Study of Hospital Concessions in Chile (P166011)

Reimbursable Advisory Services

Executive Summary

WORLD BANK GROUP

The work that this executive summary is based on has been prepared as part of a Reimbursable Advisory Services (RAS) Agreement. The RAS has been delivered by the World Bank in response to the specific request made by Government of Chile on March 09, 2018. Under the RAS, the World Bank has been providing technical assistance to the Government of Chile as part of both entities' *Joint Study Program*. The development objective of the RAS was to provide evidence-based advice to the Chilean Government on the advantages and disadvantages of its current hospital concessions[1] framework in view of best practices identified in international experiences with hospital concessions. The following executive summary gives an overview of the assessment and recommendations made as part of this work.

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[1] In this Executive Summary of the activities performed under RAS P166011, the terms *concession* and *public private partnership* are being used interchangeably. Likewise, the terms *concessionaire* and *consortium* are also being treated as synonyms for the purpose of this summary.

1. Introduction

Public private partnerships (PPPs) are a public policy instrument that seeks to employ the availability of private capital and the private sector's ability to efficiently manage projects for the creation of public infrastructure and the provision of public services. PPPs were first introduced in various sectors with construction needs in the United Kingdom the 1990s. The first project pertaining to the health sector was awarded to a private consortium in 1997. Since then, more than 100 hospitals have been built as PPPs in the UK alone. Other countries (such as those analyzed as part of this study) have followed track and developed their own concession schemes for the construction and operation of hospitals. The main reasons for the use of PPPs are to i) impose budgetary certainty by setting present and the future costs of infrastructure projects over time and ii) incentivize the private sector to deliver projects on time and within budget. From a fiscal point of view, a PPP allows the government to distribute a large investment over time, since the private concessionaire usually contributes the capital necessary for the construction of a hospital, an airport or a highway. Once the hospital or other infrastructure project comes into operation, the concessionaire is paid back on an annual basis for making agreed upon services available by using the built infrastructure. Governments developing PPP schemes have sought to overcome a history of slow execution and excessive spending of traditional public-sector investment projects by exploiting the market forces applying to projects run by the private sector.

The Government of Chile initiated a program of hospital concessions in 2007, leading to the tendering for two hospitals (Maipú and La Florida) in 2008. By 2015, these two hospitals had been commissioned. In 2010, a list of additional hospitals to be commissioned was identified, including three hospitals in the north of the country (Antofagasta, Salvador-Geriátrico and Félix Bulnes), Sotero del Rio in the Metropolitan Region of Santiago, a network of hospitals in the southern cities of Curicó, Chillan, and Linares, and finally a network of hospitals in the Fifth Region of the country (i.e. the Valparaíso Region), namely the hospitals of Quillota-Petorca and Marga-Marga. The hospital concession model developed in Chile follows the DBOT (design, build, operate and transfer) principle. A private entity designs facilities based on the public authority's specified requirements, builds the facility, operates the facilities and finally reverts the ownership of the hospital back to the public authority after a certain time period. The objective of the concession program was and is to close hospital infrastructure gaps with greater speed, to improve the maintenance of hospitals, to ensure higher quality auxiliary services (hospital laundry, building security, cleaning etc.) by creating a competitive market among private companies for the construction as well as the provision of maintenance and auxiliary services.

The extended use of the model for hospital concessions has however been slower than anticipated. In many countries, public–private partnerships for the provision of health care, and in particular concessions of hospitals, have shown to be politically controversial. Chile is no exception, and the potential implications of hospital concessions on the cost and efficiency of health care services sparked public debates about the privatization of health service delivery. Having said that, the concession model used in Chile (by different incumbent political parties across government cycles) never actually included the provision of health care services themselves by a private provider but was limited to administrative processes[2]. Furthermore, the debate in Chile has mainly focused on the question whether hospital PPPs

[2] Operating the hospital, the 'O' of the DBOT approach, refers to infrastructure maintenance and the provision of non-clinical support services, leaving clinical services unaffected by the hospital concessions.

should be employed or not, leaving considerations about the different ways of implementing and regulating hospital concessions aside.

In 2014, the Government put the plans for a concession of some of the previously identified additional hospitals (i.e. Marga-Marga, Quillota-Petorca, Sótero del Río, Curicó, Linares and Chillán) on ice, but continued with the procurement processes for the hospitals of Antofagasta, Salvador-Geriátrico, and Félix Bulnes, for all of which contracts had been awarded by 2014. These three hospitals constitute the current portfolio of hospitals under construction. Some of the hospitals for which a concession was foreseen have instead been built using the traditional bidding process for civil works. This was also the case for the following list of hospitals that previously had been in planning: Salamanca, Exequiel González Cortés, Chimbarongo, Penco-Lirquén, Florida, Pitufquén, Quilacahuín, Lanco, Futaleufú, Puerto Aysén, Puerto Natales, Porvenir, Puerto Williams, Copiapó, Rancagua, Laja, Los Ángeles y Lautaro. Around 20 additional hospitals are in the process of being built and another 20 are under planning. Reiterating the importance of investments in the public hospital sector to continue with the improvement of the public network of hospitals and health care centers, the government coalition that entered power in 2018 has indicated the intention to build 30 new hospitals in their government program.

Table 1: Chilean Hospital PPPs – under Construction and in Operation (as of March 2018)

Hospital	**Number of Beds**
Maipú (in operation)	375
Florida (in operation)	391
Antofagasta (in trial phase)	671
Félix Bulnes (under construction)	523
Geriatric Hospital Salvador (under construction)	642

The previous government administration had committed to thoroughly assessing the hospital concession program and therefore had ordered technical reports that can support the new government as well with an evidence-based decision-making process. In December 2016, the Ministry of Civil Works hence produced a report based on the concession experiences of the Maipú and La Florida hospitals (*Relevant issues in the implementation of hospital concessions based on the experience of operating facilities*). The report identifies lessons learnt and provides recommendations for the future improvement of contract management in hospital concessions. Apart from this more general assessment of the hospital concession model, the Ministry of Health also commissioned a more specific quantitative study applying the "Value For Money" methodology (essentially a cost-benefit analysis) to the hospital concession program (*"Study and assessment of the cost and financing schemes for hospital concessions",* finished during the first half of 2018). To gain additional insights from a comparative review of international experiences and best practices for hospital PPPs, the Government of Chile requested the study being the subject of this executive summary.

2. Objectives and Scope of the RAS

The main objective of the RAS was to provide evidence-based advice to the Chilean Government on the advantages and disadvantages of the current hospital concessions framework in view of best practices

identified in international experiences with hospital concessions. To achieve this objective, the task team working on the RAS identified and analyzed key elements of the Chilean framework for hospital concessions and compared the framework based on these key elements to cases of best practice for hospital concession models from a selected group of countries (e.g. Spain, Australia, England, and Canada) in which the vast majority of relevant international experiences with hospital concessions have been made. The comparative evaluation assessed factors such as: (i) the aptitude of the framework to effectively assign and manage risks; (ii) the aptitude and flexibility of the framework to adapt to new requirements; (iii) the ability of the private operator to provide quality health care services in a timely manner; (iv) the use of good practices in contract management by the private operator; and (v) the presence of stable and adequate policies and institutions for the development of the public-private partnership.

The agreed upon deliverables under the RAS were as follows:

(i) Comparative analysis of the current concession framework and relevant international experience, focused on economic model, institutional structure, auxiliary service provision, monitoring and control system
(ii) Comparative analysis of the current concession framework and relevant international experiences, focused on the ability of the framework to adapt to the changing needs in the health sector
(iii) Assessment of the findings of the study produced by the Ministry of Civil Works in light of international experiences
(iv) Recommendations to optimize the current framework for hospital concessions.

3. Analytical Framework of the Comparative Analysis

For the comparative analysis of the Chilean and other hospital concession schemes, a desk review of the key documents describing the concessions model was carried out, government officials involved in the concessions program were interviewed, and finally case studies of the experiences of Australia, Canada, Spain and the United Kingdom were prepared. This approach allows to identify (i) objectifiable issues pertaining to the legal framework and contractual basis of hospital concessions and (ii) perceptions and the *user experience* of key stakeholders.

The qualitative evaluation of the Chilean scheme for hospital concessions and the comparative analysis of international experiences focused on examining factors such as: The PPP scheme's ability to effectively assign and manage risks, the ability of the concessionaire to assume responsibility for the service provision in a timely manner and with the required quality, the use of best practices in contract management by the concessionaire, and the presence of stable and adequate policies and institutions for the further development of the PPP. To systematically examine the characteristics of the different hospital concession schemes, the following analytical framework identifying functions and parameters of hospital concessions was applied to guide the analysis.

Table 2: Main Functions and Parameters of Hospital PPP Schemes

Function	Parameter
1. Governance	1.1. Regulation
	1.2. Auditing
	1.3. Reporting of information
	1.4. Dispute resolution mechanisms
2. Governability	2.1. Dual control
	2.2. Transparency
	2.3. Stakeholder engagement
3. Feasibility and financial sustainability	3.1. Services included in the PPP
	3.2. Prequalification of bidders
	3.3. Outsourcing of PPP services
	3.4. Staff integration
	3.5. Payments
	3.6. Guarantees
	3.7. Incentives and penalties
	3.8. Insurances
	3.9. Risk transfer
4. Management	4.1. Performance indicators
	4.2. Measurement processes
	4.3. Monitoring
5. Contract termination	5.1. Timelines
	5.2. Reasons for and mechanisms of rescission
	5.3. Anticipatory breach of contract

Source: *PPP Guide for Practitioners - Module 11: Project Structuring*, Department of Economic Affairs, Ministry of Finance, Government of India, p. 143, April 2016.

4. Mechanisms to Adapt PPPs to Changing Health Needs

One of the fundamental characteristics of PPPs is that the public sector obtains certainty about the cost and quality of services provided by the private sector throughout the life of the concession. This security does however come at a price. Namely, the other side of the coin is that a PPP inherently limits the public sector's flexibility to adapt the service delivery at a concessioned facility to changing (health) needs (resulting from the development of new technologies or changes in the demographic and epidemiological profiles of the population being served). To mitigate this loss of flexibility, PPPs need to incorporate tools to modify the services provided by the concessionaire with the greatest possible efficiency and while protecting the rights of both contract parties. These tools consist of mechanisms stated explicitly in the concession contract itself, as well as procedures to modify the contract.

Contract Adjustments: The main adjustment mechanisms contemplated in the PPP schemes of the analyzed reference countries are i) the performance of minor works and other modifications and ii) changes in the service level provided and performance indicators measuring the service provision under the PPP.

Minor works: Internationally, concession contracts include the concept of minor works that will be required frequently during the contract duration and whose cost does not exceed a limit specified in the contract. In some cases, the contract includes a catalogue of works and services with the corresponding - previously agreed upon - prices, whereas in the case of other contracts, the concessionaire sets the price. In the case of Chile, concession contracts foresee the establishment of a Reserve Fund to finance activities not included in the original plan of the PPP. Such a Reserve Fund provides a tool similar to those used in other countries to carry out minor works, leaving Chile aligned with the international experience.

Changes in service levels and performance indicators: For instance, in the United Kingdom, the concession contract foresees an annual review during which both parties can propose changes. If the changes do not affect the risk profile of the concession in a significant way, the amendment is made by mutual agreement without the need to modify the contract. In the case of Chile, the concession contracts currently do not incorporate any mechanism that allows the revision of service levels or performance indicators without the need to modify the contract.

Contract Modification Procedure: The procedure for making changes to a contract is one of the most important aspects of any PPP, since it regulates the possibility for both contract parties to make necessary adjustments throughout the life of the concession. The following main features were identified across PPP schemes: The modification procedure is mainly designed to be used by the public sector. Although the consortium may request changes to the contract, it is usually at the sole discretion of the public sector to accept the change. Best international practice includes establishing a maximum number of days for each stage of the modification process. For example, the concessionaire has a fixed number of days to respond to a proposed change. If the public sector does not agree with the cost proposed by the concessionaire, it may decide to cancel the request for change or request "expert determination. In Chile, the MoPW and the concessionaire can agree on a modification to increase service levels by signing the corresponding agreement complementary to the concession contract. All in all, the contract modification procedure in Chile is like the one of the other international experiences, except for the particularity that the MoPW mediates between the MoH and the concessionaire and the fact that eventually, if no other solution is reached regarding a planned modification, a litigation will be entailed. The main adjustments to align the procedure in Chile with best practices would be to establish time limits according to which each a response to a change request has to be made and to establish a predesigned contract modification procedure within a concession contract.

5. Comparison of Findings from the World Bank Analysis and those of a MoPW Study

For the comparative analysis of the findings of the World Bank and MoPW studies, the findings of the MoPW Study were first classified according to the framework (and its dimensions) used in the comparative analysis performed by the World Bank (see Table 2). In a second step, a comparison of the similarities and differences of the two studies' findings was carried out.

The findings of both studies coincide with respect to two central functions: (i) the management and (ii) the feasibility and financial sustainability of the Chilean PPP scheme. In the case of the management function, the findings are mainly aligned regarding the measurement processes and the monitoring of the hospital concessions scheme. As far as viability and financial sustainability are concerned, the two studies

are aligned in focusing on implementation difficulties and the further development of the concession scheme related to: (i) staff integration; (ii) the trial period and (iii) some of the concessioned services. The WBG Analysis scrutinizes the effectiveness of the systems of sanctions and incentives, while this dimension is not further addressed by the MoPW Study. In contrast, with respect to the function of management, and more specifically in the assessment of the difficulties related to measurement processes and service level, the two studies reach different diagnostics of the root problems and the options for how to improve the design and application of the information system to measure service levels. Finally, the findings of the two studies diverge regarding the dimensions of (i) Governance and (ii) Governability. Table 3 shows the Mapping of the Dimensions Considered in the World Bank Analysis and the MoPW Study.

Table 3: Mapping of the World Bank Analysis and the MoPW Study

Function	**Parameters**	**Corresponding Function/Parameter in the MoPH Study** *Using the Numbering of MoPH Study*	**Concurrence of Findings from the Two Studies**
1. Governance	1.1. Regulation	1.1. Governance - Dialogue and collaboration between management teams	**Different assessment.** The dialogue between the involved parties is far from fluid. The position of the Fiscal Inspector is dominant, there is a lack of knowledge of the concession mechanisms among management teams. There is resistance by the concessionaire to assume responsibility for management problems.
		1.3. Governance - Operation of the concession operation committee	Similar conclusion
	1.2. Auditing	*The issue of audits is shortly mentioned, but there is no dedicated section.*	*N/A*
	1.3. Reporting of information	2.5. Use of information and generation of baselines	Yes
	1.4. Dispute resolution mechanisms	6. Contract adaptation	Similar conclusion
2. Governability	2.1. Dual control	*Not dealt with in the study.*	*N/A*
	2.2. Transparency	2.1 - Service Levels and Indicator Management: Management of registration, assessment and inspection	Similar conclusion

Function	Parameters	Corresponding Function/Parameter in the MoPH Study *Using the Numbering of MoPH Study*	Concurrence of Findings from the Two Studies
	2.3. Stakeholder engagement	7. User feedback	**Different conclusion.** The WBG analysis considers the system for user feedback to be weak and that it should be regulated in another way.
		3.2. Service Provision: Complaints and suggestions	**Partially concurrent conclusion**. The WBG analysis deems that an improvement of the system mainly requires a better classification of events, a separate registration of work orders and incidents of non-compliance as well as a clear classification of what non-compliance constitutes.
3. Feasibility and financial sustainability	3.1. Services included in the PPP	3.1. Service Provision: Services considered in the bidding conditions	Similar conclusion
	3.2. Prequalification of bidders	*Not dealt with in the study*	*N/A*
	3.3. Outsourcing of PPP services	*Not dealt with in the study*	*N/A*
	3.4. Staff integration	1.2. Governance: Management of staff integration	Similar conclusion
		5. Trial period	Similar conclusion
	3.5. Payments	*Not dealt with in the study*	*N/A*
	3.6. Guarantees	*Not dealt with in the study*	*N/A*
	3.7. Incentives and penalties	*Not dealt with in the study*	*N/A*
	3.8. Insurances	*Not dealt with in the study*	*N/A*
	3.9. Risk transfer	*Not dealt with in the study*	*N/A*
4. Management	4.1. Performance indicators	2.3 - Service Levels and Indicator Management: Number and relevance of indicators	Similar conclusion

Function	Parameters	Corresponding Function/Parameter in the MoPH Study *Using the Numbering of MoPH Study*	Concurrence of Findings from the Two Studies
		2.4 Service Levels and Indicator Management: Customer orientation and use of satisfaction surveys	**Different conclusion.** The customer orientation is considered to be weak by the WBG analysis. The use of surveys is partially discretional for the Fiscal Inspector
	4.2. Measurement processes	2.2. Service Levels and Indicator Management: Use of computer systems for the management of indicators	Similar conclusion
		2.5. Service Levels and Indicator Management: Use of information and generation of baselines	Similar conclusion
	4.3. Monitoring	2.1 - Service Levels and Indicator Management: Management of registration, assessment and inspection	Similar conclusion
5. Contract termination	5.1. Timelines	*Not dealt with in the study*	*N/A*
	5.2. Reasons for and mechanisms of rescission	*Not dealt with in the study*	*N/A*
	5.3. Anticipatory breach of contract	*Not dealt with in the study*	*N/A*

6. Conclusions and Recommendations from Comparative Analysis

As a disclaimer it should be stated that - when comparing the Chilean PPP scheme to international experiences - the short implementation history of PPPs in Chile needs to be kept in mind.

The hospital concession scheme in Chile still lacks operational maturity and the feedback loop from the first implementation experiences may not have terminated yet. Some of the observations made about the sparse experience with PPPs in Chile may be due to design flaws (regulatory or contractual) or simply due to the short implementation history. Nevertheless, the comparison of the Chilean PPP model for hospitals with the corresponding schemes in Spain, Canada, the United Kingdom and Australia (all of them with a longer implementation experience) makes it possible to identify - while taking into account the different implementation stages and the origins of their respective regulatory systems –possible courses of action to optimize the Chilean PPP scheme.

The first conclusion of the comparative analysis is that the Chilean experience with implementing PPPs is in line with the other analyzed international experiences. Most of the problems that surfaced during

interviews with government representatives and other stakeholders are well in line with the problems (real or perceived) reported during the initial phases of PPP programs in other countries.

In the international experience, in particular the one of the United Kingdom (being the most extensive one), some of the problems perceived during the early implementation of hospital concessions were caused by a lack of knowledge regarding the obligations of the concessionaire and available correction and dispute resolution mechanisms among public officials. This observation is corroborated by several of the key interviewees consulted during the preparation of this study for Chile.

The only unique aspect of Chile's experience is the fact that the MoPW has the sole authority to act as grantor of any type of public infrastructure (including hospital establishments) as a consequence of the Chilean legislation for concessions. Therefore, the contractual relationship underlying a hospital concession is formalized between the concessionaire and the MoPW, assigning a marginal role to the MoH, especially during the operation phase of the PPP. In contrast, either MoHs or hospital councils are the grant authorities and have the responsibility of managing the concession contracts, monitoring the concessionaire's performance and making payments to the consortium. This peculiarity of the Chilean legal framework creates a situation under which the Fiscal Inspector exerts the control over the concessionaire but belongs to a different institution (MoPW) than the entity in fact receiving the concessioned services (MoH). This constellation has the potential of creating issues in the management of the concession and it actually worsens the agency problem (it is not only one entity (the concessionaire) that is able to make decisions and take actions on behalf of another entity (MoH), but there is even a third entity involved that is in charge of supervising the actions taken).

Given that the Fiscal Inspector is the sole regulator of both administrative processes and procedures as well as any consequences from these during the construction and operation phases, there is no dual control mechanism apart from the fact that the Comptroller General of the Republic or the Audit Office of the MoPH may get involved. This situation is not only problematic, because there is no adequate segregation of functions that would actually favor the use of dual control, but also because unnecessary delays in response times may be caused due to the amount of different issues for which the intervention of the Fiscal Inspector is required.

Based on the interviews with public officials, desk review of relevant documents, and the analysis of relevant international experiences, the following potential areas for improvement in the current PPP scheme were identified (see Table 4). They are grouped into *regulatory*, *contractual* and *operational* aspects; suggestions to adapt or readjust the current PPP scheme are made as well (see Table 4).

Table 4: Areas for Improvement in the Chilean PPP scheme and Suggested Readjustments

Type	Key aspect to be optimized	Readjustment
Regulatory	The original institutional design of the Direction of Concessions at the MoPH did not anticipate the need for knowledge among its staff going beyond the specific technical requirements of public works (i.e. no specific health sector knowledge was foreseen). The Direction of Concessions is in charge of many different types of public infrastructure projects. In the case of the health sector, the operational phase tends to be even more complex than the construction phase and requires specific knowledge of the functioning of a hospital.	A dedicated team in charge of hospital concessions may be worth establishing given the intricacies of hospital concessions. It should be evaluated if it is convenient to make regulatory changes and to delegate the responsibility of managing the concession contracts during the operation phase to the MoH in order to empower the principal (the MoH), as a specialized institution, in the supervision of the contract.
	The MoPH is far removed from the day-to-day operational reality of hospitals. The hospital director who in fact holds the main tasks of managing the hospital does not perform a direct supervision of the contract and is not recognized as the main authority neither by the concessionaire nor by the issuer of the concession (MoPH). The Fiscal Inspector, as the main interlocutor for the concessionaire to solve controversies, is not part of the health system.	The real solution to the issue would be to empower the hospital authorities to supervise the contract and to interact with the concessionaire. The ownership of the contract by the hospital management and the relationship with the concessionaire is fundamental to the success of a PPP, even though this solution requires the modification of the Concessions Law, by which the figure of the Fiscal Inspector is regulated. Still within the current mandate, it could be ensured that the Fiscal inspector needs to consult with the hospital director on certain issues. Also (which is easier to achieve) reinforce (via the bidding conditions) the functioning of the Coordination Committee and complement it with specific operational committees (for cleaning, food, maintenance and other services) that allow an agile resolution of problems that arise during the daily operation of the hospital.
	The planning horizons of concession projects (from the prequalification of bidders to the actual commissioning of a contract) are extensive (even though shorter than under traditionally procured projects) and increase the risk that the project needs to be	Strengthen the mechanisms to adapt the Pre-investment Study to the needs of the population and the professionals that form part of the hospital. This includes a better planning process within the MoH, which should establish a Transversal Group for Hospital

Type	Key aspect to be optimized	Readjustment
	modified and that new requirements not contemplated in the contract emerge.	Concessions among undersecretaries to effectively improve the identification of relevant health problems and the clinical management technology to be used in addressing these problems.
Contractual	The mechanisms to validate contract changes, both for modifications and for renegotiations, require the same formalities and approvals, which, apart from the entailing budgetary implications, turns them into complex processes.	This issue requires legal modification. To minimize the impact of modifications and renegotiations, (i) the planning process should be improved and (ii) foreseeable modification procedures should be incorporated in the mandates and bidding conditions of the concession.
	The system of sanctions and fines is ineffective. The "space" to punish a contract breach is very narrow, given that maximum amount of fines that a concessionaire can accumulate within a given year before officially the concession would need to be ended (i.e. 5,000 UTM[3]) is actually irrelevant in view of the cash flows of the concessionaire. At the same time, given the actual required performance levels under the concession, 5,000 UTM in fines are accumulated relatively easily (corresponding to 20-25 occurrences of an event measured by sentinel indicators), which then – strictly speaking - would lead to the cancellation of the concession, with all the operational and reputational costs that it implies. Given that the recognition (and subsequent payment) of fines by the concessionaire would quickly bring the concession to the brink of being ended, many fines are not being executed in practice (the concessionaire eventually makes them a subject of lengthy litigations). As a result, the fines do not fulfill their actual purpose of encouraging a better performance by the concessionaire. Any dialogue between the concessionaire and the MoH/MoPW regarding improved performance beaks down.	Review, and if necessary, adjust the sentinel indicators used in the contract. Change the relative weights assigned to the indicators to promote a better performance of the concessionaire, generating space for dialogue and the allowing for improvements without the need of evoking the termination of the contract due to accumulated fines. Increase the amount of 5,000 UTM as the maximum permissible amount of accumulated fines per year before a concession contract gets canceled.
	The system for incentive payments is ineffective as well. The difference in the return to capital that the incentive payments	Emphasize the incentives of the concessionaire to provide good results by increasing the variable part in the

[3] UTM stands for Unidad Tributaria Mensual, a measurement quantity used for real estate transactions and that is automatically and daily being updated for inflation.

Type	Key aspect to be optimized	Readjustment
	can cause is very small. The total worth of the incentive-based payments for a hospital concession only corresponds to approximately 2.2% of the concessionaire's annual cash flows. The resulting difference in the return to capital is very small, rendering the current reward mechanism very ineffective.	payments to the concessionaire, make the importance of payments according to the fulfillment of service levels bigger. Increase the minimum obligatory equity share of a concession consortium to reduce the return required by shareholders.
	Although there is a risk transfer from the public sector to the concessionaire under the PPP, it is rather low. The public sector still retains risks related to cases of force majeure or price increases in equipment and materials after the *No Objection* was given to a price proposed by the concessionaire but before the transaction has been carried out.	Rethink the balance of risks transferred and increase the proportion of risks assumed by the private sector. In international experiences with hospital PPPs, the first generation of contracts also involved low levels of risk transfer , but as the number of concessions and the familiarity with their management increased over time, a greater risk transfer via changes in the payment models was introduced. Contracts and their documentation should be further standardized, which would reduce the procurement costs for both the public and private sectors. As the standard contract evolves, it is normal to see a change in the risk profile of projects over time. Once investors and financiers have a better understanding of the sector and the risks, the private sector gets willing to take on a bit more risk.
Operational	There is a lack of experience in the management of the concessions scheme among hospital staff and ignorance of the contract and its components. There is a lack of introduction to the concession scheme for hospital staff. The expectations regarding the commitment and responsibilities of the concessionaire do not necessarily match reality.	Organize training for the staff of the concessioned hospitals (if an existing hospital is turned into a PPP) before the start of the concession and hire and train the staff before the concession (in the case of new hospitals). Inform health professionals about the scope of concessions and the commitments taken on by concessionaires and make them participate in the decision process. Establish communication channels with the population served by the hospital to manage expectations regarding PPPs and explain the concession model to be built and implemented in a regular

Type	Key aspect to be optimized	Readjustment
		manner from the beginning of the concession.
	Lack of integration of hospital staff and the personal of the concessionaire and its subcontractors.	Define and include regular periodical processes of functional integration of hospital staff and staff of the concessionaire in the Trial Period.
	Lack of experience in monitoring and control mechanisms.	Develop the monitoring and supervision capacity of the MoH. The Transversal Group formed by different undersecretaries should not only be involved at the planning stage but also monitor the construction process and especially the Trial Period and eventual operation of a hospital PPP.
	As in other countries, the supervision and monitoring of the concessionaire's performance relies on an extensive and complex indicator system. The design of the SIC information system however, which is of great importance for the evaluation of service quality and critical for the schemes of fines and incentive payments, mixes up work orders and problems of non-compliance of services, although both issues are of a different nature and are notified by different types of staff.	Establish a separate registry for work order and actual incidents.
	During the operation phase of a concession, the SIC information system as a mechanism of interaction between the hospital and the concessionaire is not effective. The organizational culture of hospitals relies on and prioritizes a direct management style interpersonal treatment both for work orders and for the resolution of contingencies and shortcomings. The SIC information system however requires the user to not only report the incident, but also to notify when and if it has been resolved, even for minor work orders. At the same time, each incident is automatically closed by the system, once a predetermined period has elapsed, such that all the incidents eventually are being resolved. Due to the above, the accuracy of performance reports using the data from the SIC information system is being compromised.	In addition to the previous point made: Simplify the monitoring system based on a set of indicators ranked by relevance and easy to measure and monitor.

Type	Key aspect to be optimized	Readjustment
	The performance evaluation (and the concessionaire's obligation to issue a periodic report with the main performance indicators) is a complex process that does not generate trust of the contract parties in the actual results.	Make user feedback part of the monitoring and control systems (through complaints and satisfaction surveys). Require the concessionaire to apply the internationally established quality systems: ISO 9001, ISO 14001, an energy efficiency plan and an environmental impact plan. Perform mandatory annual financial audits conducted by an independent firm and financed by the concessionaire. Review, and if necessary adjust, the sentinel indicators of class A and B.