

## Part 6. HEALTH SECTOR GUIDELINES

This section provides guidance specific to the health sector, and is structured as follows:

- **Preface**
- **PPP Primer and Phases in PPP Development**
- **Phase I: PPP Project Identification and Screening**
- **Phase II: PPP Appraisal & Preparation**
- **Phase III: Structuring and Drafting the Tender and Contract Documents**
- **Phase IV: Tender & Award**
- **Phase V: PPP Contract Management & Performance Reporting**

### **PREFACE**

The health sector is regulated by the Public Health Proclamation No. 200/2000 dated 9 March 2000 (the “Health Proclamation”). The Proclamation deals with the institutional framework of the health sector and the protection of public health and related control. The public health authority is the Ministry in charge of health at federal level, the Health bureau at regional level and, if any, a Health Bureau at city level. Additionally, there is a Public Advisory Board at federal and regional levels.

Ethiopia has implemented successive Health Sector Development Plans (HSDPs) since 1997. The health sector transformation plan, in line with the Growth and Transformation Plan (GTP) phase II, has set ambitious goals to improve equity, coverage and utilization of essential health services, improve quality of health care, and enhance the implementation capacity of the health sector at all levels of the system. GTP II highlights the role of the private sector in the delivery of health service will be promoted, while it will be effectively regulated to ensure the provision of good quality health service that satisfies all citizens.

As governments struggle to stretch their healthcare funding and produce better results, many are increasingly turning to PPPs with the private sector. There are four key factors driving governments worldwide to use the PPP model for health sector improvements:

- Desire to improve operation of public health services and facilities and to expand access to higher quality services
- Opportunity to leverage private investment for the benefit of public services
- Desire to formalize arrangements with non-profit partners who deliver an important share of public services

- More potential partners for governments as private healthcare sector matures

Under GTP II, the strategic directions for health sector development highlights the role of the private sector in the delivery of health service will be promoted, while it will be effectively regulated to ensure the provision of good quality health service that satisfies all citizens. The Ministry of Health considers that the following areas are prime targets for PPPs: diagnostic centres for lab and imaging services, tertiary care services, and oncology. Since a number of these potential PPP projects fall below the \$50M threshold, the Ministry of Health has also been in discussion with the Ministry of Finance to accommodate these important projects especially if a case can be made to scale them up with a viable replication model.

The PPP Proclamation (article 2(2)) defines the Contracting Authority as “Public Body or Public Enterprise which intends to enter into a Public Private Partnership Agreement with a Private Party”. It must be noted that (i) “Public Body” is defined as an organ of the federal government wholly financed by the Federal Government and (ii) “Public Enterprises” as enterprises fully owned by the Federal Government. As such the Contracting Authority in the Health Sector is the Ministry of Health or as relevant a public hospital fully owned by the Federal Government.

The Ministry of Health initiated and coordinated the development of the Public-Private Partnerships in Health (PPPH) Implementation Guidelines<sup>1</sup>. This step was taken in 2016 before the current national PPP Framework was put in place. The objectives of PPPH in Ethiopia are set out as follows;

- Improve access to quality and affordable health services to the citizens of Ethiopia by allowing and enabling the private health sector to operate in a policy-supported partnership with the public health sector.
- Create effective platforms to nurture untapped opportunities, facilitate exchange of technology, knowledge, and practices between the public and private sectors;
- Avail comprehensive tertiary health services for the short term and long term redirection and attraction of medical tourism respectively;
- Encourage the private sector for a high-end diagnostic services (laboratory and imaging services), high-end clinical services such as organ transplantation, cardiac and orthopedic care, hemo-dialysis, radiotherapy, neurosurgery and rehabilitation medical services and others unmet needs driven by PPPH projects in the premises of the public health facilities;
- Guide the existing partnership to fully complement government public health programs in terms of coverage, standardization of services, and improvement of service quality.

The guidance was aligned with the guiding principles and values stipulated in the Strategic Framework for PPP in the health sector in Ethiopia (2013). This 2013 PPPH framework lays out in general the boundaries and priorities for partnership in health and is designed for use in particular by public and private partners who plan to engage in PPPH and by the public in general. More specifically, the document is meant to provide general guidance to establishing, implementing, mainstreaming, coordinating, monitoring and evaluating partnerships between the Government of Ethiopia and the private health sector.

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<sup>1</sup> The Ministry of Health initiated and coordinated the development of the Public-Private Partnerships in Health (PPPH) Implementation Guidelines with the assistance of USAID.

These health sector PPP Guidelines will refer to the 2016 PPPH Guidelines to identify key issues and procedures.

### I. PPP PRIMER AND PHASES IN PPP DEVELOPMENT

#### Key Issues to Consider:

Since the 1990s the **Infrastructure-based model** has become the most common form of healthcare PPP and has been implemented on a global scale—including in Australia, Canada, Egypt, Italy, Japan, South Africa and across Latin America. Outside of Egypt and South Africa there are few examples in Africa. The key issues to consider for this type of PPP include:

- **Clearly defined incomes make it easier to obtain the required political backing:** The on time and within budget reputation of this model makes it easier to measure success and gain the political and public backing that is often lacking in health PPPs. It allows the public sector to continue to focus its efforts on managing healthcare delivery, and not affect health care worker jobs, and transfers the risk and responsibility for facility construction to the private.
- **Few incentives for private partner to invest in innovative design:** Since the incentive systems for this type of PPP focus on cost and on-time delivery they favour large facilities based on standard or pre-existing models. Government needs to emphasise project design, and its impact on service delivery, during the bidding process, otherwise there are few incentives for the private partner to invest in innovative design since they are not involved in patient care once the facility is operational.
- **Risk of building a white elephant:** There is a risk that new facilities are built but they are not aligned with demand for services, rather they are built for political reasons. This phenomenon tends to be more common with Infrastructure-based PPPs compared to those that include clinical service delivery, where the private partner has an incentive to link capacity with future service demand. Governments risk over-investing in facilities, and could face long-term contractual payments for facilities that are no longer needed.

**Discrete Clinical Services PPPs** have been widely implemented globally including Africa, this is largely due to the lower risk profile and lower cost of these projects, and it could pave the way for more complex PPPs. The key issues to consider for this type of PPP include:

- **Offers a means to stimulate competition among private sector operators:** in nascent health PPP markets government may need to consider offering incentives, such as volume guarantees, to attract new entrants. Over time, stimulating competition among the private sector can expand access, increase efficiency, encourage innovation and result in long-term savings for the government.
- **Effective model to address constraints in the public provision of discrete services:** These specific constraints in public healthcare delivery include lack of access to trained staff, or appropriate technology and medical equipment. This asset-light PPP model provide a proven solution for countries that do not have sufficient government capacity or regulatory infrastructure to manage more complex PPP models. The flexibility of the model offers a solution to a range of other health service delivery needs. A word of caution, the most cutting-edge (and usually more expensive) equipment may not be necessary to achieve considerable improvements in quality of care. The government

needs to ensure that the new technologies are aligned with local need, government financial limits and long term management capacity.

- **Demonstrate lower costs and improved quality:** Success of the PPP will usually rest on the private partner's ability to deliver clinical services at a lower cost while maintaining or exceeding quality of care. Health services such as diagnostics or dialysis offer a relatively low risk, asset-light, lower capital cost opportunity to demonstrate the private sector's ability to positively impact healthcare delivery. The PPP must include clearly defined metrics, transparent monitoring and evaluation, and publicly available outcomes.

The **Integrated PPP** is the most complex and least common model. The Lesotho Hospital PPP was the first of its kind in Africa and due to its complexity there are few examples in Africa. The key issues to consider for this type of PPP include:

**Take stock of government capacity:** While this model has the highest potential to improve clinical performance it is highly complex, and governments will need to take stock of their political support and capacity to manage such projects.

**To manage hospital volumes and cost, an effective referral management system is needed:** There is a general tendency to go straight to a hospital to seek care, hospitals are not designed and are too expensive to treat all patient volumes. Effective primary care services and robust referral management should be integrated into the PPP contract. Hospitals are better placed to manage patient care and patient volumes driven by secondary and tertiary care.

**Clinical quality and performance standards must be identified and maintained:** A robust framework for any PPP is important, although more so for the Integrated PPP model to ensure its enforcement. To support PPP contract management, which is often a challenge for many governments, national or international hospital accreditation agencies can be used to identify appropriate clinical standards and to perform periodic reviews.

**Stakeholder buy-in is critical to success:** Integrated PPPs represent a major shift for the public healthcare providers as they come under private management. There is high potential of resistance to change due to: new human resource and performance management practices to the project that are significantly different from public management norms, and greater use and enforcement of performance management standards, timekeeping and reporting. Sufficient time must be spent to work with key stakeholders in a collaborative manner early on in the process, including identifying and implementing key training to ensure a successful transition.

**Status of personnel as public or private employees:** A key decision concerns whether healthcare staff will transition from public to private employment as part of the project, or whether the staff will be comprised of a mix of both. The path typically depends on the local context and each project must consider the most effective solution for its situation depending on factors such as the availability and skillsets of providers in the region, existing union and civil service employment contracts, and potential impact on recruitment and retention caused by potential wage differentials and employment expectations between the private and public employers.

In general, successful health public-private relationships are rooted in the following considerations:

## PPP Guidelines - Appendix

- Undertake a careful assessment of which type of PPP meets the government's vision for the private sector's role in the health sector. There are different PPP arrangements in health that can be implemented, including the construction of health facilities, outsourcing non-clinical services including catering and cleaning services, as well as arrangements with private laboratories for the provision of capital intensive equipment or the outsourcing of the day to day hospital management to the private sector, among others.
- Start with a pilot PPP project that is modest in scale and relatively straightforward to replicate which generates deal flow and interest from credible private partners. For example, delivering imaging or lab services separately or together as part of a Diagnostic center.
- Strike a balance between providing a public service and generating a return on investment for the private sector partners.
- Consider the fiscal impacts of health PPPs, tools such as the IMF's PPP Fiscal Risk Assessment Model (PFRAM) support the all critical fiscal assessment of PPP projects.
- Implement a robust monitoring and evaluation framework under the PPP, with adequate baselines and key performance indicators to ensure that the performance specifications can be tracked.

PPPs can be applied across many areas of health infrastructure and services, and typically seek to capture private sector capital and expertise to improve the provision of a public service. By making capital investment more attractive to the private sector, well-structured PPPs can mobilize private investment into public service delivery, within a risk sharing mechanism. Since PPPs are highly complex undertakings it is important to ensure that project outcomes support larger health system goals, and that PPP facilities and services are integrated into the wider health system.

The models that have shown the most promise in healthcare PPPs in developing countries are focused discrete clinical service like laboratory, diagnostic, dialysis and other specialist services. Once a track record has been established a country can gradually move to more complex PPPs that are also more capital intensive like hospital facility PPPs.

### **Type of Possible PPPs**

Governments play a central role in the provision and regulation of health care. However, there is an increasing recognition that, on their own, governments cannot deliver enough services to achieve universal health coverage and meet their populations' needs. Governments everywhere are grappling with rising healthcare costs and increased demand for healthcare services in the face of ongoing budget constraints. All players in the health area, including the private sector, will need to be involved if countries are to deliver universal health coverage and meet Sustainable Development Goal (SDG) <sup>3</sup> on Health. PPPs in healthcare provide opportunities for governments to leverage private sector resources and expertise, to enable investment in large-scale projects that advance national and local public health goals, such as improving quality of service delivery, and expanding access to care.

The private sector already plays a substantial role in the financing and implementation of health services across the African continent. An estimated 60 percent of health care financing

PPP Guidelines - Appendix

in Africa comes from private sources, and about 50 percent of health expenditures goes to private providers, according to the World Bank Group’s IFC.





The majority of facility-based PPPs bundle these functions into three models as presented in Figure 1:

- Infrastructure-based model – to build or refurbish public healthcare infrastructure
- Discrete Clinical Services model – to add or expand service delivery capacity
- Integrated PPP model – to provide a comprehensive package of infrastructure and service delivery

Government’s decision of which model to pursue is driven largely by local health needs and environmental (e.g., political, social) factors. The threshold of risk and responsibility that the government seeks to allocate—and that the private partner is willing to accept—are also major determining factors. Discrete Clinical Services models are beginning to gain traction in Sub-Saharan Africa as an ‘asset light’ option, and are less complex to implement than the other two models.




The different forms of PPPs presented here are in line with the PPP legal framework on more specifically article 5 of the PPP Proclamation.

Table 1: PPP Models

			
PPP Model type	Infrastructure-based model	Discrete Clinical Services model	Integrated PPP model
PPP model components	Infrastructure + financing + nonclinical services + clinical support services (as relevant)	Clinical services	Infrastructure + financing + nonclinical services + clinical and clinical support services
Private partner responsibilities	Private partner is contracted to <b>design, build, finance and maintain</b> facilities. Delivery of nonclinical services can be included (e.g., laundry, cafeteria). More advanced projects include delivery of clinical support services (e.g., lab, radiology)	Private partner is contracted to <b>deliver</b> discrete clinical services (e.g., clinical support services, specialty care services)	Private partner is contracted to <b>design, build, finance, operate</b> facilities and <b>deliver</b> nonclinical and clinical services.
Common PPP model names	Design Build Finance Maintain (DBFM), Design Build Finance Maintain Operate (DBFMO), Design Build Operate Transfer (DBOT), Private Finance Initiative (PFI), Infrastructure PPP, Accommodation model	Operation management (O&M) contracts	Design Build Operate Deliver (DBOD), Clinical services PPP, Integrated PPP, Public Private Integrated Partnerships (PPIP), Alzira model
Healthcare delivery impact			

The figure below presents a typical allocation of risk for these 3 PPP models.

Table 2: Typical Allocation of Risks and Responsibility across the PPP Models<sup>2</sup>

	 Infrastructure based model	 Discrete Clinical Services model	 Integrated PPP model
<b>Types of risk</b>	<b>Infrastructure based model</b>	<b>Discrete Clinical Services model</b>	<b>Integrated PPP model</b>
<b>Planning/design risks</b>			
Land acquisition and planning	Public	Public	Public
Design	Shared	Private	Private
Changes in planning/approvals	Varies	Varies	Varies
<b>Construction risks</b>			
Construction	Private	Private	Private
Cost overruns	Private	Private	Private
Completion delays	Private	Private	Private
Latent defects	Varies	Varies	Varies
<b>General risks</b>			
Force majeure	Shared	Shared	Shared
Changes in legislation/guidelines	Shared	Shared	Shared
Financing	Private	Private	Private
<b>Operational risks</b>			
Operating and maintenance costs	Private	Private	Private
Equipment	Varies	Private	Private
Demand for services	Public	Public	Varies
Labor and staff issues	Public	Shared	Private
Clinical performance failures	Public	Private	Shared

<sup>2</sup> Source: Health and Economics Analysis for an evaluation of the Public Private Partnerships in health care delivery across EU, European Union

## LESSONS LEARNED:

### The Queen Mamohato Memorial Hospital PPP, Maseru, Lesotho

- The Government of Lesotho faced an urgent need to replace the deteriorating 450-bed Queen Elizabeth II Hospital (the main public hospital in the country). Through a transparent competitive tender process the government contracted Tsepong (a consortium headed up by South African healthcare provider Netcare) in 2008 to:
  - Construct a new 425-bed Queen Mamohato Memorial Hospital (390 public + 35 private beds);
  - Renovate 3 strategic primary health care clinics in the greater Maseru area
  - Manage facilities and equipment; and
  - Deliver all clinical care services for 18 years (including 3-year construction period).
- The remuneration of Tsepong is based on an annual fixed service payment of USD 32.6 million (paid as a unitary charge) for delivery of all services, escalated only by inflation annually. Tsepong can also earn a profit from running a 35-bed private patient unit within the hospital. The project raised USD 120 million (85% debt + 15% equity) and construction of the hospital began on March, 2009. It was successfully completed and commenced operations in October 2011.
- In terms of access, according to the official data the national hospitalization rate was 3.2% of the population each year, which means that previously the hospital could treat only 64,000 patients on annual basis. However, the new hospital is designed to treat all patients who present at the hospital and filter clinics, which is up to a maximum of 20,000 in-patient admissions and 310,000 outpatient attendances annually.
- In terms of affordability according to IFC's assessment, the Lesotho project was affordable for the government, on an operational cost comparison; the government does not pay much more for the PPP than it used to spend on the operation of the Queen Elizabeth II. Yet it is receiving vastly improved facilities, medical services and patient care. The project has also ensured maximum risk transfer to the private operator, protecting the government from most of the financial, operational, and legal risks inherent in a project of this nature. However, the project has been subject to criticism due to the cost of the unitary charge in relation to the national health budget. Critics have pointed out that the annual budget for the Queen Elizabeth Hospital and the filter clinics in 2007-08 was less than USD 17 million.
- The Lesotho PPP structure was the first 'integrated' PPP hospital project in Africa, and one of only a handful of similar projects worldwide. Even in its early stages the project was subject to criticism. Yet, this project demonstrated that it is possible in a low-income country (with deteriorated health facilities, lack of equipment, shortage of staff and inefficient management) to embark on a very ambitious project that is attractive to private investors and affordable for the government



and patients, who can benefit from high-quality health services.

### Romania Dialysis PPP

- Romania's national health system could not keep up with the growing demand for dialysis services: there a backlog of patients and a critical shortage of trained personnel and existing facilities were outdated and inadequate.
- In 2003, the Government of Romania began a pilot program to convert dialysis clinics at eight public hospitals (covering 25% of the country's dialysis patients) to private management and operation to address unmet demand, aging facilities, shortage of trained staff, and lack of national standards.
- Under the PPP contract, the private operator assumed full responsibility for renovating and equipping facilities; purchasing, maintaining and operating the equipment; procuring all medical supplies; recruiting, training, and managing staff; and treating public patients according to new dialysis standards. Under the PPP:
  - Private operators receive per treatment payments, with full responsibility over facilities, staff and treatment
  - New best-practice national standards developed and implemented
  - Possibility to open NEW centers after 3 years of operation of the existing ones
- The tender resulted in the award of the eight centers to four major international companies. An independent evaluation of the project—which served one in four dialysis patients in the country— showed that the privately-managed clinics delivered higher-quality and less expensive care to the public than their publicly-managed counterparts.
- The PPPs generated investment of US\$41 million (including US\$36 million from the private sector) in dialysis treatment and clinics. According to the evaluation undertaken by the World Bank Group the PPP project:
  - Resulted in savings of US\$4.5 million for the national health programme (when compared with similar public centers).
  - Led to improved service quality and facilities.
  - Paved the way to set up national performance and quality dialysis services.
  - Led to government replicating the model to more than 30 centers nationwide.
  - Paved the way to introduce the private sector into this field, more than 85% of dialysis centers in Romania are privately operated.

**II. PHASE I: PPP PROJECT IDENTIFICATION AND SCREENING**



No sectoral specificities.

**III. PHASE II: PPP PROJECT APPRAISAL AND PREPARATION**



No sectoral specificities.

**IV. PHASE III: STRUCTURING AND DRAFTING THE TENDER AND CONTRACT DOCUMENTS**



**Tender Document Preparation**



Legend

- Tasks as per the PPP Framework
- Recommended additional Tasks

### **Checklist: Contract Clauses in the General Tender Documentation and Draft Contract**

While the tendering process is broadly similar across all sectors, the contractual clauses need to be tailored to each sector. In the case of healthcare PPPs, the contract employs a direct relationship between payment and performance: payment amounts, timing and triggers are used as tools to incentivize the private partner and align behavior with desired outcomes.

Payments to the private partner under a health PPP generally fall under four categories:

- **Availability payment:** payment for making the hospital available to the contracting authority. The payment is usually fixed, paid quarterly or annually, and covers the capital expenditures, operating expenditures, debt and profit.
- **Service payment:** variable payment based on the type and volume of services/procedures performed by the private partner.
- **Capitation:** variable payment on a per-person basis to manage the overall health of a population.
- **Payment penalties:** a reduction or delay in payment if contract terms, such as pre-agreed key performance indicators (KPI), and expectations are not met.

PPP contracts generally specify a single payment mechanism to cover both the infrastructure and services provided. In some cases, a mix of payment streams is used to separate the infrastructure portion of the project from the variable costs of service delivery. Typically, the public sector will not make any payments until key terms in the contract—such as completion of construction—are met. This arrangement incentivizes the private partner to ensure on-time completion of the activities, and meet performance and quality standards outlined in the contract.

Projects that include clinical service delivery involve much more complex arrangements, with payments and payment amounts linked to delivery of services across large populations and/or achievement of better health outcomes. For example, the Integrated PPP model implemented in Maseru, Lesotho is based on a unitary payment arrangement that encompasses both the availability payment and service payment to the private partner. The annual unitary payment for capital and operating expenses from the government is based on set inpatient/outpatient volumes and it is adjusted annually for inflation. There is an incremental payment for additional volumes. The revenue from co-located facilities are shared.

The following section provides a checklist of items to cover across the three most common PPP models in healthcare.

#### **Infrastructure-based model**

- Over the term of the contract management responsibility for the land and facility (ies) is transferred to the private partner. At the end of the contract term all facilities revert to government responsibility.
- At a minimum, the private partner takes on the risk of design and construction, cost overruns, delay in expected completion of the project and maintenance costs. As

most payment under this model is provided upon completion of construction (typically 18 to 24 months after the contract is initiated), the private partner is incentivized to complete construction and/or renovation on-time and within budget. Moreover, because its capital is at risk, the private partner has strong incentives to continue to perform well throughout the life of the contract.

- The private partner is remunerated for the cost of construction via an amortized annual payment over the term of the contract along with an annual maintenance contract payment. This structure makes the project more affordable since it allows the private partner to take advantage of long-term debt financing opportunities.
- Projects that bundle operation of nonclinical services into the contract transfer additional risks and responsibility to the private partner for the cost and operation of these services. Nonclinical services often include: housekeeping, utilities management, information management, grounds maintenance, reception, parking, waste management, laundry and catering or cafeteria services. They are paid for usually covered through a single annual payment as these costs can be quantified relatively easily. At least every five years these service costs are re-assessed against the value achieved at regular intervals during the term of the contract.

### **Discrete Clinical Services PPPs**

- The range of contracts vary and cover a broad variety of services, including laboratory, diagnostic, dialysis and other specialist services. The contracts typically focus on the number of services provided or patients reached.
- The contracts are performance-based and incorporate requirements such as maintenance or replacement of clinical equipment. While these contracts are less complex in nature they nonetheless still require a robust monitoring framework and performance regime driven by pre-agreed key performance indicators.
- Given the lower capital investment requirements the term of these PPPs are up to 10 years. The term should align with the lifecycle of clinical equipment, but can become longer-term as contracts are extended. The advantage of longer terms is that they leverage greater private investment to allow for more time to recoup the investment.

### **Integrated PPP model**

- As the most complex of all PPP models it aims to improve public health services while remaining cost neutral to both the government (e.g., a similar budget outlay), and to patients, who incur the same or lower out-of-pocket payments as they would in a public hospital, but for improved services.
- The private partner is responsible for all facets of delivering patient care services as outlined in the contract. This typically includes delivering all care within the hospital and refurbishment and management of a small number of referral clinics, giving them ability to coordinate care and manage referrals.

## PPP Guidelines - Appendix

- The contract can take a step further and include all primary care and referral clinics in the health district in the PPP contract. This approach requires greater community and political buy-in since it allows the private partner to have a greater role over the spectrum of services and referrals in that district.
- The private partner is also responsible for managing all ancillary support services, including, but not limited to, delivery of clinical and nonclinical support services (laboratory, radiology, housekeeping, cafeteria, etc.) and determining and managing equipment and patient systems required to provide care. The human resources for most or all care services and support services is typically staffed and managed by the private partner.
- To manage the components of financing, design, construction and service delivery the model includes a comprehensive set of agreements between the parties. The contracts need to be flexible enough to address key changes, such as shifts in demographics and service delivery needs, over the length of the contract. The private operator is not only responsible for assuming the risk for delays and cost overruns in the construction phase (as with other types of PPPs), but also for service delivery risks. These risks include managing fluctuations in service demand, attaining strict service quality standards and managing human resources.

### V. PHASE IV: TENDER & AWARD



No sectoral specificities.

### VI. PHASE V: PPP CONTRACT MANAGEMENT & PERFORMANCE REPORTING



Post-award contract management and performance monitoring would follow the same procedures outlined in the PPP General Guidelines.

