ABSTRACT

**Background:** Public-Private Partnerships for the development of hospitals bring together managers from three participants: investors, operators and government.

**Objectives:** The authors conducted a Phase II study to determine the validity of a survey instrument intended to solicit the perspectives of managers from the investor, operator and government officials involved in the development of hospital PPPs.

**Methods:** Interviews were conducted with 33 managers, representing the participant constituents and using a previously developed survey instrument, in an effort to determine the validity of the survey for potential use in a larger study.

**Results:** As expected, the interviews revealed varying perspectives on hospital PPP depending on the respondent’s employer.

**Conclusions:** Management education for hospital PPPs should be based upon the International Hospital Federation Leadership Competencies.

**Keywords:** Public Private Partnerships, Management Competencies, International Hospital Federation

INTRODUCTION

Public-Private Partnerships (PPP) can be significant tools for economic development in many parts of the world. Internationally renowned financial economist Mohamed El-Erian (2016) has written of “promoting the replicable use of public-private partnerships” as an important initiative for new development banks such as the Asian Infrastructure Investment Bank (p. 106). El-Erian goes on to note that PPP have not been fully exploited:

...Despite analytical progress, the focus on enlarging the scope of public-private partnerships continues to lag. The potential is definitely there. As an example, just
think of, on the one hand, severely underfunded infrastructure investment needs and on the other hand, the large pool of long-term capital looking for long-dated opportunities (be they sovereign wealth funds, insurance companies or pensions). It is a gap that is especially glaring given that a part of this pool is also seeking to have socially beneficial impacts. Yet too little has been done by governments to offer a matching menu of partnership options, and this despite the fact that...there are encouraging operational examples (p. 150-151).

PPP have been used successfully in the health care sector of many national economies. A frequently observed use is in the construction and operation of hospital facilities (Sekhri, Feachem and Ni, 2011). Initially, hospital PPP were conceived as accommodation models where private financing paid for the construction and building maintenance of such facilities. Sekhri et al write that the early models have been superseded in many instances by more progressive “integrated” models that combine delivery of clinical services with the construction, building maintenance, and non-clinical service management traditionally found in the older PPP hospital models.

Barlow, Roehrich and Wright (2013) write that in Europe the experiences with the accommodation models “arguably have not met expectations for achieving greater efficiencies at lower costs” (p. 146). The authors argue that the newer models which include clinical service management “offer greater opportunities for efficiency gains but are administratively harder to set up and manage (ibid).” Given shortages of public capital for new infrastructure in Europe “the attractiveness of these partnerships to European governments will grow” (ibid).

In an effort to better determine how participants in healthcare PPP view the venture and their respective roles, an initial pilot survey was conducted in Mexico in the fall of 2015. The authors of the current paper conducted a Phase II study in the Fall of 2016 in an effort to validate the survey instrument used in the pilot study of the previous year. The current study included 29 survey responses from Mexico and one each from Kenya, the Republic of Georgia, Czech Republic and Slovakia. The survey respondents included representatives of government, investors, managers and operators of hospital PPP.

Based upon the survey results, the authors propose using some of the recently published International Hospital Federation Leadership Competencies for Health Services Managers as the basis of further educational efforts for PPP participants.

A REVIEW OF THE LITERATURE

The first utilization of public-private partnerships (PPP) to bolster infrastructure and health improvement projects could be traced back to the late 1970’s; however, their popularity did not expand until the late 1990’s and early 2000’s as a response to growing international financial crises and changing societal needs (Levai 2012; Stadtler 2016; Stevenson 2016). Developed and developing countries ranging from the United States and European Union to former Soviet states and African nations have begun using PPP as a mechanism to increase private funding for public infrastructure ranging from health and education institutions to requisite utility and transportation needs that have been failed by numerous government approaches to financing, development, and reengineering (Levai 2012; Ameyaw& Chan 2015; Stadtler 2016; Tikhomirov et al. 2016). Stadtler (2016) notes that PPPs are essential to provide services to disadvantaged individuals, spark societal transformation, increase standard of living, and enhance economic viability.

In order to comprehend why and how PPP have been and are still used, one must understand what they are and the keys to their successful use. Unfortunately, a standard definition does not exist as an
assortment of administrative structures based on provision of services and partnership arrangements makes one definition difficult. However, an extensive review of literature uncovered terminology and design features that are shared throughout multiple descriptions. Terms and concepts such as cooperation among stakeholders, level of risk, mutual interests, common goals, relationship, collaboration, and of course, public and private sector are pervasive in the literature.

An early definition developed by the Institute for Public Policy Research (2001) is still applicable today as a starting point to understanding PPP. They describe a PPP as a “...risk-sharing relationship between the public and private sectors with the objective of bringing about a desired policy outcome.” Summarizing and combining the concepts posited by Barlow, Roehrich, and Wright (2013) and Reynaers and Grimmelikhuijsen (2015), one could describe a PPP as a hybrid form of governance that uses a variety of governmental approaches ranging from simple outsourcing to almost complete privatization to transfer financial risk and operational responsibility for services from public to private entities.

Public healthcare entities in both developed and developing countries benefitted from the introduction of PPP due to two primary reasons: operational efficiencies and economic security. As described by Hallowell (2016), PPP were introduced in high income countries (Australia, Canada, United Kingdom, France, Italy) first and progressed to other developed and developing countries as policymakers and government agencies increased the engagement of private companies “...to finance and deliver new health infrastructure and related services.” (pg. 35).

As public entities began to suffer under increased financial crises, PPP made it possible to enhance the ability to obtain necessary investment and allocate financial risk as it is easier for private organizations to obtain funding and reduce transaction and financing costs (Caballer-Tarazona & Vivas-Consuelo 2016; Hellowell 2016).

The business models in private organizations have helped to increase clinical performance and enhance efficiency in hospitals and other healthcare facilities (McIntosh et al. 2015). Caballer-Tarazona & Vivas-Consuelo (2016) and Hellowell (2016) also emphasize the importance of the incentives private organizations have to reduce operating costs and unbridle innovation as the majority of the healthcare related PPP contracts are structured so the private provider does not get paid until the contracted deliverables are reached. Any costs they could drive out of the organization while maintaining or improving quality are a win for the private entity.

Unfortunately, applying PPP to healthcare has drawbacks as well. PPP still face a lack of a clear definition for PPP (Barr 2007). They also struggle with the lack of cohesive evaluation processes, limited description of good outcomes, mixed evidence of decreasing costs while increasing quality, and a perceived erosion of stakeholder confidence in missional emphasis (Marks 2014; Caballer-Tarazona & Vivas-Consuelo 2016; Hellowell 2016). In addition, Haslim, Sapri, and Low (2016) highlighted the challenges facing PPP formation in healthcare in lesser developed nations. They emphasized the top three challenges faced in Malaysia: developing a fair risk management model, reaching contract agreement due to the dissimilar structure of private and public entities, and understanding project complexities.

Caution is advised, however. A few key issues to consider when reviewing the results of the application of PPP to hospitals exist. McKee, Edwards, and Atun (2006) summarized these issues into four themes.
Cost – Even though private organizations have greater access to funding, Cost is still a barrier to entry for many private companies. This is more evident when a single payor is present as the financial risk is greater.

Quality – As experienced in most hospitals, a trade-off exists in cost savings, procurement time, and quality.

Flexibility – Since PPP operates under long-term contracts, it is hard to change as rapidly as healthcare changes.

This is especially true in the development of new facilities as the time to develop partnerships, obtain funding, design, and build places an emphasis on innovation in the design phase or the organization risks being behind the development curve from the beginning.

Complexity – The success of PPP in infrastructure development does not translate well to large, complex projects, such as teaching hospitals.

ASSESSMENT OF PPP HEALTH CARE MANAGERS

The initial observations and a case study guided the development of the questionnaire used for the interviews in this study (Annex 1), derived from the authors’ direct experience in the development of these PPP models in Mexico and other countries. Different models have been continuously evolving with changes in the level of care. In Mexico for example, the PPPs started with tertiary care regional or national reference hospitals with inherent policy and management problems derived from the complexity characterized by high cost and technological procedures which require a functional reference/ contra-reference and continuity of care from the rest of the healthcare system. In recent efforts to continue with this PPPs there has been a movement towards less complex smaller general hospitals and/or outpatient and primary healthcare services which present more manageable characteristics (SSA, 2015).

The first step was to design and test a questionnaire with 8 managers of one of the partnerships where the authors had extensive contacts and knowledge. Based on that pilot testing, and with minimal adjustments on the questionnaire, a larger number of managers (29) were interviewed in a second hospital in Mexico with similar characteristics. Most of the findings of the pilot study were confirmed, but the size of the sample added more details on the open questions that addressed the benefits of the PPPs, the problems encountered while managing and delivering services, the specific actions that would help to minimize those problems; the appropriateness of the interactions among the PPP partners and the level of preparedness of the high and middle manages to perform their functions.

The last step was to continue exploring diverse types of PPP models in different countries. Included here are the initial results of the current phase of the study involving interviews with one representative manager from four countries: Kenya, The Czech Republic, The Republic of Georgia and The Slovak Republic.

FINDINGS

The most important benefits identified by the PPP managers of the client (hospitals) were the availability of complete comprehensive services, better maintenance of equipment and infrastructure, quality in the delivery of medical services, quality of the physical infrastructure, the availability of several medical and surgical specialties, better infrastructure; high technology, state of the art medical equipment, and length of time to equip the hospital.
The most important benefits of this model of PPPs identified by the operators were: quality and effective healthcare services, financial support and stability, impact on infectious diseases and reduced morbidity from AIDS/HIV, innovation and structure; complete comprehensive service, quicker action which improves care, quality of services, conservation of facilities and cutting-edge equipment. Finally for the investors the benefits of this model of PPP were: transfer of public private operational risks, fixed cost for the project life horizon, services with high quality and reasonable cost, maintenance in accordance to the manufacturers’ specification for all infrastructure technology, better infrastructure, state of the art medical equipment, efficient services, care of the infrastructure, and development of new organizational culture.

The most frequent problems that the interviewees face in their role in the PPP included the following:

For the client (hospital): difficulty in modifying the informatics system, ambiguity in contract language, no defined process for external damage or normal use of equipment, delay in non-healthcare process implementation given the demands of the hospital, rotation of non-healthcare personnel, complaints of users about third party contractors, lack of knowledge of the general public in relation to the model, the roll-out of the model and the lack of experience, fear, resistance to change (attitude), design of the system, lack of supervision from the provider side, excess demand for patient care and insufficient staff, personnel not trained and with little experience, high costs, the development of the informatics system, payment for service, poorly trained managers, and no willingness to work hard.

For the operators the problems identified were: under qualified staff, political climate, lack of cooperation, no vision for the future, high staff turnover, lack of staff acceptance of the project, financing, misuse and lack of resources, lack of care of facilities, inadequate emergency service, heating, and lack of communication among PPP participants.

The investors’ perceived problems were: contract accomplishments not well defined or ambiguous, requisites and levels of service are not well known the public sector need to comply with responsibilities in acquisition of accessories, lack of communication, lack of coordination of new projects, clash of the traditional culture with the new culture (public/private), lack of understanding of the focus and objectives of the project, and low cooperation within the new organizational culture.

CONCLUSION

Based on this validation study, there is clear need for health care competencies as characterized by the International Hospital Federation Leadership Competencies for Healthcare Service Managers framework. The findings from Phase II align with competencies defined in the five domains of Leadership, Communications and Relationship, Professional and Social Responsibility, Health and Healthcare Environment, and Business found in the IHF competency model (International Hospital Federation, 2015).

A repetitive theme in the results revealed the need for well-trained, experienced supervisors and employees. Respondents emphasized the need for operational expertise, education, and training. Domain 3, Health and Healthcare Environment include a specific subcategory on Health Workforce. The competency maintains the need to demonstrate optimizing healthcare workforce around local critical workforce issues such as shortages and skill mix among other needs (IHF, 2015). Domain 5, Business include a specific subcategory on Human Resource Management. Two competencies are described here. The first entails the need to provide leadership in defining staff roles and responsibilities, job classification and grading systems, and workforce planning. The second competency promotes effectively
managing human resources process such as scheduling, appraisals, recruitment and retention, education and training, productivity measures, and several other functions. It is clear that global health managers need to develop, motivate, and obtain buy-in from employees.

A overarching theme that threads through the survey results involves governance, leadership, and strategic planning. Leadership and governance topics were discussed in relation to the survey results and competency model before, but the discussion now concerns application to strategic planning. Appropriate governance structure and leadership must be in place for effective strategic planning. The respondents indicated that a strong vision with employee engagement is needed to allow sufficient time for the strategic plan to be developed and executed. Additionally, proper monitoring and evaluation against benchmarks and performance indicators is needed for ongoing improvement. Domain 5, Business subcategory Organizational Dynamics and Governance identifies competencies to effectively apply knowledge of organizational systems theories and behaviors and to manage within the governance structure of the organization. Two additional competencies under this subcategory include creating and maintaining a system of governance that ensures oversight of the organization and the ability to demonstrate leadership within the governance structure (IHF, 2015).

It is clear that the IHF competency model is validated given the results of the Phase 1 and the recent Phase II survey research. There are evident competencies needed by health care managers in global settings and PPP. The question now deals with the approach needed to develop these competencies identified by leaders from the field.

Next Steps

The literature review as presented provides evidence on the benefits and challenges associated with PPP. The IHF competency model supported through Phase 1 case research and this Phase II survey research provides a solid framework for developing training and education modules for global health managers to be effective in leading PPP.

REFERENCES


ANNEX I

Questionnaire for Middle and High Level Managers in Public-Private Partnerships (PPP)

Thank you for your time to complete this questionnaire. In different countries PPPs in health care might have diverse structures. As defined in this questionnaire the “Client” is the entity responsible for providing healthcare services (most likely a public healthcare agency); the “Investor” is the financial partner (private company that has the contract with the governmental entity); and the “Operator” is the organization providing support and technology services. In some countries the Investor and the Operator could be two different functions provided by the same company. Please adapt the answers to the specific composition of PPPs in your country.

Date: ___________________________
Hospital Unit: ____________________
City:____________________________
Country: ________________________

1. Part A. Who do you represent in the PPP?
   A) Client (Hospital)
   B) Investor
   C) Operator
   D) Other (Please explain ____________________________________________)

Part B. What is your position? _____________________________________________

Part C. Are you a high level or middle manager? Check one:
   □ High Level Manager
   □ Middle Manager

2. How long have you participated in this PPP?
   Years ______________________________________________________________
   Months ______________________________________________________________
3. What experience have you had in similar projects and which ones were they?

What role did you perform?

4. What are the most important benefits that you identify in this model of health delivery (i.e. PPP)?

1. 
2. 
3. 
4. 

5. Part A. Describe the three (3) most frequent problems you face in your role in the PPP.

1. 
2. 
3. 

Part B. Considering the three problems you identified, please indicate which of the following component(s) they correspond with.

- A) Structure (organization, resources, norms/regulations)
- B) Process (procedures, communication, leadership, culture)
- C) Results/Outcomes (qualitative, quantitative)

6. Which actions do you think could help resolve or minimize the problems indicated in the previous questions?

1. 
2. 
3. 

7. Part A. Are the interactions among PPP partners in your unit appropriate for a strategic alliance to achieve common goals?

- Yes
- No

Part B. Why?

8. Are the middle and high level staff prepared to assume the managerial roles that are required to perform their functions?

- Yes
- No

Part B. Why?

9. Are you familiar with the characteristics and scope of the contract of service delivery of your PPP?

- Yes
- No

Part B. Why?

10. What recommendations would you offer to establish strategic public-private collaborations in the future so they have an impact on the delivery of health services?

1. 
2. 
3. 

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