Health

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1. Introduction

In this second edition, we expand on some of the areas examined in the first edition and in particular:

- review how some of the then proposed public health service reforms have developed across Western Europe and the extent to which the private sector has participated;
- look again at some examples of the legal/commercial arrangements that have been developed in the United Kingdom to effect the private sector's participation in the provision of public health services; and
- consider the impact of the global economic crisis on PPPs and, in the context of the UK, the different views on the use of the PPP model for public healthcare projects.

2. Health service models and reforms, and private sector participation, in Western Europe

Healthcare systems vary widely across Western Europe, where both public and private facilities co-exist. The systems tend to fall into one of two differing forms of public insurance models. The United Kingdom, Italy and Spain use an integrated model, where the insurance provider also provides the services. In contrast, France, Germany and Belgium use a contract model where there is a separation between the services and the insurer.

Set out below is a brief synopsis of the healthcare systems and the most recent reforms in the United Kingdom, Italy, Spain, Holland, France, Belgium and Portugal, together with some examples to date of where the private sector has participated in effecting those reforms.

2.1 United Kingdom

Proportion of gross domestic product (GDP) spent on health	8.4% (2006)
Annual expenditure on health per capita (average exchange rate $)	$2,417 (2006)

Source: House of Commons Library (OECD Health Data 2008)

(a) The National Health Service

The United Kingdom's National Health Service (NHS) was established on July 5 1948, following the enactment of Nye Bevan's National Health Service Act in 1946. The NHS took control of over 2,500 hospitals and was organised broadly into three parts (hospital services, family doctors and local authority community care), involving the creation of 14 regional hospital boards and 147 local health authorities.

The underlying principles of the NHS then were that it was funded predominantly from taxation and that it would in general be free at the point of use, comprehensive and available to all, regardless of means to pay. Many of those principles remain true today.

Since 1948, the NHS has undergone some notable reforms relating both to organisation and to intensive capital investment. One of the more significant organisational changes was implemented by the Conservative government in the late 1980s and early 1990s, following its paper "Working with Patients" and later the NHS and Community Care Act 1990. The objectives of the reforms were fairly familiar: improvements in efficiency, quality, equity, choice/responsiveness and accountability. It was hoped that these objectives would be satisfied by the creation of the so-called 'internal market', whereby health authorities ceased to run hospitals directly and instead became purchasers of healthcare services from providers which, in theory, could be from the public or private sectors. Public sector providers (eg, hospitals, organisations providing care for the mentally ill and ambulatory services) became self-governing NHS trusts with certain responsibilities and powers to enable them to fulfil that provider role. It was hoped the changes would enable health authorities to focus on assessing the health needs of their resident populations and purchasing health services necessary to meet those needs, while leaving the providers to focus on delivering services efficiently in competition with others.

In addition, primary care providers (eg, general practitioners (GPs)) were encouraged to hold a devolved budget used to purchase certain health services directly. The intention was that this would create an alternative purchaser to the health authorities and improve the quality of secondary care, given the direct relationship between the GP and the hospital.

Not all expectations of the reform were realised. The internal market did not really become a true market at all, as real competition was often not possible or expected. The cost of administration was also higher than perhaps expected, opening the government to criticism for diverting valuable resources away from front-line health services into management, when in fact improvements in the management of the NHS were much overdue.

New Labour was elected as the governing party in 1997 and fairly quickly set about putting into effect a key manifesto promise: the abolishment of the internal market. Its white paper entitled "The New NHS – Modern, Dependable" set out a challenging timetable of further reform which, in practice, built upon the Conservatives' "Working with Patients", evidenced by the retention of:

- the capitation-based budget allocation to health authorities (budgets based on population size, age structure and deprivation);
- the devolved powers for NHS trusts; and
- the purchaser/provider split.

However, there was an emphasis on cooperation between participants in local health economies rather than competition, which manifested itself in the new government seeking to reduce management costs through simplifying the contracting process.

In July 2000 the government published its NHS Plan, a 10-year plan of investment in infrastructure and reform of the NHS. The key elements of the NHS Plan (and subsequent documents supporting the original NHS Plan) are:

- major investment in new hospitals, modern IT systems and additional consultants, GPs and nursing staff;
- the creation of patient choice;
- the reduction of waiting times for outpatient appointments to three months and for inpatient appointments to six months;
- the introduction of practice-based commissioning;
- the creation of foundation trusts;
- new contracts for GPs and consultants;
- the introduction of payment by results; and
- improvement of primary care in deprived areas.

Nine years into the plan, much has already been put into effect. For example, over £7 billion has been invested in health projects using the Private Finance Initiative (PFI) alone; independent sector treatment centres (ISTCs) are now an alternative source of treatment to patients; the Local Investment Finance Trust (LIFT) Programme has delivered over 260 schemes at a capital value of over £1.8 billion; and 122 NHS trusts have successfully converted to foundation trust status. That said, while the National Programme for Information Technology in the NHS is up and running, it has been the subject of much criticism due to delays and increases in costs; and the introduction of payment by results (leading to a lack of certainty in income forecasting) is causing many trusts to re-examine their investment plans, including scaling back their plans for PFI projects. In early December 2009 Health Secretary Andy Burnham announced that the plans were to be pared back to their core elements.

In 2008 the government conducted a review of how social care is organised and funded and ran a six-month consultation process with the public, service users and staff, which resulted in a green paper published in July 2009. The paper, entitled "Shaping the Future of Care Together", set out the government's proposals for reforms of the system of social care and is based on achieving the following objectives:

- improvement of prevention services;
- provision of national assessment of individual needs;
- creation of a joined-up service consolidating health, housing and social care services;
- provision of appropriate information and advice;
- provision of personalised care and support; and
- provision of fair funding.

In November 2009 the government enacted legislation that builds on the improvements already achieved in the health sector. The Health Bill received royal assent on November 12 and became the Health Act 2009. The Health Act is aimed at improving the quality of care and contains the following key measures:

- placing a duty on all NHS bodies, private sector and third sector providers of NHS services to have regard to the NHS Constitution;
- piloting direct payments to give patients greater choice and control over their healthcare;
- introducing new powers to de-authorise foundation trusts in certain exceptional circumstances;
- creating new quality accounts that will help to improve the quality of health services;
- increasing powers of suspension to strengthen the ability to hold to account those who fail to meet the requirements of public office;
- establishing a regime for unsustainable NHS providers to protect patients and staff from failing services;
- reforming pharmacy services to ensure that pharmacies are providing high-quality services based on local needs; and
- strengthening tobacco control to protect children and young people from the harm caused by smoking.

At the time of writing, the date of the coming into force of the Health Act has not been set.

(b) Private sector participation

For the private sector, the implementation of the NHS Plan has impacted on a number of areas, including:

- the development of PFI, with 77 PFI hospital schemes operational and a further 28 under construction;
- the creation of LIFTs between the public and private sectors that then contract with primary care trusts to create facilities and provide certain facilities management services for the primary care sector, with over 260 LIFT facilities having reached financial close; and
- the development of ISTCs whereby the private sector is providing in excess of 170,000 procedures per year.

Each of the above is examined in more detail in Part 2.

2.2 Italy

Proportion of gross domestic product (GDP) spent on health	8.9% (2006)
Annual expenditure on health per capita (average exchange rate $)	$2,374 (2006)

Source: House of Commons Library (OECD Health Data 2008)

(a) The Italian National Health Service

The Italian National Health Service (*Servizo Sanitario Nazionale* (SSN)) was created in 1978 with the initial intention that it would be financed from taxation. In reality, until the late 1990s the SSN was financed by a combination of compulsory employer/employee/self-employed contributions, tax and patient co-payments. This was amended in 1998, when compulsory contributions were replaced by regional corporation tax. Since 2001 and the reform of the Italian Constitution, the state and the regions have shared responsibility for healthcare.

The state has exclusive power to define the basic benefit package, which must be uniformly provided throughout the country. The 20 regions have responsibility for organising and administering the healthcare system. Most recently, central government has surrendered a share of the revenues from value added tax (VAT) to the regions. The central government contribution is calculated on the basis of the estimated cost to provide all citizens with 'uniform' levels of care. Each region receives a central grant equal to the *quota capitara* (amount of money per person), less the revenues raised by regional taxes. Further changes to move away from central government contributions to regional contributions are planned to take effect from 2011.

In comparison to much of Western Europe, patients in Italy enjoy great flexibility in their healthcare. To obtain medical care there are only two limiting factors:

- Patients must use healthcare facilities in the area in which they reside; and
- They must have a doctor's prescription for most forms of care.

However, patients can choose their own provider, as long as it has a contract with the SSN and possesses the necessary capacity.

This method of providing healthcare does not exclude private sector participation. However, all private providers serving SSN patients must be accredited by the region. The individual regions also maintain the choice of which private sector participants they are prepared to negotiate service agreements with. Among private sector participants in the health sector in Italy, there is growing concern as regards the role of private providers within the regions that have large private health sectors, particularly Lazio (Rome), Lombardy (Milan) and Campania (Naples). Private sector healthcare providers in these regions view the regulations that are aimed at governing the private sector, including the need for accreditation, as a scheme to give an unfair advantage to public providers, a position which is supported by the Italian Competition Authority.

(b) Private sector participation

In recent years Italy has introduced PFI-style procurement within the health sector for the provision of hospital buildings. Italy's first hospital PFI project, the Ospitale di Mestre, worth €210 million, reached financial close in 2005. The Ospitale di Mestre deal represents the first example in Italy of a PPP project financed to international standards in compliance with the Italian project finance legal framework. The procurement process for the project was complicated by the need to apply international PPP practices within Italian law and by the use of English law for the finance documents.

Since the culmination of the Mestre project, a pipeline of projects has been quietly building up in the Italian PFI sector. The Merloni Law that has been in place since 1998 appears to be working successfully for local contractors, even those outside Italy have initially seen it as confusing.

In addition, recent changes to procurement legislation allowing a selected bidder to match the offer of a winning bid on any given concession have made the procurement process cheaper and quicker. Monselice hospital, Naples hospital, Trento proton therapy centre, Brescia hospital extension and renovation, new co-generation plants for hospitals in Vimercate, Udine, Alta Padovano and Campo Saint Piero, and extensions to hospitals in Careggi and Iona are among the projects expected to move forward in the coming months.

2.3 Spain

Proportion of gross domestic product (GDP) spent on health	8.4% (2006)
Annual expenditure on health per capita (average exchange rate $)	$1,985 (2006)

Source: House of Commons Library (OECD Health Data 2008)

(a) Spanish healthcare system

The Spanish healthcare system is tax based and over the past 20 years the responsibility for care has largely been devolved to Spain's 17 regions. Private insurance companies provide complementary healthcare coverage and increasingly play a role in covering services not included in the basic package, which are designed to avoid waiting lists. In 2003 18.7% of the population purchased private insurance policies. The autonomous regions decide how to organise or provide health services and implement the national legislation.

The Inter-territorial Council (*Consejo Interterritorial del Sistema Nacional de Salud*) is composed of representatives from the independent communities and the state administration, and is in charge of promoting the cohesion of the health system. The healthcare system is financed by general taxation, including value added tax and income tax, and also from regionally raised taxes. Private healthcare financing complements public financing with out-of-pocket payments to the public system, as well as the private sector (eg, private outpatient care) and contributions to voluntary insurance.

Spain's healthcare system has undergone major reform in recent years. Key changes include the development of a new reformed primary healthcare network and the evolution of financing and management structures. The government has devolved the health services to 17 autonomous regions across the country and has implemented a tax-funded system similar to other countries across Western Europe. However, there remain limitations in the form of a central government that continues to provide the majority of the funding for healthcare and coordination of national policy.