concise modules aimed at reducing costs of rent seeking (including corruption, nepotism, negligence, etc.). In many countries, PPPs are governed by separate legislation for the PPP policy (introduced e.g. in Belgium, Italy, Poland, Portugal and Spain). Usually, pro-competitive measures are replicated in the PPPs' legal framework. The discussed legal framework can be supported by measures aimed to encourage public service motivation among officials and administration, including monitoring and well-targeted incentives (IPA, 2013). Good practices in the area include dissemination of public service values and the communication of goals and principles consistent with those values in New Karolinska Solna – a PPP agreement between the Stockholm County Council and the project company Swedish Hospital Partners AB (NKS, 2017).

B. Mechanisms for lowering transaction costs

The specific goal of the public procurement framework is to maximise the number of bids, which enhances competition and allows for reducing the project's costs. However, to be accurate, public procurement requires detailed project specification which increases transaction costs and reduces the number of bids. There are many concepts as to how transaction costs could be decreased, which would stimulate the attractiveness of the PPP market and increase the number of bidders, and in turn would increase competition and hence – efficiency. These include mainly separate PPP legislative acts (which is parallel with the public procurement framework) and project pipelines (De Clerck & Demeulemeester 2016, ADB 2015). A good practice illustrating this aspect area is the centralised support structure for PPP

projects in Lithuania. The structure includes the Invest Lithuania platform and the Central Project Management Agency which provides comprehensive assistance to the development of PPP projects (Invest Lithuania, 2016).

C. Mechanisms for safeguarding financial efficiency

In order to enhance the efficiency of projects implemented by PPPs, certain specific performance measurement procedures are used. These procedures should be executed *ex ante*, during the project life cycle, and *ex post*, after the project is completed. The choice between internalised traditional procurement in the public area and PPPs – *ex ante* performance measurement – is based on benchmarks such as the Public Sector Comparator (PSC). The PSC is a comparison between the cost of the proposed PPP projects and the benchmark cost, which is a cost-estimation of the specific service using traditional procurement. The PSC reveals the value for money (VfM) of a PPP project. Value for Money is the strategic parameter behind any “make or buy” option questioning whether a PPP proposal is more efficient than any alternative, including public procurement (Moro Visconti 2014). It is not always legally required to follow performance evaluation procedures. In some countries, PPP policies may endorse VfM principles without providing specific criteria to determine how the VfM will be calculated. In jurisdictions where a formal VfM process is not required, a procurement process may embed some VfM principles, including quantitative and qualitative performance benchmarks. To the extent that VfM principles are embedded in the PPP policy, a policy-wide governance mechanisms to support PPP efficiency are provided. Otherwise, PPP projects require project-specific governance. The United Kingdom is the best known and most prominent example of good practices in complex implementation and regular updating of the VfM standard for all sectors, including healthcare (HM Treasury 2012).

The financial sustainability in the healthcare sector is strongly connected with fiscal sustaina-

bility, and that is why the planning process for PPPs should address fiscal risks. Therefore, the key success factors in reducing fiscal risks include avoidance of excess capacity (e.g. Hospital Plans, Germany), effective competition among public and private healthcare providers (Germany, France) and firm contract management (Portugal) (EC, 2011). In the PPP contract for outpatient dialysis services in Romania, the Ministry of Health set the prices based on a regional price comparison study, a flat fee for hemodialysis treatment and an annual fee for peritoneal patients (Nikolic, Maikisch 2006). The contract produced improved patient services at lower costs to the national health system

D. Mechanisms promoting desirable environmental and social outcomes

There are several types of governance mechanisms promoting PPPs’ focus on multiple goals, including environmental and social ones. In the last decade, the use of environmental criteria in public tenders has been increasingly diffusive (the so-called green public procurement). The same pattern of criteria setting is sometimes applied in the PPP legislation, thus constituting a policy-wide ground for formulating environmental and social goals in healthcare provision via PPPs, for example in Germany. A common approach to mitigating the environmental impact of the infrastructure is to set targets in terms of energy performance, or carbon dioxide emissions per square metre, or a requirement to use recycled materials.

The standards for the criteria targeting social performance (e.g. equality, employment practices, impact on the local communities) are relatively underdeveloped. Public authorities are normally obliged to consult with the local community before undertaking an infrastructure project. This most often takes place at the planning stage, through a formal consultation process, open meetings and/or voting by a local council or assembly.

Although the VfM concentrates on economic efficiency, healthcare and environmental outcomes can be safeguarded also in the VfM evaluation. In this regard, three solutions are possible. The

first is providing and following the guiding principles as to how environmental and social impacts should be considered in the PPP assessment even if there is no legal requirement for this (triple-bottom line). The second solution is embedding environmental and healthcare outcomes in the analysis of the PSC (by using tools similar to those employed in the cost and benefit analysis, for example contingent valuation). The third solution consists in setting a number of criteria, not purely financial-ones, for the award of the contract. This entails using multi-criteria decision methods for establishing appropriate weights for multiple heterogeneous criteria (adopted for example in Lombardy, Italy). The selection of the appropriate mechanism should be based on the project's specificity. Such solutions are referred to as the Quality and Cost Based Selection (QCBS) or, more frequently, as the Most Economically Advantageous Tender (MEAT). Expert committees or expert evaluation panels are set up to ensure that the qualitative criteria are objective and well-explained (Austria). Post-bid dialogue sessions usually address the quality standards and non-financial performance of the project.

An example of a good practice in the sphere of environmental and social impact management is the Kocaeli Hospital PPP in Turkey, where the complex environmental and social assessment was made public, where bank specialists and consultants made a visit to the site to clarify the issues and mitigation measures, and where the European Bank of Reconstruction and Development monitors the project's environmental and social performance by reviewing the lender supervisor's reports, annual environmental and social reports and by periodical monitoring visits (EBRD 2016).

E. Mechanisms for ensuring healthcare quality

The quality of service is an important pillar of healthcare sustainability. On the market, supply and demand govern both the quality of services quality and the prices. In the case of PPPs, market forces only partially influence the final

outcome. In practice, payments are usually made by public authorities, in the hope that competition will enhance the quality of services. However, healthcare is a peculiar industry. Demand for a service – a market force – is driven mainly by consumer satisfaction, which is very loosely related to the actual quality of a given service. The physician–patient dyad is a type of a principal–agent relationship and an example of asymmetry of information. This relationship, to be beneficial for the patient (appropriate quality of the service) and the society (no cherry-picking of patients) in terms of healthcare service provision via PPP, has to be supervised by an agent who acts in the public interest. Public partners are generally better suited for this role, which is important in the context of service quality target-setting, measurement and monitoring. Monitoring and evaluating healthcare outputs are the core activities in contract and project management. Best practices in the market include setting appropriate measures to be monitored as well as choosing appropriate professionals to carry out the monitoring process (healthcare professionals). For example, the quality control at the Holistic Care Center Waldviertel (Austria), including monitoring of the medical and economic performance, is conducted by an inter-university advisory board responsible for developing and monitoring the quality standards of holistic care. For proper quality management, internal and external transparency is a necessity. In Berlin-Buch Hospital (Germany), the quality of services is ensured through e.g. public Annual Medical Reports to transparently track key performance (Nikolic, Maikisch 2006).

Healthcare service quality, accessibility and affordability are highly impacted by the values of the private partners and the model of payment adopted in the PPP contract. Availability payment – a yearly sum independent of the fulfilment of the demand, but conditional on delivering the agreed service quality, has been well-tested as a solution, and contributes to the quality of services provided via PPPs. An interesting model of payments was introduced in Ribera Salud in Spain, where both infrastructure and treatment are provided by PPPs. The payment is a “capitation” model in which the regional health authority makes a standard payment

for each member of the population in a single local area forming a defined catchment area. Furthermore, the terms of the contract discourage the consortium from reducing the volume or quality of healthcare services provided to its catchment population, since the costs incurred by patients travelling outside the concession are charged to the hospital company and there are disincentives to offering care to non-catchment citizens (Barlow et al. 2013).

F. Mechanisms for managing conflicts

A PPP contract typically specifies the commitments, contributions and benefits accruing to each partner, as well as conflict resolution mechanisms such as arbitration clauses or lawsuit provisions. Performance measurement and monitoring as well as other incentives against the opportunism of both partners should be specified in the contract. It is argued that, in complex projects with a long gestation, such as healthcare investments, there may be a high risk of abandoning the project at some stage of its development. Therefore, the project's efficiency may strongly benefit from a proper transfer of these risks to the private sector, with binding contractual penalties (Moro Visconti 2014). Such penalties are yet another incentive against the opportunism of a private partner. An example of concrete practices to ensure healthcare quality are the contracts of Castelfranco Veneto and Montebelluna Hospitals in Italy. The rule is that penalties would be levied if the private partner did not meet the required performance standards. The second important rule is that the private partner has to reinvest 19.6% of the fee paid out annually by the Health Authority in technological upgrades (EC, 2014).

Both the contract and the legal framework are always incomplete to some extent. An important success factor for PPPs for healthcare is an ongoing dialogue and good communication between the partners. Regular meetings and well-designed and smooth information flow help to achieve it.

The governance mechanisms briefly described above are not commonly employed in PPPs for healthcare. However, the dissemination of good

practices is necessary to improve the outcomes of the healthcare system.

Conclusions

Healthcare sustainability is a complex goal, where financial, social and environmental objectives must be achieved in order to safeguard healthcare viability. PPPs as a path for the provision of healthcare infrastructure can enhance or impair healthcare sustainability due to a number of conflicts of interest that might occur. The PPP governing mechanisms can be programmed as sustainability drivers to improve the resilience of healthcare to the benefit of all the stakeholder groups. Policy-wide instruments should focus on appropriate legal frameworks for PPPs to enhance an efficient management of tenders, sound financial planning and proper management of social and environmental issues during the project's lifetime. The contract is perceived by both parties as playing a central role in governing complex, long-term supply arrangement. An appropriate model of payment should be specified in the contract along with the monitoring scheme, communication rules and contractual penalties. All these mechanisms must be suitable for the specific nature of the healthcare sector. Best practices in the area should be promoted and used as templates for designing PPP frameworks and PPP contracts in the countries of Central and Eastern Europe which strive to modernise their healthcare systems.

References

- Asian Development Bank (ADB) (2015). *Infrastructure Public-Private Partnership Pipeline Development Support*. Retrieved from: <https://www.adb.org/sites/default/files/project-document/161269/48350-001-tar.pdf> (27.02.2017).
- Alexander, K., Brown, M. (2006). Community-based facilities management. *Facilities*, 24 (7/8), 250–268.
- Barlow, J., Roehrich, J., Wright, S. (2013). Europe sees mixed results from public-private partnerships for building and managing health care facilities and services. *Health Affairs*, 32 (1), 146–154.

Bauzon, S. (2015). Classical distributive justice and the European healthcare system: Rethinking the foundations of European health care in an age of crises. *Journal of Medicine and Philosophy*, 40 (2), 190–200.

Birch, S., Murphy, G.T., MacKenzie, A., Cumming, J. (2015). In place of fear: Aligning health care planning with system objectives to achieve financial sustainability. *Journal of Health Services Research & Policy*, 20 (2), 109–114.

Boone, T. (2012). Organizing for sustainability: Exploratory analysis of the healthcare industry. In T. Boone, V. Jayaraman, R. Ganeshan (red.), *Sustainable Supply Chains* (pp. 37–48). New York: Springer.

Borgonovi, E., Compagni, A. (2013). Sustaining universal health coverage: The interaction of social, political, and economic sustainability. *Value in Health*, 16 (1), 34–38.

Broadbent, J., Gill, J., Laughlin, R. (2008). Identifying and controlling risk: The problem of uncertainty in the private finance initiative in the UK's National Health Service. *Critical Perspectives on Accounting*, 19(1), 40–78.

Buffoli, M., Capolongo, S., di Noia, M., Gherardi, G., Gola, M. (2015). Healthcare sustainability evaluation systems. In S. Capolongo, M.C. Bottero, M. Buffoli, E. Lettieri (eds), *Improving Sustainability During Hospital Design and Operation* (pp. 23–29). Springer International Publishing.

Capolongo, S., Bottero, M.C., Buffoli, M., Lettieri, E. (eds.) (2015). *Improving Sustainability During Hospital Design and Operation: A Multidisciplinary Evaluation Tool*. Springer International Publishing.

Canadian Medical Association (CMA) (2010). *Health Care Transformation*. Retrieved from: <http://www.cma.ca> (11.06.2013).

De Clerck, D., Demeulemeester, E. (2016). An ex ante bidding model to assess the incentive creation capability of a public–private partnership pipeline. *International Journal of Project Management*, 34 (1), 117–131.

EBRD (2016). *Koaceli Hospital PPP*. Retrieved from: <http://www.ebrd.com/work-with-us/projects/psd/koaceli-hospital-ppp.html> (15.07.2017).

European Commission (EC) (2011). *Health and Economics Analysis for an Evaluation of the Public Private Partnerships in Health Care Delivery Across EU*. Retrieved from: https://ec.europa.eu/health/expert_panel/sites/expertpanel/files/ppp_finalreport_en.pdf (1.03.2017).

European Commission (EC) (2014). *Expert Panel on Effective Ways of Investing in Health*. Retrieved

from: https://ec.europa.eu/health/expert_panel/sites/expertpanel/files/003_assessmentstudyppp_en.pdf (15.07.2017).

Engel, E., Fischer R., Galetovic, A. (2008). *Public-Private Partnerships: When and How*. Cowles Foundation for Research in Economics, Yale University.

Engel, E., Fischer, R., Galetovic, A. (2013). The basic public finance of public–private partnerships. *Journal of the European Economic Association*, 11 (1), 83–111.

ESG (2015). *Acting Together: A Roadmap for Sustainable Healthcare*. European Steering Group on Sustainable Healthcare.

Grimshaw, D., Vincent, S., Willmott, H. (2002). Going privately: Partnership and outsourcing in UK public services. *Public Administration*, 80 (3), 475–502.

HM Treasury (2012). *A New Approach to Public Private Partnerships*. Retrieved from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/205112/pf2_infrastructure_new_approach_to_public_private_partnerships_051212.pdf (15.07.2017).

Institute of Public Administration (IPA) (2013). *Public Service Motivation*. Retrieved from: <https://www.ipa.ie/pdf/PublicServiceMotivation.pdf> (27.02.2017).

Invest Lithuania (2016). *PPP in Lithuania Overview of PPP Climate & Opportunities*. Retrieved from: <http://www.investlithuania.com/wp-content/uploads/2014/03/PPP-in-Lithuania-Overview-of-climate-and-opportunities.pdf> (25.07.2017).

Kaplan, R.S., Porter, M.E. (2011). How to solve the cost crisis in health care. *Harvard Business Review*, 89 (9), 46–52.

Koppenjan, J.F., Enserink, B. (2009). Public–private partnerships in urban infrastructures: Reconciling private sector participation and sustainability. *Public Administration Review*, 69 (2), 284–296.

Laba, T.L., Usherwood, T., Leeder, S., Yusuf, F., Gillespie, J., Perkovic, V., Essue, B. (2015). Co-payments for health care: What is their real cost? *Australian Health Review*, 39 (1), 33–36.

Luo, Y., Liang, F., Ma, Z. (2013). The effects of contractual governance and relational governance on construction project performance: An empirical study. *International Journal of Digital Content Technology and its Applications*, 7 (8), 741.

Leenaars, K., Jacobs-van der Bruggen, M., Renders, C. (2013). Determinants of successful public-private partnerships in the context of overweight prevention in Dutch youth. *Preventing Chronic Disease*, 10.

Leisink, P., & Steijn, B. (2009). Public service motivation and job performance of public sector

- employees in the Netherlands. *International Review of Administrative Sciences*, 75 (1), 35–52.
- Maarse, H., Jeurissen, P., Ruwaard, D. (2013). Concerns over the financial sustainability of the Dutch healthcare system. *DICE Report*, 11 (1), 32–37.
- Marchegiani, L., Nenni, M. E., Peruffo, E., Pirolo, L. (2012). Linking value assessment to the business model framework in high innovative services of public utility – A simulation from the aerospace industry. *International Journal of Economics and Management Engineering*, 2 (3), 98–103.
- Marty, D., Rapp, C., McHugo, G., Whitley, R. (2008). Factors influencing consumer outcome monitoring in implementation of evidence-based practices: Results from the National EBP Implementation Project. *Administration and Policy in Mental Health and Mental Health Services Research*, 35 (3), 204–211.
- Moro Visconti, R. (2014). Multidimensional principal-agent value for money in healthcare project financing. *Public Money & Management*, 34 (4), 259–264.
- Nikolic, I. A., Maikisch, H. (2006). *Public-Private Partnerships and Collaboration in the Health sector: An Overview with Case Studies from Recent European Experience*. HNP Discussion Paper. Retrieved from: <http://documents.worldbank.org/curated/en/909681468139198131/pdf/378070Public0p1partnerships01PUBLIC1.pdf> (25.07.2017).
- Organisation for Economic Co-operation and Development (OECD) (2010). *Health System Priorities When Money is Tight*. OECD Health Ministerial Meeting, Paris, 7–8 October, Paris: OECD. Retrieved from: <http://www.oecd.org/health/ministerial/46098466.pdf>
- Peters, B.G., & Pierre, J. (2010). Public-private partnerships and the democratic deficit: Is performance-based legitimacy the answer?. In M. Bexell, U. Mörth (red.), *Democracy and Public-Private Partnerships in Global Governance* (pp. 41–54). Palgrave Macmillan UK.
- Peters, B.G., Pierre, J., Röiseland, A. (2014). Financial gains and value loss? The impacts of local mixed companies. *Annals of Public and Cooperative Economics*, 85 (1), 87–102.
- Phiri, M., Chen, B. (2014). *Sustainability and Evidence-Based Design in the Healthcare Estate*. Berlin, Heidelberg: Springer.
- Pluye, P., Potvin, L., Denis, J.L. (2004). Making public health programs last: Conceptualizing sustainability. *Evaluation and Program Planning*, 27 (2), 121–133.
- Proctor, E., Luke, D., Calhoun, A., McMillen, C., Brownson, R., McCrary, S., Padek, M. (2015). Sustainability of evidence-based healthcare: Research agenda, methodological advances, and infrastructure support. *Implementation Science*, 10 (1), 88.
- Ritz, A. (2009). Public service motivation and organizational performance in Swiss federal government. *International Review of Administrative Sciences*, 75 (1), 53–78.
- Rodriguez-Mozaz, S., Chamorro, S., Marti, E., Huerta, B., Gros, M., Sánchez-Melsió, A., Balcázar, J.L. (2015). Occurrence of antibiotics and antibiotic resistance genes in hospital and urban wastewaters and their impact on the receiving river. *Water Research*, 69, 234–242.
- Samad, L., Iqbal, M., Tariq, A., Shahzad, W., Khan, A.J. (2015). Equitable access to comprehensive surgical care: The potential of indigenous private philanthropy in low-income settings. *World Journal of Surgery*, 39 (1), 21–28.
- Sarvi, J.E., Balaji, V., Pillay, H.K. (2015). Public-private partnerships in information and communication technology for education. *ADB Briefs*, 49 (1), 1–8.
- Scherer, A. G., & Palazzo, G. (2011). The new political role of business in a globalized world: A review of a new perspective on CSR and its implications for the firm, governance, and democracy. *Journal of Management Studies*, 48 (4), 899–931.
- Stirman, S.W., Kimberly, J., Cook, N., Calloway, A., Castro, F., Charns, M. (2012). The sustainability of new programs and innovations: A review of the empirical literature and recommendations for future research. *Implement Sci.* 7 (17), 1–19.
- Ugarte, C., Gutierrez, G., Phillips, N. (2012). *A roadmap to funding infrastructure development*, Cintra Infraestructuras S.A., Spain, International Transport Forum Discussion Paper OECD Publishing, pp. 1–8.
- United Nations (UN) (1987). *Report of the World Commission on Environment and Development: Our Common Future*. Retrieved from: <http://www.un-documents.net/our-common-future.pdf> (26.07.2017).
- www.nyakarolinskasolna.se/en/The-New-Hospital (15.07.2017).

Mechanizmy zrównoważonego zarządzania partnerstwem publiczno-prywatnym w sektorze ochrony zdrowia

Niejasne definiowanie celów w zarządzaniu ochroną zdrowia oraz zbyt uproszczone podejście do analizy projektów w formule partnerstwa publiczno-prywatnego (dalej: PPP) utrudniają formułowanie mechanizmów zapobiegania i rozwiązywania konfliktów interesów w ramach PPP w sektorze ochrony zdrowia. Efektywne rozwiązania w tym zakresie są słabo znane w krajach Europy Środkowo-Wschodniej. Celem tego artykułu jest w pierwszej kolejności ustalenie poprawnego rozumienia zrównoważonego systemu ochrony zdrowia, następnie przesunięcie kontekstu analizy PPP z perspektywy czysto finansowej w kierunku poprawnie określonej perspektywy filarów zrównoważonego rozwoju ochrony zdrowia i ostatecznie zidentyfikowanie mechanizmów zarządzania PPP wspierających zrównoważoną ochronę zdrowia. Zastosowanymi metodami badawczymi są: szeroka analiza koncepcyjna literatury światowej oraz zewnętrzna, internetowa, analiza danych zastanych publikowanych przez konsorcja PPP, instytucje finansowe i agencje publiczne zaangażowane w zarządzanie PPP w ochronie zdrowia w Europie. Określono, że zrównoważona ochrona zdrowia jest problemem złożonym i wieloobszarowym. PPP mogą wspierać albo hamować rozwój każdego z obszarów zrównoważonej ochrony zdrowia. Jakość oddziaływania PPP na zrównoważoną ochronę zdrowia wynika ze złożonych konfliktów interesów. Wykorzystanie określonych mechanizmów zarządzania w kontraktowaniu i zarządzaniu PPP jest niezbędne do wspierania finansowego i pozafinansowego obszarów zrównoważonej ochrony zdrowia. Bez tych mechanizmów niemożliwe jest zapewnienie trwałości ochrony zdrowia z korzyścią dla dawców kapitału, społeczeństwa i sektora publicznego. Doświadczenie zdobyte w ramach niektórych projektów PPP w ochronie zdrowia inspirowało projektowanie systemu mechanizmów zarządczych.

Słowa kluczowe: zarządzanie projektami w ochronie zdrowia, interesariusze ochrony zdrowia, trwałość ochrony zdrowia