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SmartLessons

real experiences, real development

White Elephants¹ Are NOT an Endangered Species PPP Transaction Advisory Services in the Health Sector

Health is the fastest-growing segment of IFC's PPP Transaction Advisory Services business, with 20 completed transactions, a strong pipeline of active and potential projects, and new requests from client governments every week. Nevertheless, identifying the best project for a country is not always easy. We are frequently asked to either deal with white elephants which already exist or to help create them. This SmartLesson provides some candid lessons for avoiding this.

Lessons Learned

Lesson 1: New hospitals aren't always needed.

Often, we are asked by governments to help "find someone" to operate a hospital which has been built with a grant or soft loan. Sometimes, these hospitals are state-of-the-art and often large (too large for a modern hospital), but the government has no money to run them. And sometimes they are in a poor location vis-à-vis demand. And often, they are both.

In these cases, we will figure out how much it will cost to operate it, then assess the feasibility of attracting private-paying patients, and then figure out the gap that will have to come from government. But we are not miracle workers. If there is no ready private-patient market nearby and the government has no money, we won't have a solution.

We frequently hear that such-and-such facility will: (a) stop nationals from flying abroad for treatment because high-quality treatment will now be available at home; and (b) it will attract all sorts of potential patients from nearby countries (and sometimes not-so-nearby). Some investors have, indeed, been successful at doing this, but mostly via private hospitals for private patients. Adapting a white elephant to this market is much more difficult.

¹ The term 'white elephant' is used to describe a burdensome possession that the owner cannot dispose of and whose cost (particularly the cost of upkeep) is out of proportion to its usefulness or worth.

One government even suggested that they divert to their new hospital all the funds they were now paying to lower-cost private hospitals for treating public patients. Sorry, but how can IFC displace existing lower-cost efficient private hospitals with some expensive huge new hospital?

And one country showed me a large new "mothballed"² hospital which they had built through public procurement and wanted me to find private management. Then they told me they had 19 such mothballed hospitals.

Lesson 2: But some existing hospitals aren't needed, either

When I first started in the business of PPPs for health, 11 years ago, it came as a surprise to me that there are far more hospitals around the world than I ever imagined. It came as an even greater surprise that the global trend in medical care is toward fewer hospitals, with far fewer beds, more outpatient space, and much more medical care being delivered outside of hospitals. This is due in part to advances in medical technology and changes in provider payment systems which no longer pay on the basis of beds and hospital days.

Some countries, mostly in Central and Eastern Europe, have 3-4 times the number of hospitals and beds than they need in a modern

² The term 'mothballed' means anything which is put into storage or whose operation is suspended.

medical setting, all built in a different time and era. Their plan for disposing of them has been to ask IFC to privatize them. We have tried but so far never succeeded.

Why has this been so difficult? There are several factors to explain it. First, there are already too many hospitals competing for scarce government or national health insurance payments. But the ones they want privatized are often the most dilapidated and overstaffed. Second, staff are resistant to the idea of private management. It will either threaten their job security or their informal (and illegal) payments which they may now be receiving directly from patients. And lastly, investors don't want the headache of taking on an existing facility and staff. They would much rather build a new efficient facility and hire their own staff. Provided they can secure a contract with the public insurer, this will be far more competitive at attracting patients and more efficient than operating an existing hospital.

The best solution is typically to close several old hospitals and replace them with one new one.³ But globally, it has proven very difficult to close hospitals anywhere. Community resistance often scuttles these efforts.

In Mexico, we were able to implement PPPs for two new hospitals which will, when open, replace two old ones. In this case, the improvement will be significant and obvious. Our client spent considerable time building consensus for this modernization solution.

Lesson 3: White elephants can come in many forms and from many sources.

While hospitals seem to predominate in the white elephant herd, we have seen other species. These typically come via equipment suppliers and other sponsors selling their latest high-priced medical technology. Often, this technology does indeed have an important medical use. But can every country afford a cyclotron?⁴ And should a country pay for one when it has so many other pressing health needs?

But many white elephants are homegrown, straight from the Ministry of Health. They often reflect a political objective. A new hospital in an important political district will undoubtedly help secure votes.

Lesson 4: Back-of-the-envelope.

When faced by white elephant proponents from within the government, the best response is a quick assessment that not only shows the estimated cost to the government, but translates that cost into terms everyone can understand. A real example: If you build this facility, we estimate the end cost will be \$75,000 per patient. With those funds, you could treat X patients in the primary care center or Y patients in the emergency department of the nearby hospital.

When faced with potential white elephant invaders from outside the country, the best response is to emphasize to

³ A provincial governor once said to me: "We don't need another hospital." I replied: "No, but you need a new one."

⁴ A cyclotron is used to produce radioactive isotopes for medical use.

the government the need to conduct a proper feasibility study and, if potentially viable and beneficial, to have a competitive tender. But a tender doesn't necessarily eliminate bad projects, particularly if the government is guaranteeing payment. That is why a closer look at the project's need and its relative cost is crucial.

Lesson 5: Don't be bamboozled by the doctors.

Most hospitals we visit are managed by doctors, and within that hospital every department is also managed by a specialist. Typically, as public sector employees, they lack the resources to update and modernize their facility and equipment. They quite naturally want more modern equipment. So when we visit to discuss the possibility of PPPs, they see this as an opportunity to get new buildings and equipment.

But this misses the very essence of a PPP, which is about improving efficiency and quality through private sector delivery, rather than simply off-balance-sheet financing.

This dialogue and assessment are the toughest part of our job, because most of us are not from the medical profession. We have a set of performance benchmarks we use to evaluate hospital efficiency and quality, such as average length of stay, hospital infection rate, re-admission rate, case-mix-adjusted mortality rate, occupancy rate, and outpatient/inpatient ratio. And we always tour the entire facility (and as many other public and private facilities as we can). The indicators and the tour generally give us an idea of the real needs. But it still helps to have one medical specialist on our team who can debate the more technical points with the hospital docs.

Lesson 6: The Ministry of Finance is our ally.

Most Ministries of Health, and in fact most sector ministries, naturally push their projects and, if the projects end up becoming PPPs, the funding will often come from the Ministry of Finance. So there is little incentive for the Ministry of Health to vet and prioritize. We have a natural ally in the Ministry of Finance, because we are both interested in getting the best project possible (in terms of impact and affordability). They need our help, and we need theirs, in selecting and pruning the optimal projects.

Lesson 7: Buy services, not equipment (or buildings).

PPPs should be about buying services, not equipment or buildings. In the narrow project sense, this means that the PPP operator will be responsible for delivering an all-in service—capital financing, construction, equipment, maintenance, staffing and service delivery (clinical and nonclinical services). So ministries need to think in terms of the outputs and services they need, not the equipment and buildings they want. In practice, this is incredibly difficult, as most officials have been used to public procurement where they specify every nut and bolt they want. And even when they do grasp the difference, there is still an element of mistrust. How can I trust them to use the proper inputs, materials, dimensions, staff, equipment, etc?

Many governments have accepted the need to provide input flexibility to the bidders, but typically within the context of: “We want a hospital of 250 beds, located at Y, with these services and performance targets.” And most want to at least see a concept design from each bidder at the time of bidding, so that they can confirm that the design meets the functional requirements set out in the tender documents.

While this is a massive step forward from traditional public procurement, it may not be sufficient to prevent white elephants. If medical technology and delivery continue to change, a hospital built today could readily be obsolete in, say, 10 years. Of course, if the PPP operator is willing to bear the full market and downside demand risk (i.e., funding drops if demand drops), then potential obsolescence would not be as big a problem for the government. But this is rarely the case. I visited one hospital PPP two years ago (not IFC-advised) that had an occupancy rate of 10 percent (through no fault of the PPP operator). Yet the government was paying the full cost of the hospital’s operations. Nevertheless, the private operator was still worried, as bad press would diminish future PPP opportunities in the country.

Ultimately, we want to encourage market solutions where the private sector adjusts its offerings and delivery to match its assessment

of the current and future market. In one country, the public health insurer requested bids for health services for its insured population for a specific catchment area, but gave bidders flexibility to come up with its own solutions.

Over time, we expect a transformation, as public insurers expand their contracting and governments transition from a service delivery to a policy/regulatory role. This transformation will likely involve three elements: (a) a definition of standard services or packages of services; (b) the setting of standard reimbursement rates, regardless of provider (public or private);⁵ and (c) an accreditation mechanism so that only accredited providers are eligible for contracts. Under this system, all accredited providers would be treated equally and be eligible for reimbursement by the government or public insurer. Providers would be free to choose their location (market forces would dictate) and facility size (subject to accreditation requirements).

Conclusion

Countries that effectively integrate their public and private health care systems through large-scale contracting will provide their residents with the greatest choice and quality standards. White elephants may then truly become an endangered species.



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⁵ Some reimbursement premium may also be needed to attract providers to more remote and rural areas.