

# MODELS OF PUBLIC-PRIVATE PARTNERSHIP PROJECTS IN HEALTHCARE IN THE RUSSIAN FEDERATION: PROBLEM OVERVIEW

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## Abstract

Public-private partnership (from now on – PPP) in the field of healthcare is quite well-known in the Western world (Great Britain, Germany, USA, etc.) interaction and is relatively “young” for Russia. But despite this, the PPP sphere is widely discussed in the public field of the Russian political establishment, and the need to use PPP tools in the implementation of investment projects is reflected in government programs and development strategies. It suggests that the development of PPP is supported at the country’s political leadership level.

**Keywords:** public-private partnership, models, projects, healthcare.

## INTRODUCTION

There are two central (“classical”) PPP models in healthcare: providing and integration. Next, we will look at each of them.

The supporting or infrastructural PPP model assumes that the investor (private person) only carries out the facility’s targeted operation. In other words, a particular project company provides the conditions (infrastructure) for implementing the target function (provision of medical services). Such a PPP model includes the design, construction, or reconstruction of a healthcare facility with its subsequent technical support. But the investor can use the area for commercial activities, except for medical. For example, the agreement may provide for using 10-15% of the object’s territory on the 1-2 floor for catering, security services, etc. An individual may lease this territory for commercial purposes, although rent payments (in the prescribed amount) also receive from a medical operator [1, 2, 3].

In world practice, such a model is widespread and presented as an alternative to “state order” (models within the legislative framework on public procurement, GZ models). The advantages over the GZ model are that it is possible to distribute risks and broadcast the performance of functions. In addition, it is worth talking about the long-term nature of the PPP model as opposed to the short-term GZ model.

The project based on the infrastructure PPP model implies structuring within the framework of the PPP (No. 224-FZ). The “core” of the model, in most cases, becomes a particular project company (from now on – SEC), which represents the interests of a private partner (investor). The concept of project financing through the creation of the SEC is that loans are provided directly to the SEC [4, 5, 6]. Creditors further assume repayment of loans through the cash flows of the SEC, and debt security is limited to the current assets of the project and future income. The introduction of a separate participant in the PPP model makes it possible not to reflect the debt of the SEC on the balance sheet of the investor (initiator) of the project (Figure 1).

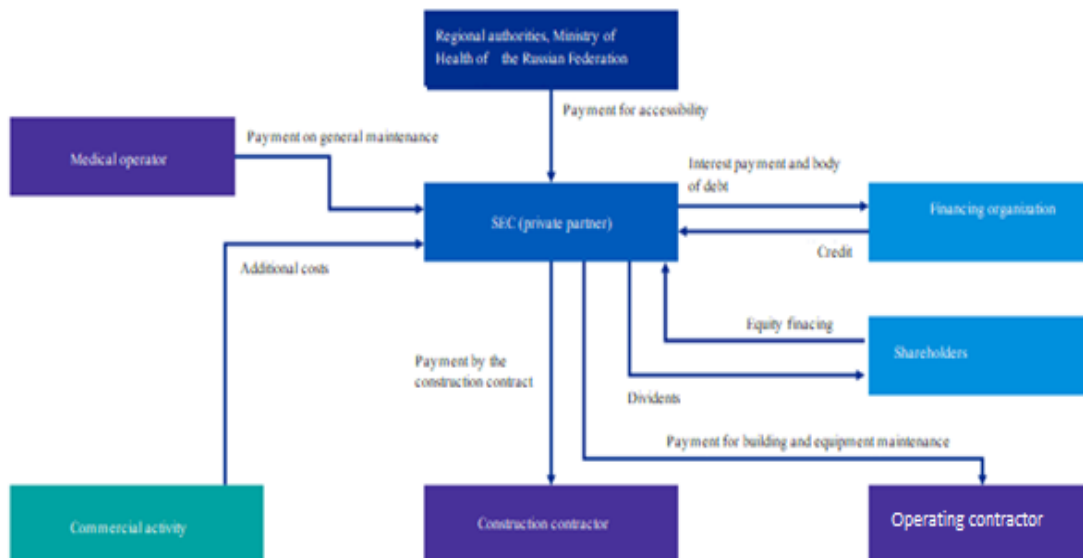


Figure 1. Scheme of the infrastructure PPP model under No. 224-FL

In this PPP model, only the technical operation of a healthcare facility is carried out. Still, at the same time, the SEC can receive income from commercial (non-core activities not related to the provision of medical services) on the facility's territory (on the MO's territory). The SEC can also receive payments for the maintenance and repair of the fund from the medical operator of the facility (MO, which provides medical services).

The primary payment mechanism of the infrastructure model under study, structured within the framework of No. 224-FL, is the availability fee (from now on referred to as the PDA). This PDD mechanism provides coverage of operating expenses, return on investments, and profitability for the investor (Figure 2). Through the PDD mechanism, the public partner can "regulate" the quality of the services provided for the technical operation of the facility. In case of improper performance of their duties, the agreement may provide penalties for a private party [7].

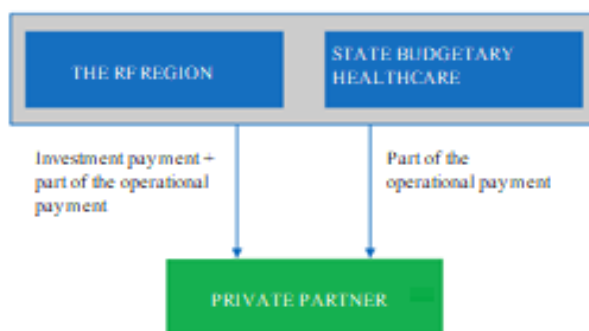


Figure 2. Sources of PZD in the infrastructure PPP model under No. 224-FL

The PZP payment consists of two parts (Figure 3):

- investment, which includes funds for loan payment, return of invested funds and is non-indexed (within the framework of official inflation);
- operational, which includes the funds necessary for maintaining the facility and carrying out current and/or significant repairs, is indexed (within the framework of official inflation).

In addition, the PDD payment can be divided into

- the undiminished part, which is fixed in the agreement, and these funds are directed to servicing debt obligations to credit institutions;
- the reduced part (due to fines) includes return on investment, profitability, and operating costs [8].

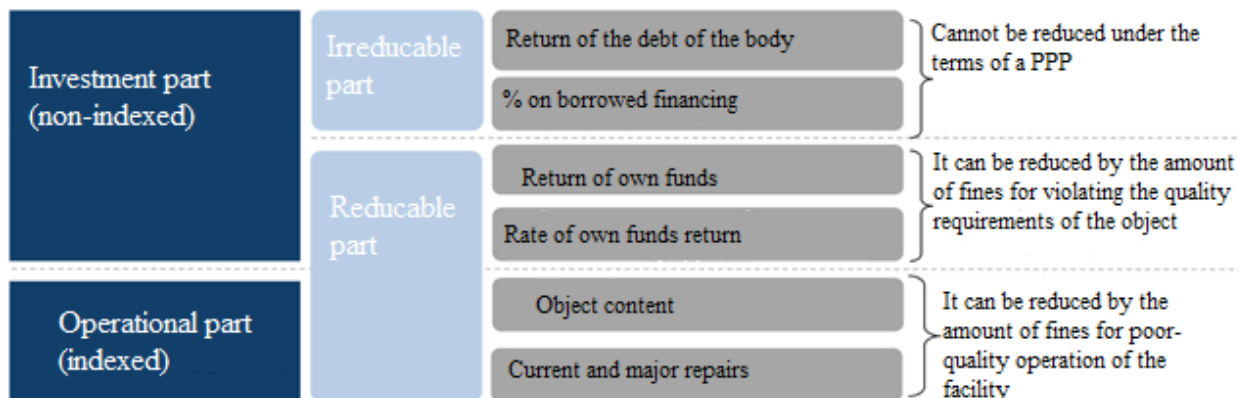


Figure 2. Sources of PZD in the infrastructure PPP model under No. 224-FL

An integrated or mixed PPP model involves the implementation by an individual of both technical and target (medical) functions. Such a model includes design, construction and/or reconstruction, and operation (targeted and specialized) for a private party. This model is more complex in structuring and operation. It carries more obligations for the personal side and more risks for the public. It is necessary to calculate the volume of medical care, predict the chances of demand, and provide additional mechanisms for regulating controversial issues. The means for protecting interests in this model are more complex and require other competencies from a private partner.

World practice has shown the insufficient effectiveness of this model. According to international experts, there is an “essential” conflict between the parties in this model. The state strives to improve the quality and accessibility of medical care and reduce costs. Business does not set a goal – commercial efficiency, which means increasing payback by maximizing profit per unit of service. But not everything is so clear. According to other experts, this conflict gives rise to “valuable” solutions when the parties are forced to look for more “subtle” ways and “common” points of contact. Due to such models, PPP is being improved, which suggests that the integration model is a “driver of competencies” and a “horizon expander” [9, 10].

The advantages of this model include the full responsibility of the parties under the agreement (complete coverage of risks) and the availability of technical and targeted operations by a private partner. The disadvantages of the model include the complexity in structuring the contract (the need for high competencies of the parties in terms of preparing an agreement), difficulties in determining key performance indicators in terms of providing medical care, as well as the subsequent implementation (achievement) of the target criteria of state programs.

The project, based on an integrated PPP model, implies structuring within the framework of a concession agreement (No. 115-FL). In this PPP model, the technical operation of a healthcare facility and the targeted (provision of medical services to the population) is carried out. The “core” of this PPP model can also be designated an SEC that represents the interests of a private partner (investor) (Figure 4). SEC can receive income both from the primary type of activity (medical care) in the form of payment for medical services within the framework of compulsory medical insurance, VMI, or direct payment (“paid” patients) and from commercial (non-core activities not related to the provision of medical services) on the territory of the facility (on the territory of the Ministry of Defense), as well as SEC may receive equity financing.

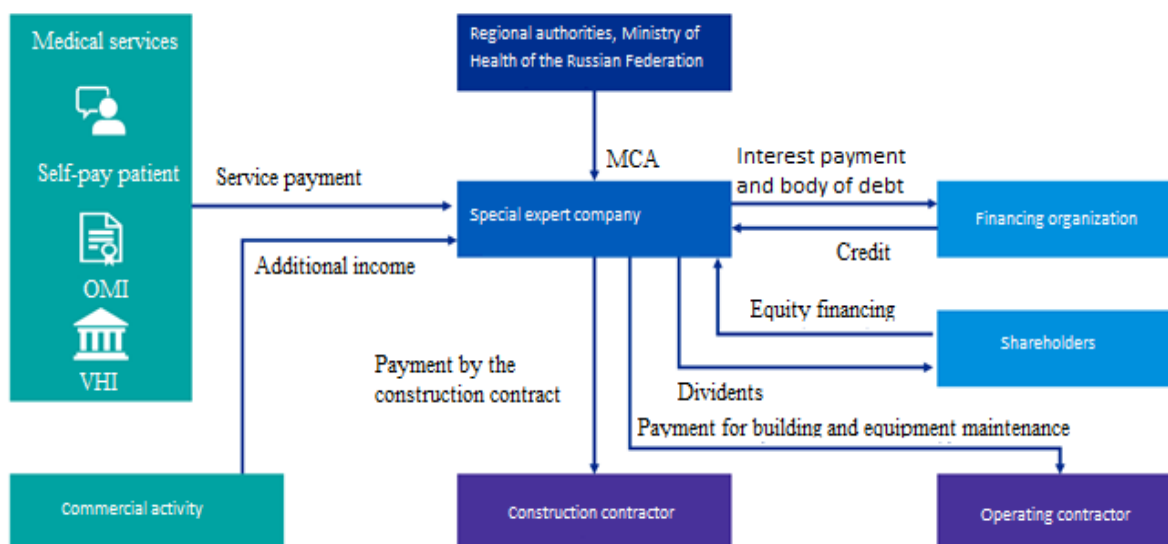


Figure 4. Integrated PPP scheme-model under No. 115-FL

Within the framework of the integrated PPP model (No. 115-FL), two payment mechanisms can be installed:

- direct fee collection;
- minimum guaranteed income (from now on – MGI)

Direct fee collection is formed by obtaining financial resources for the provided volumes of medical care performed within the framework of the quotas of compulsory medical insurance. In this case, the amount of revenue for a private partner depends on the volume of medical services and the size of the tariff for medical services, which are established through a tariff agreement between regional OIV in the field of healthcare, the territorial fund of the MGI (hereinafter referred to as TFOMS), insurance medical organizations (from now on referred to as CFOs), the Ministry of Defense and trade unions. In each region, tariffs for medical services have differences. At the same time, the risks of “demand” fall on the private partner since the volume of allocated medical services depends on the state extra-budgetary fund (TFOMS) – read - on the public side of the agreement. Since income from revenue under the MHI, VMI, and paid services may not cover the required return on investment, the infrastructure PPP model (No. 115-FL) provides for the payment of the concedent and commercial revenue (if any).

This model assumes a minimum guaranteed income (from now on referred to as MGI) towards the investor, which means a lower limit of profitability. The MGI mechanism allows you to receive compensation payments for the investor in case of non-fulfillment of the volume of medical care. Through this mechanism, a public person can regulate the quality of performance of obligations assumed by a private party. With “over” income, the private party will give part of the funds (according to the agreement) in favor of the state. Thus, there is an additional mechanism for making a profit for a public person.

## CONCLUSION

PPP in the healthcare sector is at an intermediate stage. Currently, the question of whether the PPP will go “forward,” “rollback,” or “freeze” in place is being decided. The development of society, based on its three-sectoral socio-economic division, occurs through partnership. In our example, this is the development of a “dialogue” between the state and business in which everyone solves their tasks. But both sides need political, institutional, legal, and financial stability. All these categories are interconnected, but “the fish rots from the head.” The strong influence of “senior officials” on the situation as a whole also makes the sphere of PPP dependent on their interests.

Understanding “successes” and “failures” are simple bipolar modeling that helps to understand in which direction the thicket is leaning. For PPP, in general, and in the healthcare sector, in particular, to gradually move into a mature (third) stage and outweigh the “successes,” it is necessary to reach a long-term political consensus regarding the understanding of the PPP strategy for all levels of government. It is in balance now.

There are positive examples, and this is undoubtedly a “success” in PPP, but there are no examples of replicating such best practices. This is possible with stable intersectoral and interdepartmental ties in the PPP sector in the presence of integrative (consolidated) portals for PPP.

The mandatory educational profile standard should include training in the PPP sphere. A high proportion of people employed in the public sector who can apply PPP experience is the way to solve many problems. Education in this direction will create a preponderance in the direction of PPP from the “state order”. Of course, it is impossible to say that the “state order” will outlast itself and die away. But the “state order” is a simple, primitive interaction between the state and society. The following form of interaction is PPP.

The presence of NGOs will contribute to the development of PPP institutions. A necessary element of evolution is a control system for implementation and monitoring in general, and, for example, a method for evaluating the effectiveness, monitoring and controlling the activities of private operators in a PPP project.

PPP in the healthcare sector is a unique and essential topic. It has many specific industry features, a barrier to its development. A dialogue is needed between the relevant authorities and investors to overcome difficulties. The established state health care system and the “monopoly” of compulsory medical insurance (CMI) make adjustments and set their own game rules.

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