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Spanish healthcare public private partnerships: The 'Alzira model'

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ABSTRACT

Global infrastructure reports suggest that, in the wake of the fiscal crisis, healthcare PPPs are seen as a growing area as governments switch attention to social welfare projects. Spain is unique in having had a PPP hospital in operation for over a decade which is funded through a capitation fee. This paper takes a critical approach to evaluate this project, with our analysis showing that the original project could never have been viable and that the renegotiation of the contract has been costly to the government. Viewing the contract through a financialised lens we can see how this contract has been used to 'make up' a market for the private delivery of public healthcare in Spain. We also call into question the role of the Spanish savings banks in financing this type of project, which has now been replicated with further hospitals in Spain and Portugal, as well as in developing countries such as Lesotho.

1. Introduction

Internationally, healthcare costs are increasing, due to, amongst other things, advances in medical and technological treatments, an ageing population, changing public expectations and evolving patterns of diseases, whilst at the same time government budgets are in decline. Consequently, as part of the global movement towards involving the private sector in the financing, construction and delivery of public services, the use of public private partnerships (PPPs) in the healthcare sector has contributed to the global PPP market being worth $55.5 billion by 2009 (Project Finance, February 2010).

This increase in the marketisation of health has created an opportunity for medical insurance, private healthcare and construction and facilities management companies to expand their remit into the delivery of healthcare services to the public through PPP mechanisms funded by government payments, especially in the UK, Italy, Spain and Portugal, where the national health services are funded through general taxation (Barros and Martinez-Giralt, 2009). Indeed, although the market is dominated by transport projects, social infrastructure, including healthcare projects, is seen as an attractive pipeline for infrastructure investors (DLA Piper, 2009; Project Finance, March 2010). In the case of Spain, this fits with its macro-level rationale that PPP projects provide additional investment which otherwise the state could not afford or would have to delay for many years (Vázquez, 2006; Vilardel, 2005).[1]

As the PPP policy matures, the models have become more complex. In relation to healthcare, most accounting literature has focused on hospital PPPs, notably the UK Private Finance Initiative (PFI) model whereby the private sector finances and constructs a hospital building and then delivers the service and maintenance functions over a period of around thirty

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[1] In contrast to this, the UK government claims a micro-level justification – that PPP will deliver greater value for money (VFM) over the whole life than public sector procurement despite the higher cost of private over public finance. The Australian (Victoria) rationale has changed over time (Blanken and Dewulf, 2010; English, 2005) and is now a combination of both funding related principles and the need to demonstrate VFM.

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years. This model is also in use in Spain, Italy, Mexico, South Africa, France, and Australia. However there are also many other models using private finance (IFC, 2009; McKee et al., 2006), for example, franchising, BOO (build, own, operate) and BOOT (build, own, operate, transfer), the contracting out of clinical services, such as the UK's Independent Sector Treatment Centres (ISTCs) and similar schemes in Romania and Peru, as well as management contracts in Brazil.

This paper considers the case of a PPP model which goes still further – not only does the private sector finance, construct and operate the hospital building, but it also delivers the clinical services as well. The unique feature to this contract is that the public sector role is reduced to being that of a commissioner of healthcare, as it funds healthcare services by paying the provider a capitation charge derived from the public health budget. The first hospital to use this model was the La Ribera hospital in the town of Alzira, in the autonomous region of Valencia, Spain, and this approach has become known as the 'Alzira model'.

The objective of this paper is to carry out a detailed case study of the development of the 'Alzira model'. We analyse the financial statements and compare the empirical evidence to the available narratives about the model, to determine the information gap between the rhetoric, which declares this project to be a success story, and the financial reality.

The information gap that we find is very significant because since its inception in 1999, further hospitals following the 'Alzira model' have opened in the autonomous Spanish regions of Valencia and Madrid as well as a related variant in Portugal, where the model is split into two separate contracts, one covering clinical activities and soft facilities, and another covering infrastructure operations (Barros and Martinez-Giralt, 2009).

Some proponents, such as the Global Health Group based at the University of California, claim that such a model is well suited to the funding of healthcare in developing countries as it overcomes the problems of both financing the replacement of obsolete infrastructure and the delivery of clinical services. Lesotho in southern Africa and the Turks and Caicos Islands of the Caribbean have now pursued this model for the provision of publicly available hospitals and health centres.

The paper is organised as follows. The next section reviews the literature evaluating healthcare PPPs and problematic issues arising from them. Section 3 introduces our theoretical framework. Section 4 describes the background to Spanish healthcare and Section 5 sets out our research method. Section 6 describes the project structure and provides the empirical analysis of the Alzira case. Section 7 draws out the implications of our study of the 'Alzira model', offers our conclusions regarding the future use of the 'Alzira method' and briefly considers the implications for international settings.

2. Problematic issues concerning healthcare PPPs

A review of the existing literature shows that global evaluation of healthcare PPPs is patchy, with overview studies such as Grimsey and Lewis (2004, 2005) providing little specific comment on healthcare. Thompson and McKee (2004) identify and describe, but do not evaluate, how different countries, including the UK, Italy, Spain, Ireland, Portugal and Greece, are using or considering the use of PPP for hospitals. Although, for example, Portuguese PPP hospitals have been operating since 2007, we have been unable to find any studies which evaluate them. Well over a decade after the first PFI projects went operational in the UK, there continues to be a lack of project evaluation. The UK National Audit Office (NAO), which scrutinises public spending on behalf of the UK Parliament, commented in a reflective report on PPPs that:

> 'We have yet to come across truly robust and systematic evaluation of the use of private finance built into PPPs at either a project or programme level.' (NAO, 2009, Paragraph 13)

Although the UK's Office of Government Commerce (OGC) initiated a review process to evaluate the implementation of PFI projects, these are not in the public domain and their purpose remains unclear (Edwards et al., 2004). Although there is internal benchmarking of costs within the UK National Health Service (NHS), this information is confidential, and therefore there is little specific post-implementation evaluation evidence that is publicly available (Broadbent et al., 2003; Edwards et al., 2004). This is echoed in relation to the ISTCs, where the UK NHS requirements for data collection and reporting are not being met, meaning that the policy cannot be evaluated (Pollock and Godden, 2008; Pollock and Kirkwood, 2009).

Thus, although many countries are using PPPs for healthcare, international studies of PPPs such as Hodge and Greve (2007) lament the lack of sufficient research on the outcomes of the PPP policy in practice and call for an increase in rigorous assessment of PPP projects. Despite this, there are a number of areas where the existing literature on PPP, in general, and hospitals, in particular, raises themes relevant to the procurement and operation of the 'Alzira model'.

Firstly, there are cost related issues. Cost savings were expected from lower labour costs and higher productivity (Grimshaw et al., 2002). However, as the public sector has relinquished direct control over costs, there has been 'contract drift'. Private sector costs have moved upwards, leading to increases in the PPP charges (Edwards et al., 2004; Grimshaw et al., 2002; Shaoul et al., 2008b; Whorley, 2001). This has been partly due to long term contractual 'lock in' (Lonsdale, 2005) as monopoly power reduces the contractors' incentive to produce good performance (Lonsdale and Watson, 2007). Furthermore, the public sector partners have had to implement bureaucratic practices, some of these invisible, to manage and monitor the contracts (Broadbent et al., 2003; Edwards et al., 2004), which again makes projects more expensive than the original expectations. Overall Shaoul et al. (2011) suggest that both the public and private sectors underestimated the cost of partnership working.

Secondly, there are issues around risk and risk transfer possibly because of an over-emphasis on quantitative risk, with other types of risks and uncertainties being downplayed (Broadbent et al., 2008). The UK evidence shows that in early contracts, commercial operators had an advantage in contract negotiations because the public sector lacked experience