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De facto privatisation or a renewed role for the EU? Paying for Europe's healthcare infrastructure in a recession

James Barlow, Jens K. Roehrich** and Steve Wright****

* Imperial College Business School, South Kensington Campus, London SW7 2AZ, UK, and HaCIRIC – Health & Care Infrastructure Research & Innovation Centre. Corresponding author's email: j.barlow@imperial.ac.uk

** Imperial College Business School, South Kensington Campus, London SW7 2AZ, UK, and HaCIRIC – Health & Care Infrastructure Research & Innovation Centre.

*** European Centre for Health Assets and Architecture (ECHAA), Churchillaan 11, 3527 GV Utrecht, The Netherlands

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Abstract

If plans to modernise Europe's healthcare infrastructure are to be sustained, new ways of financing it will have to be found. The PFI model has been seriously derailed by the recession, but new forms of public-private partnership – already being tried out in other European countries – may well offer more innovative approaches to delivering health services and infrastructure.

Introduction

Each year billions of euros are spent on upgrading or replacing ageing healthcare built infrastructure across Europe.^{1,2} Major expenditure is needed, not only in the new member states – predominantly those with health systems inherited from the former Soviet era – but also in countries with a more modern estate such as Germany. And stimulus packages, assembled by European governments in response to the economic crisis, have to a degree targeted the upgrading of national infrastructure, including hospitals and other healthcare facilities.³

But how will all this be paid for in an environment where finance and capital markets are blocked and public expenditure resources may be in increasingly short supply? As Nigel Edwards pointed out in a recent editorial in the *JRSM*, organisations with plans for capital expenditure are likely to find it hard to acquire funding in the current economic climate.⁴

The current crisis

Planning and delivering the infrastructure to meet future European healthcare needs has always challenged governments, healthcare providers, the finance sector and the construction industry. The complex relationships between long lasting fixed capital infrastructure, rapidly changing technologies and services, and a frequently unstable policy

context make for high levels of uncertainty about how and where capital investment should be directed. Combined with separate national health systems, tight government regulation, long maturities with low returns – and limited opportunities for income from mergers and acquisitions and corporate finance – this has conspired to ensure that the boardrooms of banks tend to be lukewarm about private investment in healthcare. The current credit crisis and economic recession have merely added another layer to these inherent complexities and uncertainties.

The impact of the crisis on healthcare infrastructure investment

Spending on European healthcare infrastructure is partly through direct public investment, partly through the European Union's Structural Funds, and increasingly – in a number of countries – through private sector resources, in the form of various types of public-private partnership (PPP). However, with the economic crisis there has been a dramatic reduction in the number of third party investors available for healthcare infrastructure projects, and commercial banks are far less willing to invest.⁵

TABLE 1. ABOUT HERE

The impact of this has been especially evident in the UK Private Finance Initiative (PFI) market for hospital projects. Fewer projects were signed off over the last twelve months than during any other period over the last decade. The annual value of signed contracts for health-related PFI projects dwindled from a peak of over £3 billion in 2006 to £520 million in 2008.⁶ Some of this is clearly due to the maturity of the PFI programme, with 53 schemes completed or on site in November 2008 out of a projected 78 over the lifetime of the programme. However, of the remaining planned projects, the consensus is that the prospects are not good, largely due to the capital shortfall. Bailing these out is probably unsustainable and a leaked NHS memo warned that there was no 'Plan B' for maintaining the programme.⁷ Capital expenditure looks likely to enter a period of famine on both the

public sector and the commercial capital markets sides. The few projects going through in PFI are funded by a 'club & hold' model, where effectively a group of banks arranges the financing together in advance (previously, a lead bank would have developed a project then 'syndicated' it to the banking market afterwards). This accesses the funding, but at the cost of reduced bank competition and therefore higher costs.

So how does the picture look elsewhere? It is important to recognise that there is considerable diversity in the way the healthcare built infrastructure is provided throughout Europe, resulting from different histories, cultures and political trajectories. Across Europe the bulk of healthcare facilities are still paid for one way or another by the state or state-controlled entities, either directly by grant or extracted from operating expenditures, for example via a component of diagnostic-related group payments (see table 1). In some countries with a social health insurance model, such as Germany, the public purse finances capital expenditure even if the sickness funds pay for recurrent cost. All countries are facing the need for severe public expenditure restraint for the foreseeable future as governments repair massively-damaged balance sheets.^{8,9} For the medium term future – which may last some time if the gloomier projections of fiscal impact apply – governments will have to run significant primary surpluses in order to bring down the debt to sustainable levels. This means hard finance ministry choices. Typically, capital expenditure has been cut before recurrent expenditure because it is less job-intensive. Even when there may be benefits in the form of economic stimulus, new infrastructure projects will have to be 'shovel-ready' – signed off and ready to start – if they are to be seen as making a significant contribution.

What of countries where there is already private provision? In Germany, there is a fast-growing trend for private for-profit hospital companies to buy public or non-profit hospitals, but to operate them within the 'Krankenhausplan' state hospital framework, therefore without cream-skimming on choice of patients treated. In addition, voluntary health insurance has been making inroads in a number of countries in recent years. In most cases, private

hospitals are increasingly funded in equity and debt capital markets, like other corporations. The Netherlands will be an interesting laboratory in coming years, since the health sector has been reorganised into systems of competing insurance payers and hospital providers, with prices for services increasingly set by the marketplace. The predominance of not-for-profit hospital trusts may be supplemented by for-profit hospital companies.

Public-private partnerships vary in form and scope across Europe – some cover hospital accommodation, some hospital accommodation and clinical services, and others pick up elements of primary care too. The sustainability and appropriateness of these different models will need to be taken into account in designing future capital investment policies¹⁰, but in any event, the PPP markets in Continental Europe are no more capable of accessing large volumes of capital in the current economic climate than is the UK's PFI.

In short, choosing a private financing route for healthcare capital investment may be an attractive short term option for governments and healthcare providers, given the public expenditure squeeze. But liquidity is still a scarce resource – long term funding (> 5 years) is hard to get and expensive, competition is weak, only 'good risks' have access to funding, and healthcare has to compete with other industries. Already, those applying for private funding are not only experiencing shortages of finance, but have been confronted by far more rigid selection criteria by banks which, more than ever, are able to cherry-pick health infrastructure projects.

The EU's Structural Funds may offer a way out for some countries, especially the new member states with hospital facilities that are now unfit for purpose, but competition for these funds will rise and it is not clear that the health sector will get much more than its traditional 1% share.

The longer term

Once the immediate effects of the credit crisis have been washed out, the constraints on government budgets may actually increase both the motivation and opportunities for private healthcare investments. Prolonged economic downturn could provide financial investors with greater incentives to sign PPP-type contracts to secure long-term income from rising and relatively stable demand for health services. Private provision of healthcare infrastructure could be seen as a way of relieving the pressure on public systems. Banks may focus more on sustainable business and begin to see the formerly dull healthcare sector in a new light.¹¹

The pensions time bomb may provide an even sharper stimulus. Fundamentally, PPP and its variants are still an attractive market for governments as well as investing institutions, especially pension and insurance funds. The fiscal burden of the current crisis to developed economies – only equalled in wartime – is in fact in net worth terms only about 11% of the ageing-related costs of pensions and healthcare in coming decades.⁹ But the exit path from the present crisis, extending as it does for years into the future, will make it even more difficult for governments to take on seamlessly their looming pension obligations, one much-discussed wolf which is now approaching the door. Governments will have little choice but to endeavour to pass on much of their pension commitments to the private sector, which will then have to create assets to match the liabilities. Healthcare capital investment, providing a relatively stable if not high return, could well be part of the mix of these assets – and with the neat effect of being to some degree correlated with the services being demanded.

Future models for public private partnerships?

What might future models of PPP look like in the UK? Although PFI has been controversial and divisive, there are some fundamental reasons why this approach was an attractive instrument for delivering new healthcare infrastructure since it allows governments to offset the risk of and responsibility for development to private parties. Concerns have largely revolved around a perceived lack of value for money^{12,13} The current funding difficulties have brought to a head the desirability of a rethink on more fundamental grounds, moving the

model away from infrastructure -only projects. One of the most cogent reservations about UK-style PFI for hospitals is that the incentives and risks allocated between the different parties – those controlling the services and those controlling the estate – are not properly aligned, and arguably the result is long-term inflexibility of the facilities.¹⁴

Future PFI projects may separate the construction of the infrastructure from facilities management, with the latter being subject to more frequent re-competition and in-house provision where this ensures value for money. Other possibilities would be to extend the PFI project beyond accommodation, and there are other models for this in Europe.¹ The Portuguese Ministry of Health has been letting contracts for hospital PPPs with separate but overlapping infrastructure and clinical service special purpose companies, although it is now turning back to a more conventional model. And the Hospital de la Ribera at Alzira in Valencia is a PPP with a whole-population responsibility for both primary and secondary care for its region, and payment by capitation. The project started as a relatively conventional accommodation PPP, albeit with population capitation providing the payment stream rather than, say, the availability and performance charges used in the UK. However, after some difficulties the project was reorganised to give the company responsibility for community services as well, with an expanded capitation payment, but freedom for citizens to go elsewhere (and any costs so incurred being absorbed by the company). This provides an incentive for the project company to treat the patient in the most cost-effective setting, not just in the hospital. The jury is out as to whether such alternative models will offer sound long-term contractual structures, but perhaps it is time to examine whether UK PFI stacks up well against these and other alternatives.

In the long term the current economic crisis may also reinforce moves towards the redesign of healthcare services, with a knock-on impact on infrastructure. Significant efficiency savings need to be achieved in the UK and elsewhere, such as reducing waste, eliminating rework and making sure that patients follow the most efficient pathways, inside and outside

of the hospital.⁴ Rethinking the role of expensive healthcare facilities is also needed.

'Hospitals' are often remarkably resistant to change, but in the longer run problems in paying for expensive facilities may well stimulate moves to shift care into wider community settings through the use of innovations such as telecare, as well as to scale down the size of built assets.

Conclusions

The need for modern healthcare infrastructure will outlast any short term impact of recession on the population's health and wellbeing. How to pay for this, in the course of a trajectory towards large ageing-related healthcare and pension commitments, is a major challenge for governments and health services across Europe. The economic crisis, and need for governments in countries where healthcare infrastructure is essentially publicly funded to reign in expenditure, may reinforce moves already underway towards an increased role for the private sector. In the short run, public-private partnerships in other European countries will face exactly the same difficulties as those in the UK – little or no available funding. But the longer run outlook for countries seeking to increase the role of the private sector in capital funding for healthcare projects may be less bleak. Banks may eventually see healthcare in a new light, as a form of stable and safe – albeit not high-return – investment, driving new and innovative forms of public-private partnership.

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TABLE 1. SUMMARY OF CURRENT CAPITAL FUNDING APPROACHES IN SELECTED EUROPEAN COUNTRIES

Country	Predominant healthcare finance source	Role of private capital in infrastructure and services provision
Finland	Tax	Limited accommodation & clinical PPP
France	SHI*	Big private elective sector Some accommodation PPP
Germany	SHI*	Rapid growth in for-profit provision under state concession Mostly state grants for capital expenditure PPP experiments
Italy	Tax	Small private sector Limited accommodation PPP
Netherlands	SHI*	Not-for-profit trusts Most hospitals use bank debt Future competition between hospitals & insurance companies will determine capital source
Portugal	Tax	Accommodation & clinical PPPs Now accommodation PPP
Spain	Tax	Accommodation PPP & some accommodation 'public-public partnership'
Sweden	Tax	PPP possible
UK	Tax	Small private elective sector Massive accommodation PPP development (PFI) Independent diagnostic & treatment centres

* SHI – social health insurance