PUBLIC-PRIVATE PARTNERSHIPS IN REGIONAL HOSPITALS: THE CASE OF CLINICAL HOSPITAL OSIJEK

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Summary

This paper presents the possibilities of development for Croatian regional hospitals through Public-Private Partnerships (PPP). The goal is to derive lessons from other countries' experiences in implementation and enforcement of the PPP model for hospitals in order to avoid future mistakes and to present possibilities of the PPP model implementation in Croatian regional hospitals, putting it in the framework of EU accession. The paper will answer questions like are there EU experiences in the PPP model application in hospitals and what are the outcomes; is the PPP model of financing public infrastructure regulated on EU level and how; are there existing preconditions in the Croatian legal system and institutional environment for the enforcement of EU experiences; how can UK's experiences be applied in Croatian regional hospitals, and finally, what needs to be adjusted and regulated in order to create grounds for PPP implementation in regional public hospitals and to avoid future mistakes in Croatia. In order to show that the PPP model of financing public regional hospitals offers possibilities of economic transformation of the health care sector, paper first tried to prove that regional hospitals in Croatia are neglected and the concentration is present in Zagreb. Secondly, the specific geographic layout of Croatia requires the development of regional medical centers where access to public health service is available to patients from the region. Thirdly, in the light of the current situation (large hospitals debts, insufficient financial funds etc.) the PPP model could offer an extra model of financing in order to provide the best quality medical service to citizens. And finally, as a good practice example, the largest PFI hospital scheme in the United Kingdom was analysed and tried to present through opportunities for Clinical Hospital Osijek (CHO) transformation using PFI model of financing.

Key words: public sector transformation, regional hospitals, PPP, EU accession, Croatia, Osijek

1. Croatian regional hospitals background

In order to present a broader picture of regional hospital possibilities, this part of a paper will analyze health care in Croatia and hospital treatment services from a demand supply perspective. It will look at basic health outcomes and demographic trends on the demand side and developments in health care delivery on the supply side.

The Croatian health care sector has undergone major changes since the early 1990s. These changes have transformed a once highly decentralized system into a more centralized, better funded and overall more efficient system of mixed public and private health care delivery (Mihaljek, 2006:266). Today, the state continues to own national level hospitals (and funds capital investment throughout the health care system), while the county governments own secondary and primary care facilities (Healy, 1999:1). Nonetheless, the system continues to face major problems. In order to present the possibilities for regional hospitals through the PPP model the status of regional hospitals in Croatia will be presented as well as their current development and problems which they are faced with.

1.1. Status of Croatian regional hospitals

In 2005 Croatia had 72 hospitals and treatment centers[1]. First, let us briefly go through the hospital development trend. The number of hospitals beds decreased during the period of 1990-2000 by around 24 percent, mostly in general hospitals[2]. This trend continued till 2005, and the number of beds decreased by over 300 compared with the previous year. At the same time there is an increase in the number of treated patients in hospitals during 2005. But after a long standing increase, the number of treated patients is now stagnating. In terms of hospital beds, Croatia has less overcapacity than the new EU member states and is basically at the average EU-15 level. Other indicators of hospital capacity compare favorably with European averages; one exception is the average length of stay in hospitals (11 days), which is longer than the EU average (9 days) (MZSS, 2006:17).

But how can we see the government's (the public sector's) behavior on the health care market and how efficient it is concerning public health care services delivered by hospitals? If the government fails in this sense, this occurs when it does not efficiently allocate goods or resources to consumers of government services, in this case health care services delivered by state and local government hospitals (Mihaljek, 2006:273). A particular indicator of this can be seen through perspective of regional hospital capacities, treat-

[1] These were two clinical teaching hospitals (Rijeka and Zagreb), 12 clinical hospitals and clinics, 22 general, and 26 specialized hospitals.

[2] From over 35,000 in 1990 to 27,000 in 2000.

ments, and national allocation of hospitals and specific geographic layout of Croatia. It all shows that regional hospitals are neglected and the concentration is present in Zagreb, as the capital city. The best way to support this statement is to look at the Croatian National Institute for Public Health (CNIPH) data concerning the number of hospital beds. Since Croatia is divided in 20 counties plus the City of Zagreb for the purpose of showing the development and status of regional hospitals those counties were distributed in four main regions plus Zagreb. Statistics in Table 1 show that there is a regional disproportion in hospital beds allocation per 1,000 inhabitants. Although capital cities should lead with the knowledge, experience and the opportunities in the treatment of citizens, these data still show that regional hospitals are neglected and many patients must travel long way to be treated in Zagreb. Analyses of public hospitals reforms show that increasing the geographic catchment area of a hospital increases travel time and costs and thus may reduce access to care.

Table 1. ***Number of hospital beds per 1,000 people in Croatian regions***

Regions	Counties	No. of beds	No. beds per 1,000 pop.	No. beds per 1,000 pop. for region
Zagreb	City of Zagreb and Zagrebacka county	6.897	9,7	**9,7**
North	Krapinsko-zagorska	1.189	8,4	**6,0**
	Sisacko-moslavacka	1.400	7,6	
	Karlovacka	706	5,0	
	Varazdinska	2.056	11,1	
	Koprivnicko-krizevacka	377	3,0	
	Bjelovarsko-bilogorska	487	3,7	
	Medjimurska	351	3,0	
West	Primorsko-goranska	2.307	7,6	**4,5**
	Istarska	810	3,9	
	Licko-senjska	114	2,1	
East	Viroviticko-podravska	300	3,2	**4,2**
	Pozesko-slavonska	610	7,1	
	Brodsko-posavska	696	3,9	
	Osjecko-baranjska	1.329	4,0	
	Vukovarsko-srijemska	597	2,9	
South	Zadarska	1.092	6,7	**4,9**
	Sibensko-kninska	447	4,0	
	Splitsko-dalmatinska	1.868	4,0	
	Dubrovacko-neretvanska	587	4,8	

Table made by authors, data from HZJZ (2006).

Centralization also may produce inequalities since poorer people can afford less travel costs. Large hospitals (even with better treatment outcomes) cannot help those

who cannot get to them (Healy and McKee, 1999:4). Maybe Croatian hospitals have enough beds related to the number of citizens but as Diagram 1 shows they are not well allocated. Zagreb Region has over 34 percent of hospital capacity, followed by the North Region, but the rest of the country has capacities that are much below standards.

Diagram 1. ***Number of hospital beds per 1,000 inhabitants in Croatian regions***

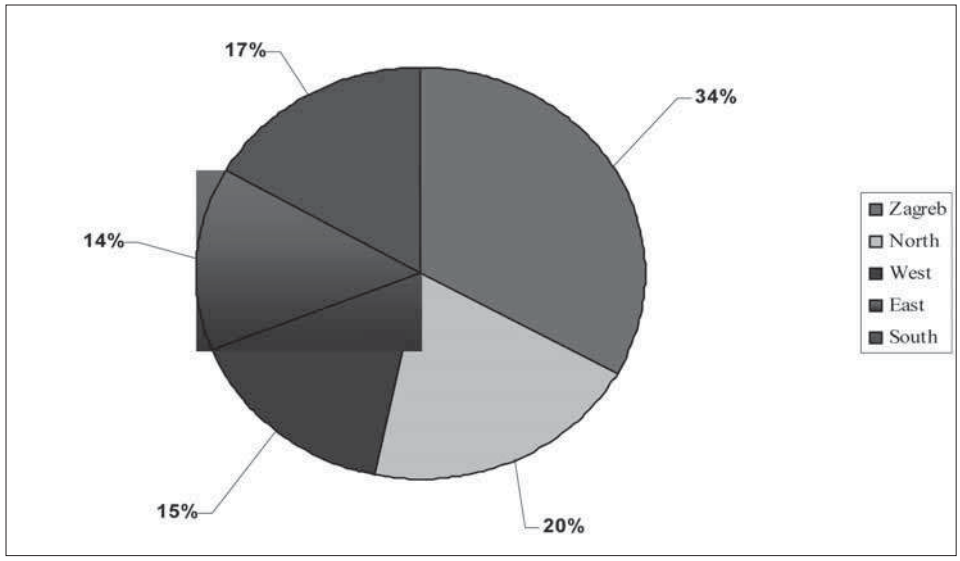

Diagram made by author, data from the HZJZ (2006).

Furthermore, the specific geographic layout of Croatia demands development of regional hospitals in order to avoid further gravitation of patients to Zagreb. In 2005 some counties had a significant gravitation of patients to hospitals in Zagreb, so statistics show that, for instance, the counties of the North region had from 5 to 17 percent of patient gravitation to Zagreb hospitals, but also Pozesko-slavonska county had 14 percent and Dubrovacko-neretvanska county had for instance 9 percent. In this sense, it is necessary to create opportunities for the development of regional hospitals and clinics as regional medical centers. What is also important, in some regions like the South region, there is not any hospital between big cities Split and Dubrovnik. Moreover, there is a political will to solve this problem since the current government is emphasizing one of the aims of health care reform as a continuing process of promotion of uniform measures of accessibility of health care service on the whole territory with an accent on polycentric development (Lovrić, 2006). Croatian hospitals today have also a problem of inadequate space. They are mostly positioned in the center of the cities and along with their fragmentation and disconnection this does not meet to the needs of modern treatment. As the Minister

of health stated, there is still over 30 percent of health care capacities that are situated in facilities from 19th century. The problem is how to adjust such locations for the purpose of a state of the art operation room since the costs of such reconstruction are too big. For the government this is a systematic and continuous problem that needs to be faced and solved. One of the potential models of finding new financing possibilities are PPPs – as they offer a huge and varied potential (Buković, 2006).

1.2. Necessities and opportunities for improvement of regional hospitals in Croatia

Good health broadly shared is intrinsically valued in all societies (Hsiao, 2006:6). The questions are why couldn't markets deliver something that is intrinsically valued in all societies? Because of the failures at the microeconomic and macroeconomic level in the design of the health care financing system. For example, primary-care physicians, paid on the basis of "capitation" payments are encouraged to sign up as many patients as possible regardless of their limited time and maybe reduced quality; capacity-based payments encourages hospitals to keep the beds full and extend the length of stay since high occupancy results in steady funding based on the per diem reimbursement; hospital payments don't provide an incentive for hospitals to increase productivity; introduction of case-based payment system in hospitals except reducing waiting lists and improving total costs control led to a form of "gaming", whereby a hospital was implicitly guaranteed the highest payment, etc. (Mihaljek, 2006:283). This is a good starting point if we talk about public healthcare services provided by public hospitals. The public sector in Croatia, as in most former socialist countries, is facing other obstacles in addition to financing – that is the general assumption that access to health care is universal, equal and basically free to every individual. It creates extra problems in the transformation of hospitals and health care reform in general. The beginning of this process is the change in peoples mind sets and adding value to health care service.

In most EU countries primary care facilities treat about three quarters of medical cases and in Croatia it is less than 50 percent. The counterpart has been a rapid growth of treatments by specialists (secondary and tertiary facilities), which expanded by 30 percent in five years (MZSS, 2006:27). These unfavorable trends in the health care sector are usually explained by the lack of resources allocated to this sector. However, Croatia does not lag behind EU-15 in terms of the share of health care expenditures in GDP. Croatia spends about 8 percent of GDP annually on healthcare and about 84 percent of these expenditures come from public sources. So the problem is probably that the relatively large resources that society devotes to the health care are partly wasted because of the failures in the system of health care financing (Mihaljek, 2006:282). At the same time, hospitals have been confronted with the lack of financial resources and reliable mechanism for quality assurance

(WHO, 2005). There have also been imbalances in the regional distribution of hospital beds but also by the type of care (acute or short term vs. chronic or long-term) and in the regional distribution of hospital resources (World Bank, 2004:25). In other words, decentralization of governance has brought most regional hospitals under the ownership of local governments, which lack adequate financial, management and oversight resources to ensure efficient functioning of hospitals. Despite the increased regional hospitals budgets in 2007[3] the hospital debts just for medications are 1,5 billion kunas and payments are overdue for 500 days (Glavina, 2006b). Hospital expenditures are rising by the annual rate of 1,6 percent for 2006 while at the same time health care provisions per citizen grew from around 370 euros in 2003 up to 510 euros in 2006 (Lovrić, 2006). Having this in mind, could these provisions be used more efficiently and could they been allocated better, and where the problems occur? Along with 3 current models of financing Croatian hospitals[4], each hospital budget is limited by the "global ceiling", with hospitals being subject to financial penalties if they exceed the ceiling (Mihaljek, 2006:283). Those hospital financing methods also have flaws, like hospital's encouragement to keep the beds full and extend the length of stay. None of the existing hospital payment methods in Croatia provides an incentive for hospitals to increase productivity: the CIHI essentially reimburses hospitals for inputs used rather than outcomes (World Bank, 2004:25). Hospital management therefore has no incentive to try to economize on inputs and realize higher net income for distribution to central and local government. On the other hand, when hospitals are faced with an unexpected rise in costs that might break the overall budget limit, the management cannot adjust staffing levels and often has to implement ad hoc cost-saving measures such as restricting the use of medications or procedure (World Bank, 2004). Besides the need for more efficient expenditures and resources control, another widely recognized weakness of the Croatian hospital system and especially regional hospitals that need to be addressed is lack of appropriate management skills (Crnjak, 2006). Hospitals are managed by physicians, who often lack the adequate training in strategic management, financial planning and other skills necessary for hospital management in a competitive market environment. Moreover, physicians in the role of hospital managers face inherent conflict of interest: as hospital managers, they decide how to allocate the funds within the hospital, so they can direct the funds to the department where they spend these funds as physicians (Mihaljek, 2006:294).

[3] Regional hospital budgets in 2007 will depend on the number of employees and also on new services that are going to be offered by a hospital. Because of these new services the hospital budget is increased by 5.2 percent compared with 2006 budget, which amounted 7.5 billion kunas. (Glavina, 2007)

[4] The hospital payment system consists of three separate components: 1) for patient accommodation hospitals are paid a flat fee per bed per day 2) physicians' services are mainly paid on a fee-for-service basis, using the WHO point system; 3) pharmaceuticals and other materials are paid separately, depending on the cost of each item.

Indeed most public hospitals in transitional countries have faced these problems, but the way of solving them is different. The foreign experiences and trends in the development of other models of financing hospitals are suggesting that it is unrealistic for the Croatian authorities and the public to expect that the current model of health care financing can be retained.

1.3. Capital investments in Croatian health care sector

CIHI finances only small portion of capital spending (less than 0,3 percent of total spending in 2005). The bulk of finance for capital spending is provided by the Ministry of Health, local governments and through foreign aid (Mihaljek, 2006:286). From 2004 and inclusive with 2006 the state invested almost a billion kunas in health care, which together with the loan of the Council of Europe[5] reached 1,7 billion kunas. These investments were accompanied with equipment procurement in total of 515 million kunas (Buković, 2006). Moreover, a significant amount was invested in critical points of hospital system recognized by long and sometimes multiannual waiting lists. This is the case of orthopedic departments (Orthopedic Clinic Lovran) and cardiac surgery (CH Osijek and CH Split) (Glavina, 2007). The plans for health-care capital investments in equipment and infrastructure for the 2007 are 623 million kunas, which represents 45 percent more capital than 2003. The rise in capital investments in this sector can be also seen if we look at trends during the period 2001– 2004 (DZS,2007:192-207).

Diagram 2. ***Annual capital investments in health care as a percentage of GDP***

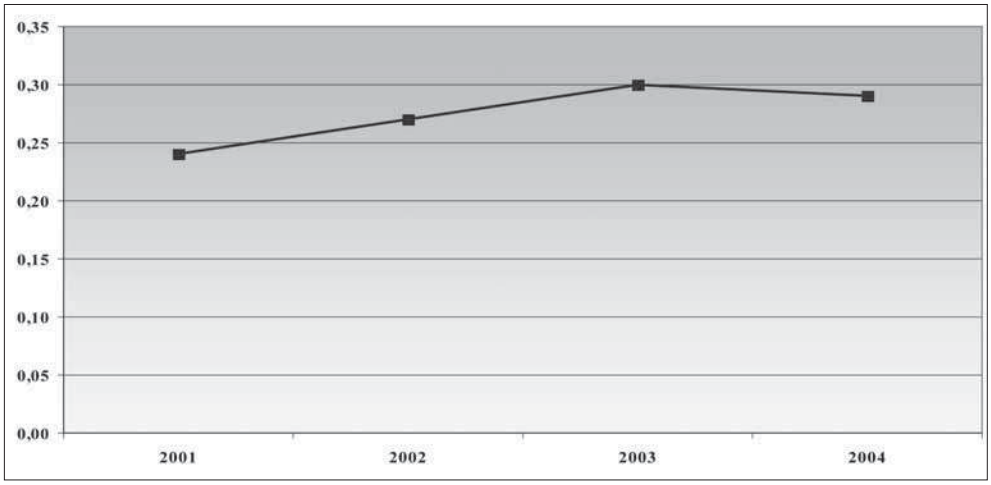

Diagram made by author, data from DZS (2007).

[5] 700 million kunas extra investment

We can conclude that capital investments have been rising slightly during the observed period, as has their proportion in annual GDP. Nevertheless, the speed of reconstruction of certain regional hospitals is too slow, the state is going into more debts in order to invest in infrastructural projects, waiting list are still too long, and certain departments in regional hospitals like psychiatry in CH Osijek do not offer adequate accommodation and conditions for patients. Above that, not all models of financing are being used.

2. PPP

Since local governments have limited resources for big infrastructural projects, PPP might overcome these problems and provide alternative models of financing regional hospitals. This section is trying to analyze whether the PPP model in hospitals may be a possible solution, by setting it against European experiences as a new trend in financing transformation of public hospitals.

PPP has many forms, but the most frequently used model is when a private company with its own resources builds a hospital in which it then for some time performs business activities, which means offers public health care service. The state pays to the private partner a service which he than provides to patients free of charge. These payments are determined in advance for an agreed period of time. When this target date expires the hospital becomes state owned again (Ott, 2006). This model presents the possibility for economic transformation of health care sector as one of the crucial resources of economic growth. Many wonder if this is going to lead to more payments for patients for their health care services. But as the government is emphasizing, the PPP model of financing is not privatization in a real sense. Since Croatia cherishes principles of solidarity this is not going to be changed. Strengthening of the state health care system does not mean elimination of private initiatives because they contribute to a faster development of medicine which is the main reason for implementation of the PPP model, where principles of welfare oriented state and entrepreneurship ideas pervade (Lovrić, 2006).

In the combination of public and tax payers money there is so many unused spaces that it is necessary to work on a further advancement of this concept and its adjustment to the local situation. Public governance interest is more and more highlighted, which can be seen in the positive stand of the Government, organization of the first PPP conference[6], formation of PPP Department within the Agency for the Promotion of Investment and Export. The PPP model might be a way to in-

[6] The first PPP Conference was held in the Economic Club of Ministry of Economy (Gospodarski klub Ministarstva gospodarstva) on March 12th 2007 under the Government sponsorship and in organization of Trade and Investment Promotion Agency (TIPA).

sure lacking resources for certain infrastructure projects and services. EC Guidelines concerning PPP emphasize that it is not a solution for all problems, and at least a „miracle solution“: all projects, and those realized by cooperation of public and private investments request an estimation of whether an investment will bring benefits to community, be it health care service, a new highway or a prison, and will this input be significant in comparison to results that traditional methods created (European Commission, 2004:4).

Let us briefly look at opportunities of this model as a new deal in Croatian hospital system. For instance, waiting lists, whether for elderly for nursing homes or mental patients, are long because there are no accommodation capacities. Now, it is not a rare case that there are 10 to 12 persons in one room, and there is only one lavatory per 50 persons. The PPP model might help solve this problem. A private partner could build a new modern object, manage and maintain it; and a public partner (state) – which gives certain amount per patient anyway – will transmit its funds to the hospital manager paying the residence of the user. The Ministry of Health called this approach to social care reorganization - a New Deal in the system of social care (Buković, 2006). There is for example a regional hospital in Vinkovci which has been built through self contributions, and now it is being renovated. But, there is still one part of the hospital that was left out and it is called skeletal (frame). Investment through the PPP model in new services and content within hospital might be a good opportunity and there are stakeholders for these projects (ibid, 2006). Management of hospitals might be also one of the opportunities for the PPP model in hospitals. For many years the health care system has been financed thought contributions and the budget, which meant that management structures got those funds and could not have cared less about their allocation and spending. Up till now there was no space for management in health care. With the announced introduction of expert councils, health care reform wants to achieve guidance in hospital development according to the financial background. Double rooms are the EU standard and Croatian system must strive to achieve that. That is what patient would expect from the obligatory insurance but at the same time, by implementing additional insurance citizens could demand higher standards and more comfort, for instance a special meal, nurse or a single room. If a hospital would provide these higher standards, it also must guarantee that it would not derange the order of obligatory insurance and optimum of guaranteed health care service. Such a practice would enable for parts of the hospitals to upgrade and transfer into, for instance, apartments bringing extra profit to hospitals. Example like this could be seen in the entrepreneurial project of General Hospital Dubrovnik. The PPP model was used for building a top-quality hotel on the sixth floor of the hospital with a five-star restaurant. These apartments, which will be identical to the ones in Dubrovnik five stars hotels, and will be rented under

the brand of the hotel, are not covered by obligatory insurance. That means that these accommodations are paid by patients, bringing extra earnings to the hospital. Through this investment, the health care tourism project worth 10 million kunas and with higher earnings, treatment standards for all patients are rising (Crnjak, 2007). Since Dubrovnik is a tourist center, although the standards will be rising there might be a possibility that hospital management and staff would in some cases concentrate more on rich patients and disregard the needs of "regular" patients. Example of improvement in hospital management is already present is some form in Croatia. Company Euromedic International took over Dutch company Danel Medical B.V., which used to manage the first Croatian health institution, Dialysis Polyclinic Sveti Duh II in Zagreb, whose reconstruction was financed through the PPP model. The main idea of Euromedic is that through PPP it invests in construction of new medical centers or purchase of sophisticated equipment for modernization of existing centers. At the same time, the public health system covers the service expenses that are offered to patients. In general, all services of medical centers managed by Euromedic are fully integrated into the state public health care system based on the agreement signed with the state insurance institution (CIHI), through support of Ministry of Health. Experiences of Euromedic have shown that the main advantage of this model is that its implementation results with long-term benefits to all included sides. It provides for people of different social status permanent health care service with highest standards in centers with state of the art technology for which the state pays the same price which usually pays to all health care providers. Good hospital management is also seen in giving certain non clinical services (food catering, laundry, etc) to companies outside of the public hospital also called – outsourcing.

2.1. PPP as a new trend in financing transformation of public hospitals

Since hospitals must change, the question is if they can change and be reformed using the PPP model of financing or not? The hospital as a complex human service organization must adapt to continuing pressures for change from its internal and external environments. On one side, we have these internal pressures which include: a changing patient population with new patterns of illness and age structures revised clinical treatment protocols, and new technology. On the other side, there are external pressures like government efforts to rein back state health care budgets, of which hospitals generally consume over half. Some authors like Healy and McKee (1999) emphasize also a problem with centralized systems of health care and the large hospitals which can be slow to change. As governments struggle with rising health care costs, PPPs in constructing and managing public hospitals might provide innovative ways to control costs and improve service. Experience shows that such partnerships offer significant benefits as long as policymakers structure the transactions carefully and create sound regulatory arrangements to ensure universal access, quality care,

and improvements in efficiency (Taylor and Blair, 2002:1). It means that even large hospitals can use PPP as a model of financing transformation in order to have better costs control and improved public services for all patients if the needed and legitimate framework is set.

2.1.1. Background

Globally, health expenditures rose[7]. The increase in spending has been driven by rising income, changing demographic and epidemiological trends, and costly new pharmaceuticals and technology. Although technology is allowing a shift to outpatient care, hospitals still account for 30–50 percent of health expenditures. Croatia also follows this trend. Hospitals treatment expenditures are still the biggest component of CIHI expenditures (4,5 billion kunas; growth over 16% from 2002-2005 (Mihaljek, 2007:289)[8]. The problem is that this growth in spending wasn't accompanied with an increase in public funding[9]. Constraints on public funding, combined with rising costs, have forced public hospitals to cut costs wherever possible while still endeavoring to guarantee universal and in many countries, free access to public patients. Governments have used different strategies to address these problems and some of them have also turned to PPPs to bring the private sector efficiency into public hospitals. The delivery of health care in almost every country involves some form of PPP. In countries where care is delivered mainly through the public system, many inputs, such as pharmaceuticals and support services, are sourced from the private sector what is a situation in Croatia. In hospitals, the situation is further complicated because of the many functions provided by such institutions. The PPP model is, inevitably, seen mainly in countries with national health services. Since the UK health care system has gone through a period of unprecedented change during 1990s with an emphasis upon supply-side competition and service delivery through a contracting system for hospital, we found the design, build, finance, and operation model also called the Private Finance Initiative (PFI) most suitable to Europe's experiences for PPP explanation.

2.2.2. Origins of the PPP model for hospitals

Privatization of public services became more widespread in UK in the 1980s. Still, for the health sector comprehensive privatization was rejected. The next step was to move the delivery of health care out of the public sector. This was seen as a

[7] From an average of 3 percent of GDP in 1950 to 8 percent (US$3 trillion) in 1999 (WHO, 2000).
[8] Recent data show that Croatia spent 7 billion kunas for hospital treatment in 2006 (Glavina, 2007).
[9] In the UK much of the increase has been financed from private sources (out-of pocket payments and private insurance), while the share funded publicly (by tax revenue and national insurance) declined by 6 percent between 1977 and 1997 (Taylor and Blair, 2002:1).

means to increase value for money, innovation, and responsiveness to users. This approach was developed by Williamson (1975) and Ouchi (1980:129-41), with Preker, Harding and Travis (2000:779-90) applying it to health care, arguing that the public sector is intrinsically less efficient and responsive than the private sector. Williamson and Ouchi's model is saying that where there is low contestability and problems of measurement then a service should be provided within a managerial hierarchy; conversely where measurement is straightforward and provision is highly contestable it should be purchased from the private sector (McKee, Edwards and Atun, 2006:890). The number of competitors in the UK market and the level of observability were the basic leading points in the creation of the PPP model of financing projects and especially health care projects such as hospitals. PPP developed as an answer to debt crisis during 1980s. Acceptable alternative to full private ownership, joint venture agreements developed (agreements of common investments) with which partnership relations were created between public and private sectors. Change in investment climate came because of limited state resources and disability for major investments in infrastructure, so it started to look as a potential source of profit which attracted private capital attention. Also, states become aware of ever growing external debts and the fact that if they continue to take major loans for infrastructure there will be less money or no money for financing other needs (Vukmir and Skendrović, 1999:6). This condition inspirited the „project financing" concept and 1992 the UK government launched the model of PFI. If comparing these processes with Croatia today, we dare say that investment climate present during 1980s in countries like the UK and the period of introducing PPP models can be now felt in our courtyard, following a similar path and trends.

2.2.3. Main players and options in the PPP model for hospitals

In the UK a company, usually in the construction sector will create a "special purpose vehicle" to bid for a contract with a health authority to build and provide clinical and other services to a hospital. The successful contractor will enter into 3 types of subcontract: with banks to finance the project; with a construction company to build the hospital; and with a facilities management company to manage it over the lifetime of the contract, typically 30 years. Over the lifetime of the contract, the health care provider undertakes to pay a defined amount from its revenues and the contractor undertakes to maintain the hospital in good order, manage facilities and provide health care service to patients - depending on the agreement (McKee, Edwards and Atun, 2006:891). Doing so, capital investments are being achieved without public sectors debts. Yet, this is still a public health care service that private partner provides and is covered by obligatory insurance. In addition to the above mentioned main players, the UK has set up other bodies to oversee these projects.

There are many different options for PPP models in hospitals, each with a different degree of private sector responsibility and risk (Table 2). These forms are differentiated most critically by whether the private firm manages medical services, owns or leases the facility, employs the staff, finances and manages capital investments. A government's decision on the most appropriate option will depend on the hospital's needs and circumstances, the government's capacity to regulate and effectively control the quality of care, and the public consensus on the need for reform (Taylor and Blair, 2002:2).

Table 2. ***Options for private participation in public hospitals***

	Option	Private sector responsibility	Public sector responsibility
1	**Colocation of private wing within or beside public hospital**	Operates private wing (for private patients). May provide only accommodation services or clinical services as well.	Manages public hospital for public patients and contracts with private wing for sharing joint costs, staff, and equipment.
2	**Outsourcing nonclinical support services**	Provides nonclinical services (cleaning, catering, laundry, security, building maintenance) and employs staff for theses services.	Provides all clinical services (and staff) and hospital management.
3	**Outsourcing clinical support services**	Provides clinical support services such as radiology and laboratory services.	Manages hospital and provides clinical services.
4	**Outsourcing specialized clinical services**	Provides specialized clinical services (such as lithotripsy) or routine procedures (cataract removal).	Manages hospital and provides most clinical services.
5	**Private management of public hospital**	Manages public hospital under contract with government or public insurance fund and provides clinical and nonclinical services. May employ all staff. May also be responsible for new capital investment, depending on terms of contract.	Contracts with private firm for provision of public hospital services, pays private operator for services provided, and monitors and regulates services and contract compliance.
6	**Private financing, construction, and leaseback of new public hospital**	Finances, constructs, and owns new public hospital and leases it back to government	Manages hospital and makes phased lease payments to private developer.
7	**Private financing, construction and operation of new public hospital**	Finances, constructs, and operates new public hospital and provides clinical or nonclinical services, or both.	Reimburses operator annually for capital costs and recurrent costs for services provided.
8	**Sale of public hospital as going concern**	Purchases facility and continues to operate it as a public hospital under contract.	Pays operator for clinical services and monitors and regulates services and contract compliance.
9	**Sale of public hospital for alternatice use**	Purchases facility and converts it for alternative use, depending on sale agreement.	Monitors conversion to ensure adherence to contractual obligations.

Source: *Taylor and Blair (2002:2).*

2.2.4. Obstacles in implementation of PPP in hospitals – policy issues

It is necessary to mention that there is still relatively little experience with PPP of hospital provision, and governments have yet to undertake rigorous evaluations. Some of the issues are cost, risk, questionable transparency and complexity. The experiences in the UK have shown that new facilities have, in general, been more expensive than they would have been if procured using traditional methods. Compared with the traditional system, new facilities are more likely to be built on time and within budget. In theory, the PFI model should contain the cost to the health authority by transferring risk to the contractors. But in practice, the consequence of less risky government bonds used to finance PFI in hospitals is that the cost of borrowing money is higher than it would be for governments. Also some of the critics emphasize that risk for the private partner is lower since hospitals are financially backed by the government — i.e. the government is a single payer, meaning that income streams to hospitals are less at risk than in markets with multiple payers (McKee, Edwards and Atun, 2006:892). Although the private partner is maybe protected more, if taking into account the financial backup by the government, the PPP still disburdens running indebtedness of the state. That means that instead of a one time basis burden in the initial phase the state budget is being charged through the years in smaller amounts (Vukmir and Skendrović, 1999:8). Also, the cost of annual charges for buildings constructed under PPP arrangements may be higher than the cost associated with hospitals built and run using conventional procurement methods. PFI contracts ensure that money is put aside to properly maintain and operate the buildings since some older hospitals constructed in the 1960s and 1970s have already reached the end of their useful life. So the quality planning in the PPP is crucial for transformation of hospitals into more efficient institutions with competent hospital management. For example, in some projects ratio of construction expenses and expenses of maintenance of object could be 1:2 up to 1:5. This ratio is correct for quality planning and construction which satisfies all needs of effective maintenance and usage of this object. In the traditional method, an investor could choose the cheapest contractor and expected expenditures which are covered by tax payers money could reach the level in which new building could be built, looking over the period of 30 years. These mistakes are frequently made, and even in Croatia we have similar situations concerning the public procurement of medical equipment which is low quality but cheap. Still, the UK government doesn't except the comparison between the two procurement models – traditional and PPP - since it is difficult because of the need to take a lifecycle view to accommodate the tradeoffs between higher initial capital cost and lower long-term operating costs. Also the obstacles can rather be a reflection of underdeveloped skills and an imbalance of power and knowledge between client and contractor which also emphasize the need of quality planning during the process and clear consensus between all stakeholders. While this arrange-

ment provides a source of much needed new finance for the state, a great deal of this funding is "off balance sheet" financing and does not appear in the government books as new borrowing. This arrangement enabled the UK government to remain within targets set for public sector borrowing. Finally, such projects are extremely, and in some cases prohibitively, complex, which is not strange since health in general is a very sensitive issue and especially issues of public hospitals transformation as they are organism by itself. Moreover, there is now a new private stakeholder in the process of offering public and free of charge health care service, which means more efforts in order to satisfy each side and reach consensus. For example, since teaching hospitals accept a wide range of referrals and provide services for various types of patients they involve many different types of stakeholders. And they also require the active participation of universities and research funders. So the difficulties in reaching agreement with all of these stakeholders, combined with the high costs of projects, have led in some cases to the collapse of a major teaching hospital development. Still it is premature to say whether the problems experienced relate to the underlying model or to their implementation but we must keep in mind that the reform and operating of the public hospitals itself is already a difficult task (McKee, Edwards and Atun, 2006:890).

3. Case study – City General Hospital Derby as a role model for CH Osijek

3.1. Analyses of largest PFI hospital scheme in UK

PPPs became especially interesting since they enable the development of infrastructure without or with minimum imminent burden to the state budget. This is extremely important for EU countries as many of them are trying to decrease the state budget deficit to satisfy Maastricht criteria. In the UK a regional health district tenders for a private firm to finance and construct a new hospital, maintain the facility, and provide services such as laundry, security, parking, and catering. The operator receives annual payments for 15–25 years as reimbursement for its capital costs and its recurrent costs for maintenance and services. In this model the public sector remains responsible for all medical services (Taylor and Blair, 2002:2). By implementing the project as a PPP the government expects to reduce the costs of procuring and operating the hospital over its lifetime, as a result of both increased efficiency in building and facilities management and transfer the risk to the private sector. Many of the PFI projects in the UK are being co-financed by European Investment Bank. The PFI financed hospitals contribute to increased efficiency and quality of medical services and therefore help in the implementation of the Government's regional and national health priorities (EIB, 2005). EIB priorities in investments are to help strengthen economic competitiveness of the country, particularly in the less favored regions, and the most vulnerable positioned sectors such as healthcare.

Positive example can be found in Derby Hospital NHS Foundation Trust[10] which closed a successful hospital financial PFI scheme worth 333 million pounds. This five-year scheme, already 50 percent complete, involves the remodeling and redevelopment of the existing hospital in Derby. It represents the future of 21st century health care, bringing together the public and private sectors in partnership that will allow the Trust to fund and sustain state of the art facilities to serve 600,000 people across Southern Derbyshire. This PFI scheme also included partnership with the University of Nottingham in order to run the Medical School which is based at the Derby Hospital site. Following the completion of Derby's new hospital in 2008, the Derby Trust will become one of the largest teaching Hospital Trusts in the UK (Derby Hospitals NHS, 2006:34). Since across the new hospital there is a joint turnover of 313 million pounds a year, the Trust's vision is one of modernization. The top-level objectives of the programme are to provide a teaching hospital, centralize all acute services on a single site and maximize real and deliverable cash efficiencies. A project of this scale brought together all interested parties in a forward-thinking partnership drawing on expertise and knowledge from both sides. In addition to regular players, the UK government distributed responsibilities to main health authorities in order to safeguard the process and always keep patients' needs first.

3.1.1. PFI implementation challenges and achievements

The main gaps or problems that needed to be faced with in this regional hospital transformation were, firstly, the health care service needed to keep pace with changes in society, and then the waiting list needed to be shortened since patients often had to wait too long. Secondly, there were unacceptable variations in standards across the UK so what patients received depended too much on where they lived. Thirdly, constraints on funding meant that staff often worked under great pressure and lacked the time and resources they needed to offer the best possible service. To tackle these problems, the government has decided to make an historic commitment to increase the funding of the NHS over the next years and to use PFI schemes as a useful vehicle for funding big infrastructural public objects (Department of Health, 2000:2). After all preconditions were satisfied the main problems were with regional hospital transformation were identified as stated, and PFI as a tool was chosen. Challenges like finding a suitable private-sector partner, identifying a site for hospital, stakeholders' endorsement,

[10] The UK NHS is a healthcare system. Health services continue to be funded nationally, and available to all citizens. NHS provides a universal service for all, unlike private systems it doesn't exclude people because of their health status or ability to pay. It is funded out of public expenditure, primarily by taxation. Individuals remain free to spend their own money as they see fit, but public funds are devoted solely to NHS patients, and they can't be used to subsidies individuals' privately funded healthcare.

budget restrictions, unexpected costs and risk premiums needed to be confronted during the implementation.

3.2. Opportunities for Osijek hospital transformation through PFI

The opportunities for the CH Osijek transformation through PFI are presented, firstly by comparing the main region characteristics and thereafter presenting the values of the Derby scheme in Croatian circumstances.

The county of Derbyshire constitutes nearly 2 percent of the land area of England (Derbyshire County Council, 2006:42). More importantly, Southern Derbyshire population constitutes nearly 1 percent of UK's population, and the city of Derby nearly 37 percent of Southern Derbyshire population (Office for National Statistics, 2007). On the other hand, East Croatian Region population constitutes nearly 20 percent of the population in Croatia. As opposed to the city of Derby, the population of Osijek constitutes only around 13 percent of East Region population, which is an important indicator for regional medical centers such as Osijek and Derby concerning the catchment area and the discrepancies in the medical service accessibility (DZS, 2001:87). Although we cannot compare the size of the UK and its development to Croatia, we can still analyze more particular circumstances and development of regional hospitals. Firstly, one important geographical similarity is that neither region includes capital cities – London and Zagreb – and neither do counties around them, so they could move into similar directions concerning the development of referent medical regional centers. If we compare the population size (East Croatia 890 000 inhabitants vs. Southern Derbyshire 600 000), we must say that although these regions are far from being the same, the citizens of both countries have needs concerning medical care like any other human being since medical care and its accessibility is a human right. Particularly, the necessity of medical services improvement is more emphasized since Eastern Croatia predictions of population rise in the near future are more imminent backed up with already "perked up" economy. We could expect this trend to continue. As the economy of South Croatia has improved because of the tourism sector, East Croatia could develop thanks to agriculture and food processing industry. Since all patients, no matter where they come from, need medical care it is interesting to compare the number of hospital beds per 1000 inhabitants in these two regions.

Diagram 3. ***Number of hospital beds per 1000 inhabitants***

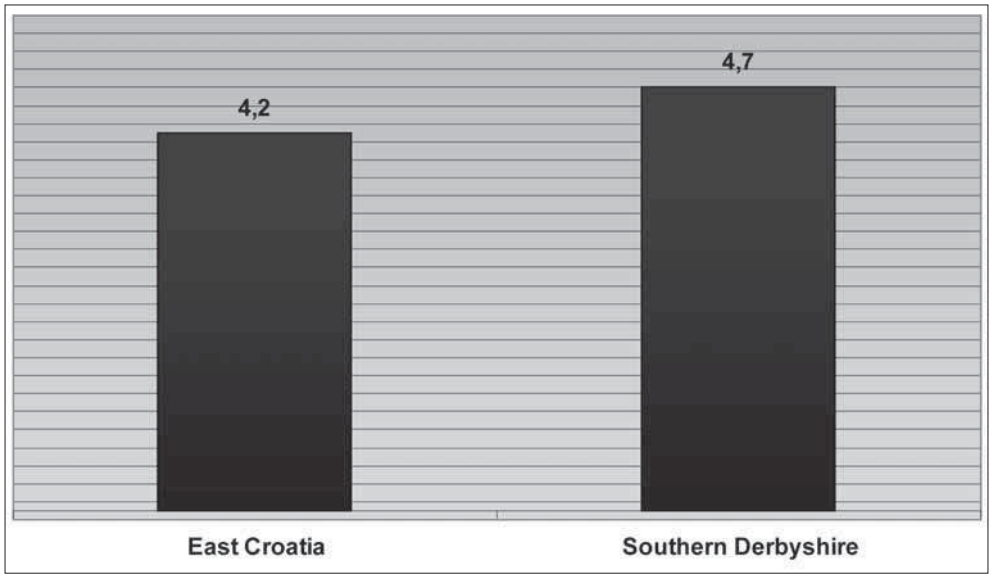

Diagram made by authors, data from HZJZ (2006) and Office of Government Commerce (2006).

The Derby Hospital example shows how the region like Eastern Croatia can include all pertaining counties (geographically speaking) and organize unique medical services to all patients without sending them to Zagreb. The point is to introduce the possibilities of transformation for some hospitals departments in CH Osijek in order to create a referent medical centre for all patients in Eastern Croatia. The emphasis is on the possibilities that mean options. It is therefore not necessary to start from scratch and transform and reorganize entire hospitals. Using good practice examples, certain hospital departments which crave for change, can be modernized through this model.

While infrastructure needs and financing constraints are more severe in developing countries than in advanced economies, all economies need to maintain fiscal discipline and respect constrains on taxation and borrowing, the usual sources for funding public investments[11]. All economies must allocate limited resources among competing needs while ensuring coverage of current spending. Therefore, governments seeking to increase public investment need to follow lessons from other countries, especially when the cost-benefit analyses show that investing in the rehabilitation and upkeep of existing infrastructure facilities usually has higher returns

[11] The Stability and Growth Pact of European Union, for example, imposes ceilings on deficit and public debt in EU members, limiting their room for maneuver with regard to public investment.

than investing in new projects (ibid, 2007:5). The Derby Hospital is one of these examples.

In order to answer the question why this good practice example can be used in case of Osijek hospital paper further tries to draw a line of comparison between circumstances in both hospitals as well as other similarities in health care systems. There is no need to implement PFI as a model for transformation of the entire hospital, but positive experiences can be transferred into some hospital departments. This is important for developing new services and facilities in Osijek hospital. For instance, angioplasty was a new service for Derby Hospital. This change in service meant that patients were now able to have their care delivered locally instead of having to travel to Nottingham or Leicester. This is the case with many patients from Eastern Croatia who gravitate to Zagreb hospitals, because certain procedures cannot be conducted in Osijek. Introducing a new medical service would not only make treatment more convenient for patients, but it will also reduce the number of patients awaiting transfer for treatment elsewhere. As the Derby experience has shown, this in turn helps to increase the number of beds available for other patients needing treatment (Derby Hospitals NHS, 2006:15). This is also backed up with really good figures concerning waiting lists, which is also the problem in Croatian hospitals. For example the Neurology Department in Osijek has one of the longest waiting lists, over 3 months (KB Osijek, 2007). In only few months after investments, many clinical areas in Derby Hospital were delivering waiting times even lower than the national target for outpatients, with 96 percent of patients waiting nine weeks or less for a first outpatient appointment following general practitioner referral (Derby Hospitals NHS, 2006:37). On the other hand, Osijek hospital has a really good start since it is located on a spacious area, it is the only clinical hospital in Eastern Croatia and has, which is very important, the Medical School and University on its own premises.

Similarities with the Croatian legal framework can be also seen in the level of centralization. In fact, in the UK centralization level was and is high and only here and there local self-governments had authority, but still did not have finance. Central Government did however set up separate systems to fund local governments. Through reviews they determine the total level of grant to local authorities, for the following 3 years but local councils also fund their spending by raising council tax. Similarly to Croatian counties that have different budgets, changes do occur also in local budgets in the UK. If a change involves more work for councils, then the Government gives them more grants. If it involves less work, then the grant is taken away. These changes in funding are often known as ‘transfers’. The principle is that funding follows responsibility (ibid, 2006:3). Although there are similarities concerning power distribution and relationships between central and local govern-

ments, the huge differences can still be seen in the local government's budgets. For the almost similar population number which probably has similar needs, Eastern Croatia has 78 percent less money at disposal in order to introduce some significant changes (82 million pounds is East Croatian budget vs. 370 million pounds Derbyshire County budget).

The Croatian Ministry of Health finances and controls all clinics and clinical hospitals, while general hospitals budget is under authority of local self-governments. Still PPP arrangements are not under the scope of local governments. They can be conducted only through leadership and guidance of the Ministry of Health and the Ministry of Finance. Also in these relationships, concerning hospitals transformation, the UK experience can be used as guidance. The new UK model of delivering medical services set up in the NHS Plan emphasizes that the centre will do only what it needs to do; then there will be a maximum devolution of power to local doctors and other health professionals. The principle of subsidiarity will apply. The centre will set standards, monitor performance, put in place a proper system of inspection, provide back up to assist modernization of the service and, where necessary, correct failure. Intervention will be in inverse proportion to success; a system of earned autonomy. This means progressively less central control and progressively more devolution as standards in hospitals improve (Department of Health, 2000:57). This could be a good approach since Croatian Government based the 2007 Budget on enforcement of further fiscal decentralization which will introduce more fair revenue distribution, which will bring a new impulse to a stronger development of Croatian regions (Ministarstvo financija, 2007:3). When talking about funding and local government's budget it is interesting to see the proportion of this PFI scheme in Croatian circumstances. The value of the Derby Hospital PFI scheme equals 23 percent of the Croatian health care budget proposed for 2007 (ibid.2007:3). The values of the Derby scheme can have a significant meaning to Osijek hospital since positive experiences can be transferred into some hospital departments.

4. Croatian political and legal preconditions

4.1. EU legislation and national scope of implementation

There are no special EU rules regulating PPP, however, every legal act with which the public institution confides to third party performance of some business must be adjusted to regulations and principles which address the free movement of services and establishment. In addition, there are directives which arrange procedures of public procurements. Although for national states this leaves at disposal different approaches in choosing a private partner for public services, the European Commission through its association with the accession process, has a wider indirect policy impact on a broad set of legal and regulatory criteria and its objective is safeguarding the public interest and the

correct use of funds. So, since in Croatia the legal situation is still evolving it could be expected that the EU will make careful due diligence an absolute requirement for PPP.

4.2. Political preconditions

The PFI model was first presented to Croatia in May 2003[12]. Four years have passed since than to the first PPP Conference[13] which indicates the government is slightly reluctant to implement PPP (Radusinović, 2007:1). With the organization of conference, launch of the agency[14] as well as creation of division for PPP development and implementation, and by publishing the Guidelines, the state authorities have shown openness for cooperation with the private sector. Necessary political preconditions for PPP implementation are surely the political willingness and good planning. Political willingness could be found in the Ministry of Health announcements of other changes in hospital system[15]. The most important, however, are capital investments through PPP, and the launch of Accreditation Agency for hospitals and health care institutions (Buković, 2006). It is necessary to emphasize that a high degree of hospital system quality which Croatia expects from the project of hospital accreditation and categorization, could be accomplished only in six to eight years and with huge efforts (Crnjak, 2006). It is therefore necessary to find alternative resources and models for investment. In order to attain an international license for Croatian accreditation, which will be the assurance of quality; it is necessary to conduct professionalization of hospital management in which PPP is already shown as a possible solution. Although there are no concrete PPP projects in public hospitals, the political background[16] in Croatia shows significant changes towards their introduction.

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[12] Presentation organized in the Croatian Chamber of Economy by experts from British University Dundee.

[13] Held in Economic Club of Ministry of Economy on March 12th 2007 under the Government sponsorship.

[14] Trade and Investment Promotion Agency – TIPA with Division for PPP, www.apui.hr.

[15] Like the implementation of a hospital system under one roof, connection of basic and clinically applicable education of medical students – campus, process of insurance reconstruction, increase of hospital revenues and outsourcing of certain activities.

[16] The Ministry of Health introduced concrete project proposals like the PPP model for CH Sestara Milosrdnica where a new neurosurgery will be constructed; construction in Vinkovci Hospital that could transform it into facilities for patient accommodation and unit for intensive care; Osijek Hospital using same model could construct thyroid and nuclear medicine center. The Government has more plans using PPP to transform dialyses center in GH Gospić (Glavina, 2007).

4.3. Legal framework and pre-accession conditionality

Since Croatia is in the EU accession process, the implications for PPP arrangements in health care sector also must be reviewed. Firstly, health care is not a part of the acquis so in case of health care reforms, the authorities would need to implement them primarily for the benefit of Croatian citizens, not because the authorities in Brussels demanded that they did so. Secondly, PPP is according to the acquis a perfectly clear arrangement and it is not necessary to bring new regulations, which also means that for candidate countries there is no conditionality which they need to fulfill in order to join the EU. National governments can decide with whom and how they will enter into agreements, on condition they respect provisions of EU law for public procurement. This means that every agreement needs to respect the "holiness" of common market activities EU principle with guarantees of free movement of goods and services and right of establishment (Gulija, 2004:3). There is still an open question whether PPP will be a part of the Public Procurement Law, new concession law or a new law on PPP will be passed. In any case, the process of institutionalization and the creation of the legal framework for the PPP model has begun. According to plans, the owner of PPP projects in the initial phase would be the Government, which would give examples and models for counties. After a certain time period the counties will take over the PPP projects and implement them in co-operation with the Ministry of Health. Founding and ownership rights over hospitals would be subject to special control because of the need to organize this system under one roof – cohesion, profession, team work, schooling (Buković, 2006). In the end it is necessary to emphasize that within the context of preparations for EU membership, PPP might contribute to further stabilization of the market and privatization of the government portfolio, directly affecting maintaining the momentum of increasing direct foreign investments and needed support in capital investments.

5. Possibilities and recommendations

Problems facing Croatian regional hospitals are not new or unique. It is necessary to create opportunities for their development and transformation into regional medical centers since international experiences in public hospitals reforms show that increasing the geographic catchment area of a hospital increases travel time and costs and thus may reduce access to care for many patients. International experiences have shown that PPP can be a powerful policy tool for improving the viability of public hospitals and the quality of their services. So policymakers have a broader menu of options for private participation. In order to implement and use these options certain conditions need to be fulfilled like: *Creation of a sample of tender competition* ***documentation*** *and Croatian* ***standard*** for total construction expenditures; *Production of the* ***rule book*** *for tender procedure and* ***criteria*** *for proposal evaluation; Further*

investments in ***education*** of national and regional leaders, project managers but also in the promotion of PPP models; *Further research* could focus on ***capability assessments or case studies*** for certain regional hospitals or only their departments; ***Presentation of these case studies*** *and research findings to the private sector;* ***Agreement and finding the best possible option*** for a certain regional hospital; National ***governance*** of PPP implementation at a first phase; *Careful attention to universal* ***access of medical care***; Attention to *linking the public funding* (whether from the budget or from public insurance) *to performance* while also rewarding quality care and patient satisfaction and ***Independent regulator -*** to monitor and enforce PPP contracts for hospitals.

Limitations of this paper are primarily regarding the short life cycle of PPP implementation in the world, but it tried to present positive and negative examples and necessary steps for analyses and evaluation of certain opportunities for public hospitals. The scope of PPP implementations and decisions is left to expert teams concerning capabilities and to state authorities concerning needed preconditions and the speed of political and legal adaptations to them. Also political willingness of the governments is evaluated as positive which is still not the affirmation of their intentions and capabilities, since we need the concrete action to support their statement and prove their knowledge and use of foreign experiences. Finally in order to implement the PPP model the situation in the hospital by itself needs to be determined. The general picture of regional hospital status is also relevant, but detailed analyses still need to be conducted for every hospital and the region.

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