

## HOSPITAL CONCESSIONS: FLEXIBILITY IN PRACTICE

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### ABSTRACT

Over the last decade hospitals concessions have been increasingly implemented around the world. Nonetheless, concession arrangements are subject to many criticisms, which are to a large extent related to the issue of flexibility. Several authors have expressed concerns as to whether concession arrangements are able to provide the flexibility these need in order to secure optimal qualitative hospital facilities and services in the future. This research is on how flexibility is actually perceived in *operational* hospital concessions. In a case study, an assessment is made on the extent to which English and Australian hospital concessions incorporate the ability to respond to changing demand patterns for clinical services, i.e. mechanisms that provide the flexibility. The outcomes of the case study analysis show that hospital concessions are difficult or expensive to change during their operational phase. However, this appears not to be a consequence of implementing the concession model in its own, but rather the result of sub-optimally designed contracts and/or procurement processes. It is argued that in order to build hospitals that are able to deliver optimal outcomes over time, in addition to a financial focus, health providers should stress flexibility by setting flexible output specifications. Besides, the contract should incorporate the right incentive structures to make both contract partners responsible for flexibility issues that might arise in the future. These outcomes can be used by future hospital boards willing to implement a concession arrangement for their (partly) new hospital building.

### KEYWORDS

DBFMO, health, PFI, procurement

### CONCESSIONS

Traditionally, governments in Western countries were responsible for providing a wide and diverse range of health infrastructure and its services. Today, many governments are deregulating and privatizing public-service delivery in the health care sector. Today, all EU member states are launching new programs or at least studying the feasibility of developing Public-Private Partnerships as a means to generate more value for money. The United Kingdom has a long tradition of PPP, known as the Private Finance Initiative. In other countries similar arrangements known as PFI, DBMFO or BO(O)T have been developed. Together these arrangements are captured under the term ‘concessions’.

Concessions are a relatively new means of providing hospitals and can overcome financing and other bottlenecks associated with traditional provision. This form of providing health facilities and its services is based on a scheme by which the public authority transfers the design, construction, operation, and financing of the infrastructure to a private organization (Bult-Spiering and Dewulf, 2006). Under the PFI, the private organization, the so-called concessionaire, finances the project and has full responsibility for operations and maintenance. Another characteristic of PFI is the long-term duration of the contract.

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Hospitals being built under concessions are expected to provide solutions to overcome the bottlenecks associated with a more traditional approach to hospital provision. However, despite these hospital concessions being increasingly implemented, they are subject to many criticisms, which are, for most of the part, related to the issue of flexibility.

## **THE NEED FOR FLEXIBILITY**

Concession contracts are signed for periods of more than 15 years and, therefore, it is important to analyse the impact on the long-run. Hospitals involve complex, long-term capital investments. Once created, hospitals are difficult to change, whether in terms of geography, culture (as they often face entrenched professional attitudes), or in their scope (the conditions treated in them) (Thompson & McKee, 2004). Despite the complexities surrounding hospital capital investments, there is growing recognition of the need for continuing investment. Investments are inevitable due to changes in the market and contexts of hospitals. (Thompson and McKee, 2004)

Demand for health services is very sensitive to variations in the hospital's catchment population, including natural demographic changes and migration pattern change. Not surprisingly, the dynamic context of a hospital makes the demand on hospitals difficult to predict, both in terms of the quantity and the type of use at the beginning of a hospital's operation and the demand at the end of operation.

Medical technologies have rapidly advanced over the past 30 years and thus have influenced the demand for clinical activities. The developments in medical technology have dramatically improved productivity and substantially increased hospital capacity for treating patients and providing interventions. Similar progress, possibly at even faster rates, is anticipated in the future.

Government policy in the health sector can also affect the demand for clinical services. For instance, the UK government recently committed itself to increasing the volume of elective work undertaken in the independent sector, which may result in a reduction of out-patient activities at 'public' hospitals. IPPR (2001) also enumerates a number of policy changes in the nature of healthcare that have an effect on demand. For example, the move towards care closer to home; the emphasis on linking professionals and specialists in networks that cut across health institutions and provide a pathway of care for patients; and an awareness of the evolving relationship between district general hospitals, regional centres, community hospitals and primary care providers.

As a result, the pattern of hospital activity may change dramatically. The long contract period of a concession makes flexibility even more important. Many hospital Trusts are only certain of their sources of income on a short-term basis, and cannot anticipate what their demand will be in 20 to 30 years time (Froud, 2003) due to changes in demographics, medical technology, and government policies, which can all be highly volatile. The fact that hospitals need to win short-term contracts to ensure demand for their health services and the long-term nature of concessions makes the transfer of risk even more hazardous.

Because of the combination of a high demand risk in hospital concessions due to the characteristics of hospital facilities and their dynamic context, and the characteristics of concession arrangements; and the negative effects should demand risk materialize, hospital concessions require flexibility.

Little research has been done on flexibility in PFI arrangements although various authors and political leaders have expressed concerns as to whether these are able to provide the flexibility these need in order to secure optimal qualitative facilities and services in the future. The King's Fund (an independent foundation working for improved health services in the London area) has claimed that PFI is in danger of becoming a white elephant, lacking the flexibility needed to keep

up with changing policies and technological progress. Several authors, including Froud (2003); Barlow & Köberle-Gaiser (2007), have expressed concerns as to whether concession arrangements are able to provide the flexibility these need in order to secure optimal qualitative hospital facilities and services in the future. The King's Fund has also claimed that concessions lacking the flexibility needed to keep up with changing policies and technological progress. However, little research has been conducted on whether how flexibility is actually perceived in *operational* hospital concessions.

## MEASURING FLEXIBILITY IN HOSPITAL CONCESSIONS

Flexibility performance of a hospital concession is judged upon whether the arrangement provides the ability to respond to changing demand levels for clinical activities, and also to a different configuration or desired quality level of these activities. In other words, it is analyzed whether concessions have adequate provisions to respond to changing demand levels, and whether the provisions in the concession arrangement limit the flexibility of health authorities.

These provisions are found specifically in operational outcomes. These are about whether flexibility has been an essential issue in practice, based on experience in concession projects itself.

One of the most important aspects that determine the operational outcomes on flexibility is the contract used for the project. Concession contracts apparently establish an agreed approach to flexibility. The legal contract therefore can be analyzed in order to determine how flexibility is allocated between the public and private sector partners in the specific cases. Flexibility-related issues are established in the contract specifications between the partners. In the risk allocation matrices, established in contracts, it becomes clear who is responsible for dealing with change.

Another aspect that seems to play a relatively large role in the flexibility outcomes of concession arrangements is the way the procurement process is designed. During procurement important measures like the capacity of the hospital and awarding criteria are settled. It might be of importance to analyse the procurement process accurately in finding causes that explicate the operational outcomes of concession projects.

Summarized, the assessment as to what extent operational concessions embrace the ability to accommodate flexibility is based on three levels: (1) the operational outcomes, which involves reflecting on how flexible the concession appeared after the hospital became in operation; (2) the way the procurement process was designed; and (3) the contract, consisting of the structures of exchange that should ensure the accommodation of future contingencies.

It is not clear to what extent concession arrangements undermine the ability to respond to a changing consensus about the configuration or desired level and quality of services in the future. This will be analyzed through case study research, which is described in the next section.

## CASE STUDIES

In this study, the degree to which hospital concessions accommodate flexibility in practice is analyzed. In this case study an assessment is made of the extent to which seven English and Australian hospital concession projects incorporate the ability to respond to changing demand patterns for clinical services, i.e. mechanisms that provide the flexibility. The overall flexibility of several hospital concessions is analyzed within their contexts and assessed on different levels: (1) the operational outcomes, which involves reflecting on how flexible the concession appeared after the hospital became in operation; (2) the way the procurement process was designed; and (3) the

contract, consisting of the structures of exchange that should ensure the accommodation of future contingencies.

In the case study research, flexibility was analyzed on a project-by-project basis. The assumption is that each project will have a different provision regarding flexibility issues which needs to be thoroughly analyzed and understood. It is also important to recognize that the appropriate distribution of demand risk is dependent on the resources and the capabilities of the parties to a contract, and that this can vary considerably. Given the above problems, and the underlying structure of concessions, flexibility is analyzed in several case studies. The overall objective of the case study research is to assess the process and the rationale underpinning the distribution of flexibility as it is related to demand risk. Cases will be judged upon their ability to adapt to changing clinical demand since flexibility depends on an uncertain context.

#### **OPERATIONAL OUTCOMES**

England: The employment of design flexibility appears to be performed by incumbent construction companies, which raises doubts about the effectiveness of benchmarking exercises. Design variations are mostly implemented using contract amendments rather than temporally rearranging the use of spaces (both countries).

Both English and Victorian cases show that tactical service flexibility is hardly incorporated in hospital concessions. As a result the private partner could become indifferent to optimally using the hospital reasoned from the clinical processes provided.

From the projects it appears that design flexibility is constrained by the small capacity initially set for the hospitals. The comparison of the cases reveals that the scale in the first wave of hospital concessions was set assuming conservative future clinical demand levels. In the Darent Valley and the Norfolk & Norwich PFI projects, the hospital designs were developed based on a minimum projection of the demand level for clinical services. In the Norfolk & Norwich Hospital, the design capacity already appeared insufficient when the facility opened. In the early operational phase, it had to move some of its administration and management offices outside the hospital facility to make room for the much-needed clinical services provision.

Overcrowded hospitals are favoured due to a maximized used availability charge, but also have negative impacts. Overcrowded hospitals can breed infectious viruses such as MRSA and the Norovirus (NHS Estates, 2005). In the Norwich and Norfolk University Hospital, which is mostly operating above set capacity levels, several outbreaks of viruses have taken place over recent years. An overcrowded hospital can also lead to additional costs since availability fees may raise sharply when the hospital is operated above set demand levels. Hence, the rush to certainty by setting capacity levels low in order to obtain an optimally-employed hospital facility appears futile as overcrowding brings forward new risks.

It further appears that hardly any emphasis is placed on mechanisms that allow an adequate temporally change in the hospital design. The absence of provisions to temporally change the employment of the facility implies that the ability to adapt the design of the hospital is limited.

Where there had been a design variation this has mainly been due to changes initiated by the Trust rather than the private partner. Private partners are not incentivized to initiate design variations as they do not face any rewards for these. It further appears that there is a potential mutual dependency between design and service flexibility and financial flexibility. Design and service variations mostly result in a price increase for the Trust. Most of the variations were due to new factors affecting the Trust's needs, which arose after the contract was awarded.

## **THE CONTRACT**

In Victoria, the budget for the refurbishment of the facilities is, unlike in English concessions, set for the duration of the concession arrangement. Contracts incorporate limited provisions that allow for a temporal reduction of the capacity at favourable conditions. Further, the contracts of the seven analysed concessions contain hardly any incentives for optimizations for the private partner. The costs of implementing design variations must be met by health authorities only, with no obligation for private partners for contributions in this respect.

The contracts further show us that they contain provisions to periodically market-test ancillary services are present, both in the UK as well as in Australia. Most hospital concessions allow for market-testing every five years, but other intervals are also found. However, it appears the availability part of the unitary charge is predetermined, and is not influenced by variations in the demand for clinical services.

## **THE PROCUREMENT PROCESS**

In England, decision-making of scope and scale are dominated by financial considerations. In Victoria, decision-making is made more on potential values based on an ad-hoc basis.

## **CONCLUSIONS**

Due to (1) the characteristics of hospital facilities, (2) their dynamic context and the negative effects of inflexible hospital buildings, hospital concessions require flexibility. The outcomes of the case study analysis show that hospital concessions are difficult or expensive to change during their operational phase. However, this appears not to be a consequence of implementing the concession model in its own, but rather the result of sub-optimally designed contracts and/or procurement processes. It is argued that in order to build hospitals that are able to deliver optimal outcomes over time, in addition to a financial focus health providers should stress flexibility by setting flexible output specifications. Besides, the contract should incorporate the right incentive structures to make both contract partners responsible for flexibility issues that might arise in the future.

Health authorities must be convinced of the consequences a PFI arrangement might deliver, as implementation implies restrictions to design, service and financial flexibility. In a case study the demand-risk-related VFM was assessed. This incorporated an assessment of the extent to which hospital concession arrangements incorporate an ability to respond to changing demand patterns for clinical services, i.e. mechanisms that provide the flexibility to deliver Value for Money.

The PFI design should attempt to be an optimal fit with the health authority's clinical requirements and continue to deliver an optimal outcome over time.

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