



What Works

The triple win

**Rethinking public private partnerships
for universal healthcare**

KPMG International

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Executive summary

The global picture of public private partnerships (PPPs) in healthcare is tipping on its head. Following more than 15 years of expansion and innovation in high-income health systems, enabling in some markets the largest renewal of healthcare infrastructure in their history, PPP appears to be a declining force. At the same time, health systems in Asia, Africa, Latin America and the Middle East are gearing up for their own unprecedented expansions in access to care. Universal health coverage (UHC) is an idea whose time has come, and governments around the world are looking to how private sector partners can contribute investment and skill to help them achieve it.

For governments and citizens, PPP offers one way of containing the seemingly 'bottomless pit' of UHC's potential costs, by capping commitments into the long term and leveraging ultra-lean models of care provision. For the private sector, UHC-focused PPPs offer the opportunity for large-scale projects in healthcare markets experiencing levels of growth not seen in the West for a generation. The ultimate goal of both is a 'triple win' of countries getting:

1. for governments: maximum benefit from limited public capital
2. for patients and the public: higher-quality health services at the same or less cost
3. for private players: a sustainable return on their investment and expertise.

Yet the challenge of making this relatively complex contracting mechanism work in the most complex of sectors is considerable. Countries will need to learn the lessons of the past where PPPs sometimes failed to achieve the desired results, including:

- selecting the wrong kinds of priorities and projects as applications for PPP
- setting objectives that incentivize an overly narrow focus on service targets rather than high-value healthcare
- choosing the wrong partners to work with
- making erroneous or overly restrictive assumptions about the future
- failing to generate sufficient competition and contestability.

Low- and middle-income countries will not only be content with learning from the past, however. They are also showing that they have something to teach mature health systems about the possibilities and potential of PPP for health system development. While much of the initial focus of UHC PPPs will be traditional hospital estate and equipment deals, we will also see innovation, with new forms and applications of PPP springing up from emerging economies, including:

- new **public** sector uses for PPP in pursuit of UHC, including public insurance functions and large-scale primary care
- new **private** sector partners coming to the fore, including telcos, training institutes, life science firms and multinational provider chains



— new **partnership** forms, taking forward the value- and population-based models to reward health outcomes rather than more narrow activity-based or 'estate' outcomes.

The success or failure of PPP in helping to achieve UHC will stand or fall on the ability to combine the lessons of the past with the creativity of the future. This report concludes with six insights from KPMG's most experienced global leaders on what this means, practically, for countries on the 'health for all' path:

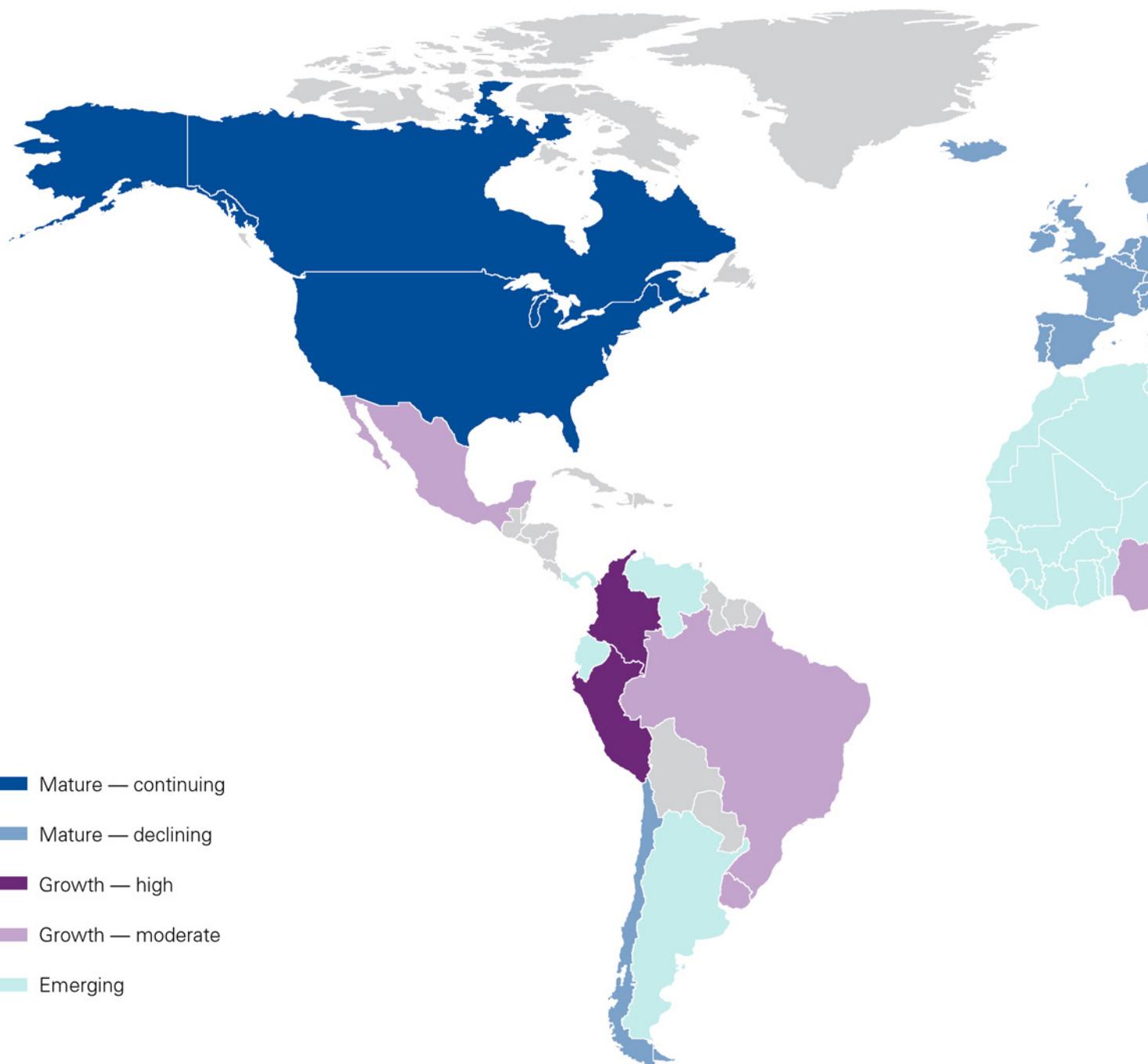
1. sweat the small stuff — be obsessed with the detail of the deal
2. active market management — don't retreat into 'tender mode'
3. scaling up capacity in the public sector — the importance of a well-resourced, specialized PPP unit
4. embrace, rather than resist, the politics of UHC
5. data systems you can trust — a PPP can only be as good as the intelligence on which it is built
6. from clarity of objectives to clarity of requirements — goals, behaviors and expectations are often implicit and assumed, but a stable partnership requires as much as possible to be discussed and set out clearly.

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PPPs and 'health for all': A global snapshot

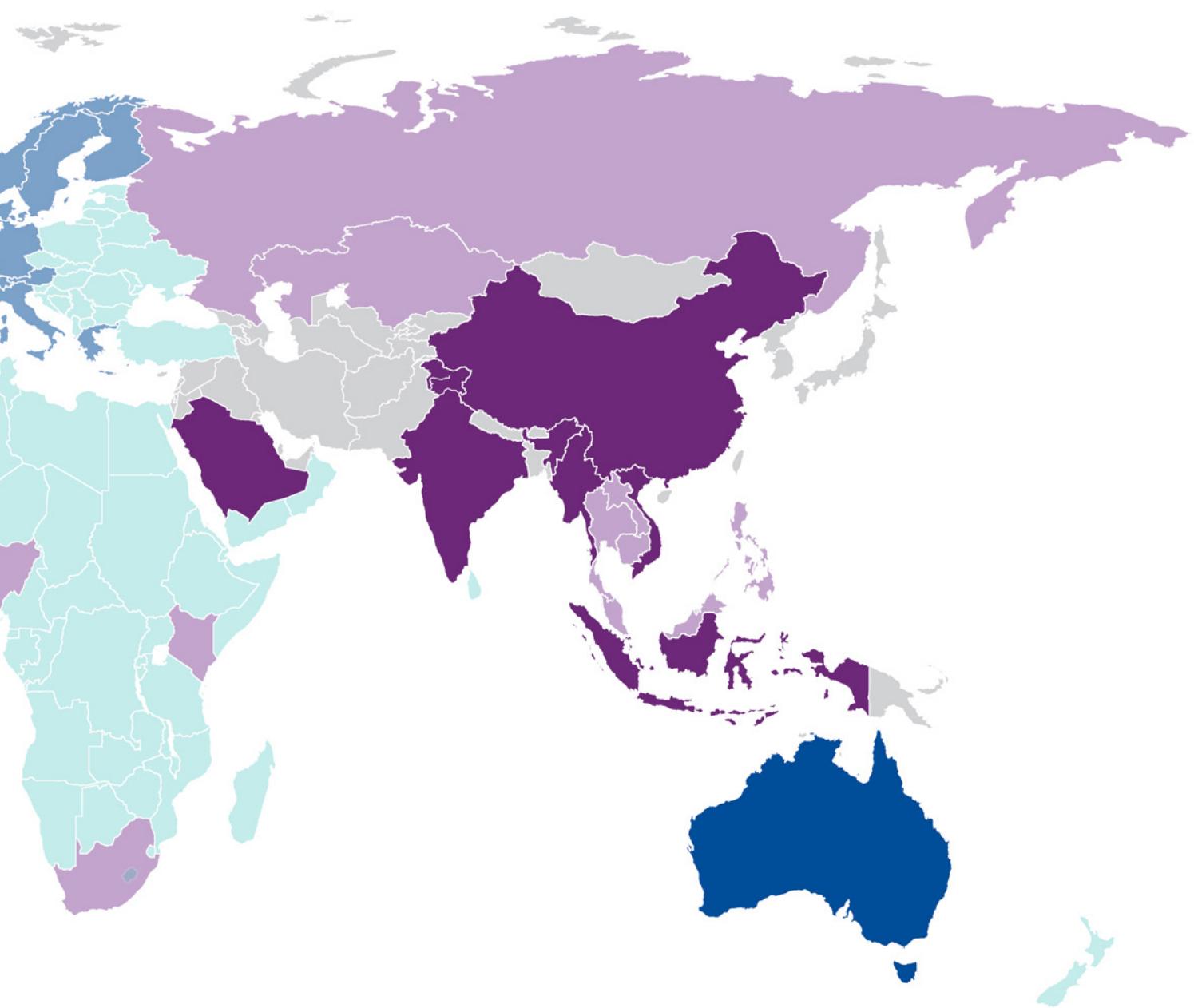


Figure 1: Status of healthcare PPP markets



Source: Healthcare and PPP Market Assessment Survey of KPMG's Healthcare Deal Advisory Network

The reality of how to achieve the United Nations commitment (SDG 3.8) of universal health coverage by 2030 is beginning to bite. Governments around the world, faced with the practical and strategic challenges of this goal, are asking how it can be achieved and who can help them.



With 88 percent of the global population consuming just 27 percent of its healthcare resources, the challenge is one of both investment and expertise.¹ If every country without UHC were to increase health spending per capita to the average OECD level, by 2030 the world would be spending US\$27 trillion extra on healthcare — a 400 percent increase on total worldwide health spending today.²

Clearly, this is wildly unrealistic. Instead, countries are looking at how private sector partners can help to not only build up the necessary infrastructure for UHC, but also develop innovative, ultra-efficient

models of service delivery that can make the costs affordable over the long term.

As the snapshot in the next chapter shows, opportunities for health sector PPPs are expanding well beyond their traditional base to far less mature healthcare markets. Across Asia, in particular, but also Latin America, the Middle East and Africa, there is interest and ambition to use PPP at almost every stage of the UHC journey. Healthcare may not have been among the first sectors that these governments look to for PPPs, but the next 15 years will see them become a cornerstone of 'health for all' strategies in many major markets.



Box 1: Drivers for using PPPs to achieve UHC

For governments:

- PPPs can limit what many fear to be UHC's 'bottomless pit' of potential costs
- many governments wish to be payers, but not providers of care
- PPPs limit the upfront investment required by the state, enabling flexibility for capital to be spread across many more public projects
- PPPs can effectively shape provider markets by influencing future private investment, aggregating existing capacity and strengthening oversight.

For the private sector:

- healthcare remains among the highest growing global sectors with overall spending growing 10 percent per year in Asia and the Gulf, 8 percent in Africa and 6 percent in Latin America
- successful private operators are keen to expand across borders
- where previously health services may have been provided by NGOs, UHC initiatives are now creating size and scale such that for-profit organizations can compete.

¹ Comparing countries spending >US\$3,000 per capita on healthcare against those spending <US\$3,000 (World Bank data).

² OECD average health spending of US\$4,735 per capita. Forty-seven countries determined as having full UHC, using KPMG proprietary UHC scoring methodology.

The scope of PPPs in health

As chapter four outlines, what is meant by PPP is evolving, but at its core every PPP involves an exchange of risk and responsibility. Through a web of typically complex contracts and agreements, PPPs essentially identify all the activities and investment associated with a project and allocate them to the partner best suited to manage them over a term of, typically, 15 to 30 years.

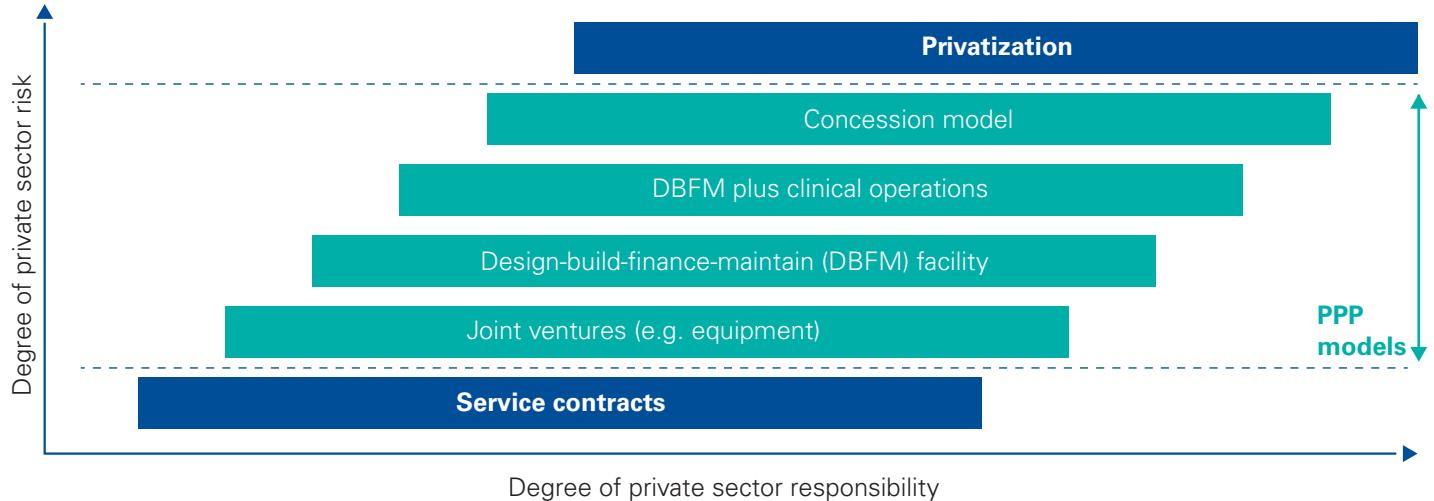
When successful, the result is a 'triple win' whereby:

- governments get a project or service that is completed at lower cost and/or higher quality than it would have been able to achieve alone or with a more basic service contract
- the public get access to healthcare that they or the government would not have been able to afford through taxation or debt alone
- utilizing the high degree of autonomy, private sector partners can deliver fundamental service changes for the long term, and make a reasonable return on their investment of time, expertise and resources.

At the technical level, PPPs are a collective term for the space in between a simple service contract and full privatization. It is often helpful to think of them as a continuum between these two poles, although in reality the specific details of particular projects make them hard to fit into such neat categorizations.



Figure 2: PPP risk-responsibility continuum



Traditionally, PPPs in healthcare have been mostly used to build and operate hospitals — partly because of the scale of upfront investment required, and partly because of the complexity of PPP deals means they are only worthwhile for projects above a certain size. In both emerging and mature markets estate construction, expansion and maintenance continue to be the dominant areas for which PPPs are used, in addition to equipment deals. However, this is changing as a wider variety of PPPs show potential in healthcare from digital health to insurance administration

to medical training to scaling up primary care (see chapter four). The UHC agenda is likely to accelerate this pluralization for two important reasons.

1. The nature of the UHC challenge is prompting governments to think about large-scale expansions of less capital-intensive parts of the health system (e.g. mass clinic expansions). While individually these projects are too small to warrant a PPP, collectively they can be an attractive proposition.
2. The UHC agenda is prompting healthcare leaders to think less about narrow vertical programs (e.g. vaccines) and more about broad, comprehensive systems and pathways of care. These are much less easily captured in a simple services contract, meaning that it often makes sense to shift some risk onto the provider through a PPP.



Box 2: The triple win in action: Hospital de Braga — a full-service hospital PPP in Portugal

A typical example of the kind of ‘triple win’ many governments hope to achieve through PPPs in healthcare is Hospital De Braga in northern Portugal, which opened in May 2011. This 700-bed greenfield development replaced an existing facility (San Marcos hospital) and was commissioned as part of a hospital renewal program that included five new facilities being put up for PPPs across Portugal between 2002 and 2007.

Serving as the main hospital for around 300,000 people and referral centre for a population of up to a million, the government’s aim was to provide state-of-the-art secondary care while minimizing its initial capital outlay. Crucially, it also wanted to leverage the best of private sector management expertise to reduce the overall cost through efficient practices, hence this particular PPP was designed to include not just the construction and maintenance of the facility, but responsibility for clinical services as well.

The deal was structured into two distinct PPPs to allow some separation of risk between the construction of the new hospital (‘InfraCo’) and the clinical services that it provided (‘CliniCo’).

- The InfraCo operated under a 30-year contract to design, build, finance and maintain the physical hospital site. This required initial capital investment of around 120 million euros for the 27-month-long build. The payment model was a blend of fixed prices and performance-related elements to ensure timely delivery and ongoing operation of the hospital at its full capacity.
- The ClniCo operated under a shorter, 10-year contract requiring around 40 million euros of capital expenditure. This covered both clinical services and general facilities management. The payment model was largely activity based but with various caps (lower prices paid after exceeding certain predefined demand forecasts) and possible deductions for a range of service failures.

Outcomes for all parties involved have been very good. The most recent value for money study into the project

by a prestigious university made a ‘conservative’ estimate that it had saved 15–21 percent of the costs compared to if the hospital had been run by a public body. Furthermore, a recent report by the Court of Auditors found that the operating cost per patient was the lowest of all hospitals in Portugal’s National Health Service.

Fernando Faria, who worked on the deal for KPMG in Portugal and is now one of the leaders of KPMG’s global PPP network, explains some of the reasons behind the project’s success: “Much of the important work went into understanding the local health economy — forecasting how demand might change, the impact of changes to other local services, where the greatest scope for efficiencies lay. It was a huge task, but as a result, the local people are receiving care that can compete on quality with the best hospitals in Europe, while the government is saving tens of millions of euros a year.”

Jose Luis Carvalho, Chief Executive of the Hospital, says that they are making a contribution to the sustainability of Portugal’s National Health Service: “All our stakeholders are pleased because we are delivering the service with quality at a very competitive price. We’re very proud of what has been achieved because the population have seen a deep improvement in both quality and quantity of provision. Hospital de Braga has increased tremendously the number of consultations and surgeries since 2009, and is now the only hospital in the country to have accreditation for clinical services, environment and health and safety at work.”

Still, the project was not perfect. The 50-month-long procurement process took almost double the amount of time government had anticipated, and despite its success, the use of PPPs in Portugal still causes public suspicion. In 2008, the Portuguese government announced that it would no longer seek PPPs that included the provision of clinical services. More recently, and despite criticism from the Court of Auditors, budget constraints in the public sector have led to the imposition of volume limitations on private providers, significantly curtailing their profitability.

2

Spotlight on Asia: The status of PPP markets in the world's fastest growing region



Thailand:

- Widespread use of PPP in energy, telecoms and transport sectors, but limited use for health service delivery so far.
- Legislation amended in 2015 to increase strategic use of PPPs, including healthcare.
- Greatest potential for partnerships that can reduce the rate of health spending growth through efficiencies or new models of care.



Myanmar:

- Current healthcare infrastructure is lacking, but the increase in public spending necessary to attract private sector partners has yet to happen.
- Government recently released a summary of its National Plan 2017–2021, the main goal of which is to extend the Basic Essential Package of Health Services (EPHS) to the entire population by 2020 while increasing financial protection.
- While full details of the National Plan are yet to emerge, it will require substantial investments in supply-side readiness at the township level and below. Government acknowledges the need for partnerships — including with for-profit providers and investors — to achieve this.
- In the medium term, opportunities in super specialty hospitals, diagnostics and workforce PPPs.



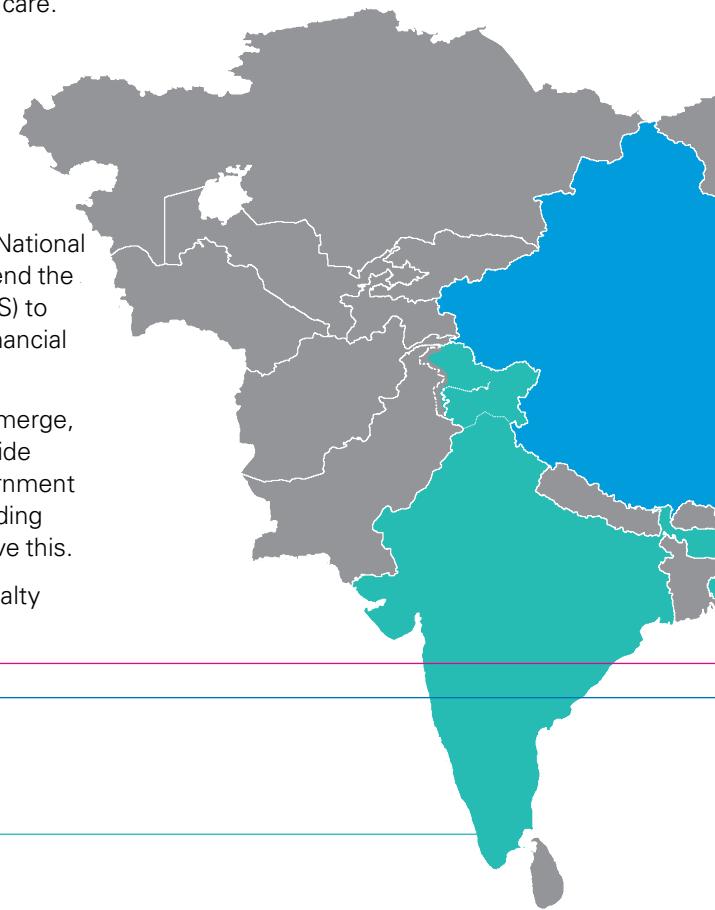
India:

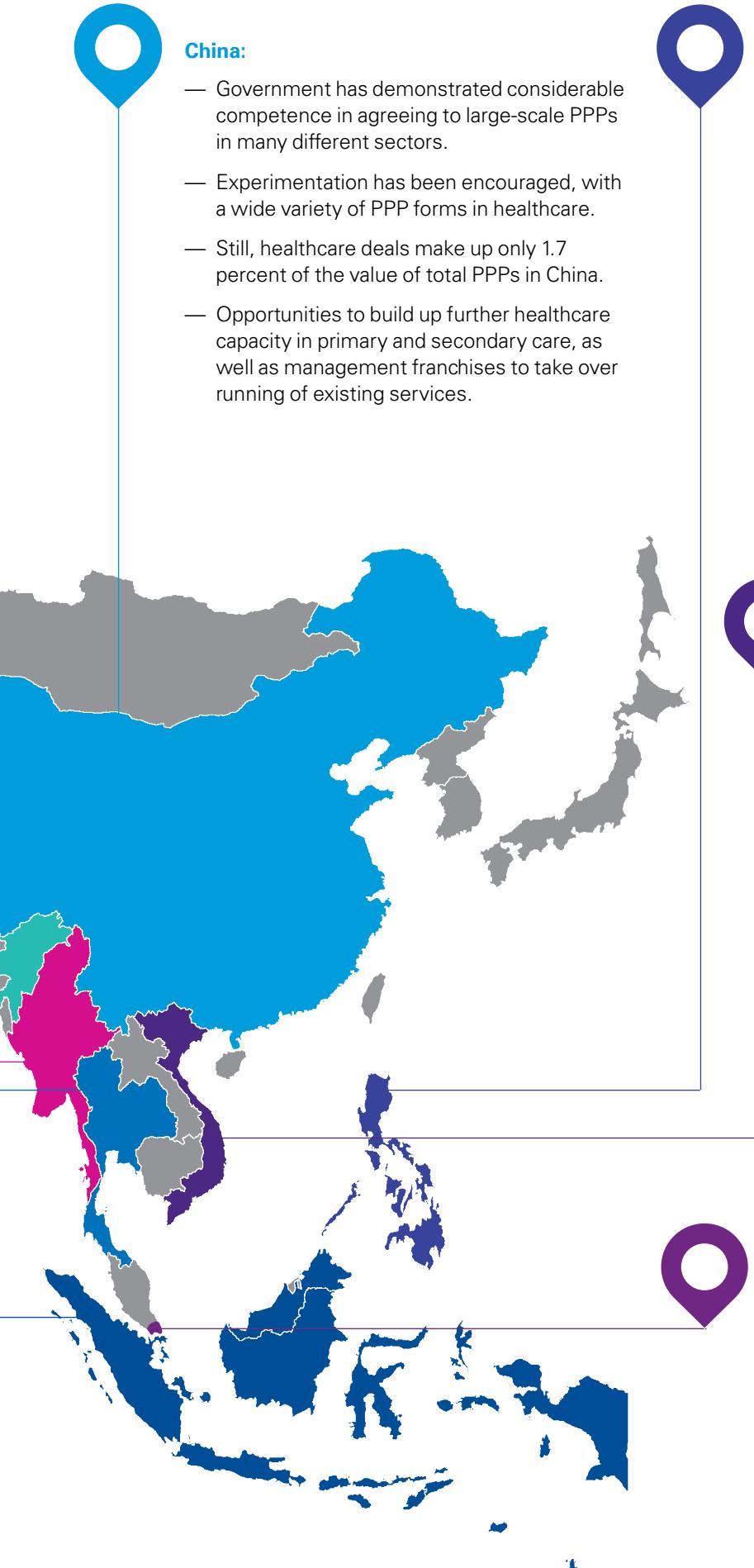
- Unprecedented rise in investment and expansion of private healthcare sector, mostly uncoordinated and underregulated.
- Trialing many different form of health PPPs, from hospital building to full concessions, and many applications — from ambulances to telemedicine to insurance.
- The government is still working on improving the quality of public providers, so privately operated PPPs are actively attractive to many patients.



Indonesia:

- Significant challenges to build up capacity of healthcare delivery infrastructure to achieve government's UHC ambitions.
- 2015 legislative shift to promote PPPs not just for economic infrastructure (roads, utilities, etc.) but healthcare too.
- Widespread use of joint ventures for medical equipment.
- Now piloting first major healthcare PPPs — new hospital wing in Medan.





China:

- Government has demonstrated considerable competence in agreeing to large-scale PPPs in many different sectors.
- Experimentation has been encouraged, with a wide variety of PPP forms in healthcare.
- Still, healthcare deals make up only 1.7 percent of the value of total PPPs in China.
- Opportunities to build up further healthcare capacity in primary and secondary care, as well as management franchises to take over running of existing services.

Philippines:

- Appetite for healthcare PPPs has cooled in recent years, with the current administration showing a somewhat less strong interest in their use.
- Several recent hospital PPPs shelved after failing to reach agreement between operators and government over an acceptable sharing of risk.
- Future PPP opportunities mainly around roads, energy, education, water, transportation and infrastructure. One health project in the pipeline is the relocation and modernization of the National Center for Mental Health in Cavite, National Capital Region (NCR).
- Track record of integrating private social clinics under Philhealth to scale up maternity services.

Vietnam:

- Strong track record of PPPs in transportation, energy and agriculture.
- Recent PPPs for two pediatric and two general hospitals, as well as numerous joint ventures for equipment and technology. Some innovation in the use of social franchising for reproductive health services at commune level ('Tinh Chi Em').
- Government actively targeting larger-scale (incl. whole hospital) health PPPs to meet rising needs and population growth, especially at the city level.
- Growth so far is sporadic, but likely to be rapid if early pilot projects yield success.

Singapore:

- Despite mixed philosophy and widespread use of private sector, healthcare PPPs not widespread in Singapore.
- Fertile discussions ongoing in many areas to curb rising costs.
- Major opportunities in home care, leasing private beds, procurement and clinics.

3

Defining success and understanding failure

While interest in healthcare PPPs in emerging markets is rising fast, in many high-income countries the picture is less positive. Across Europe, in particular, healthcare PPPs have never faced such scrutiny. Some link this to a track record showing mixed success at delivering on the promised 'triple win', but even in countries heralded internationally for their highly successful PPP hospitals — such as Spain and Portugal — these have been accompanied by considerable unpopularity with some sections of the public and politicians have often delayed or abandoned plans for further high-profile deals. Other systems, such as the English NHS, have seen a drop in the number of PPPs for 'frontline' projects like hospitals but a surge in PPPs for less visible or controversial services, such as radiology and imaging.





A decade ago, the global picture was almost the mirror opposite. PPPs were responsible for a boom in healthcare infrastructure renewal and expansion of capacity across the West. Hundreds of new hospitals and clinics were built across Australia, Canada, France, Spain and the UK at a scale that could never have been afforded by their governments alone. Emerging economies, on the other hand, were by-and-large viewed as 'untouchable', with a host of legal, political, economic and operational risks compounding to make these markets far too challenging for commercial partners to have the confidence to invest.

Rapid growth and success in PPPs for physical infrastructure such as roads, airports and power has bolstered private sector confidence in emerging economies as safer investments. Now, as UHC climbs the public agenda internationally, healthcare PPP prospects are coming into focus. Even so, caution should be exercised. PPPs are a relatively complex way of performing public functions, and when used for healthcare — one of the most complex industries — capturing the full benefits is no easy task. Emerging markets would therefore do well to reflect on the lessons learned by more mature health systems.

PPPs fail for a variety of reasons, but most often it is a perceived imbalance in the deal that leads to one party failing to see its side of the 'triple win' materialize. Some of the most common mistakes include the following.

— **Overly narrow objectives:** Failure to take into account the full scope of a particular service in the contract can encourage 'balloon squeezing', whereby the private partner is incentivized to divert certain costs (such as complex patients) onto others in the system. Conversely, they can find themselves responsible for treatments they did not expect to have to fund.

- **Wrong partner:** PPPs are more than just a means of raising private capital — the delivery partner needs to be able to significantly improve service performance beyond what the public sector would achieve. Without a truly competent partner there is little value in transferring risk — government may as well take a loan and do it themselves.
- **Incorrect projections:** An inherent weakness in PPPs is their inflexibility. Contracts are typically agreed for terms of 15–30 years, yet health needs and healthcare treatments can change considerably during this time, making detailed future planning and stress testing a critical task.
- **Inappropriate allocation of risk:** The transfer, or acceptance, of inappropriate risks can have a material impact on the viability of the outcomes. Key risks such as clinical demand, ability to modify arrangements and service performance regimes need to be

carefully considered. Without this, the commercial viability can fail and the behavior of the parties can lead to adverse outcomes.

- **Lack of competition:** In many markets, there are just a handful of private sector operators capable of taking on the management of a large public healthcare service. This can lead to a lack of competition, which prevents government from getting the best deal possible. The careful establishment and nurturing of a viable and competitive market is critical.
- **Strategic selection:** It is said of some healthcare systems that they have 'privatized profits and socialized losses'. It is often a mistake to approve private sector participation only in services that are easier to operate profitably, leaving public sector providers to run only the most complex and costly elements.

Even if all of these mistakes are avoided, PPPs, like any complex public project,

carry risk. There is no doubt that some of these are greater in many of the markets pursuing UHC compared to mature health systems like Western Europe — in particular, poor-quality data, weak regulatory structures and gaps in the workforce. Yet as Anuschka Coovadia, KPMG's Head of Health for Africa, explains, some risks are reduced: "One threat to PPP success that is significantly reduced in low- and middle-income countries' health systems is the risk of oversupply. In hindsight, we can see that some healthcare PPPs in high-income countries were too large and didn't match the level of demand they expected. In African markets, undersupply is so acute it is much less likely that a project will become a 'white elephant' due to overcapacity. Similarly, popular resistance to private sector involvement — a frequent concern in mature, publicly funded systems — may be less of an issue in countries where trust in government to deliver quality health services is low."

Box 3: Cautionary tale of an aborted PPP: Latrobe Regional Hospital in Victoria, Australia

The Australian health service has benefited from many highly successful PPPs over the last 20 years, but has also seen some failures.³ Opened in 1998, the Latrobe Regional Hospital in the State of Victoria was one of the first such projects in the nation's history — an AU\$56 million deal to design, build, finance, operate and maintain a new 250-bed teaching hospital. The contract was meant to last for 20 years with an option to extend for a further five, but just

2 years into its operation the hospital was transferred back to public ownership due to severe losses on the part of the private sector partner. There were several reasons behind this damaging and costly failure: incorrect projections about the patient case mix and staffing levels required, assumptions about future tax exemptions that did not turn out to be available, and inexperience on the part of the delivery partner in running public projects of this scale.

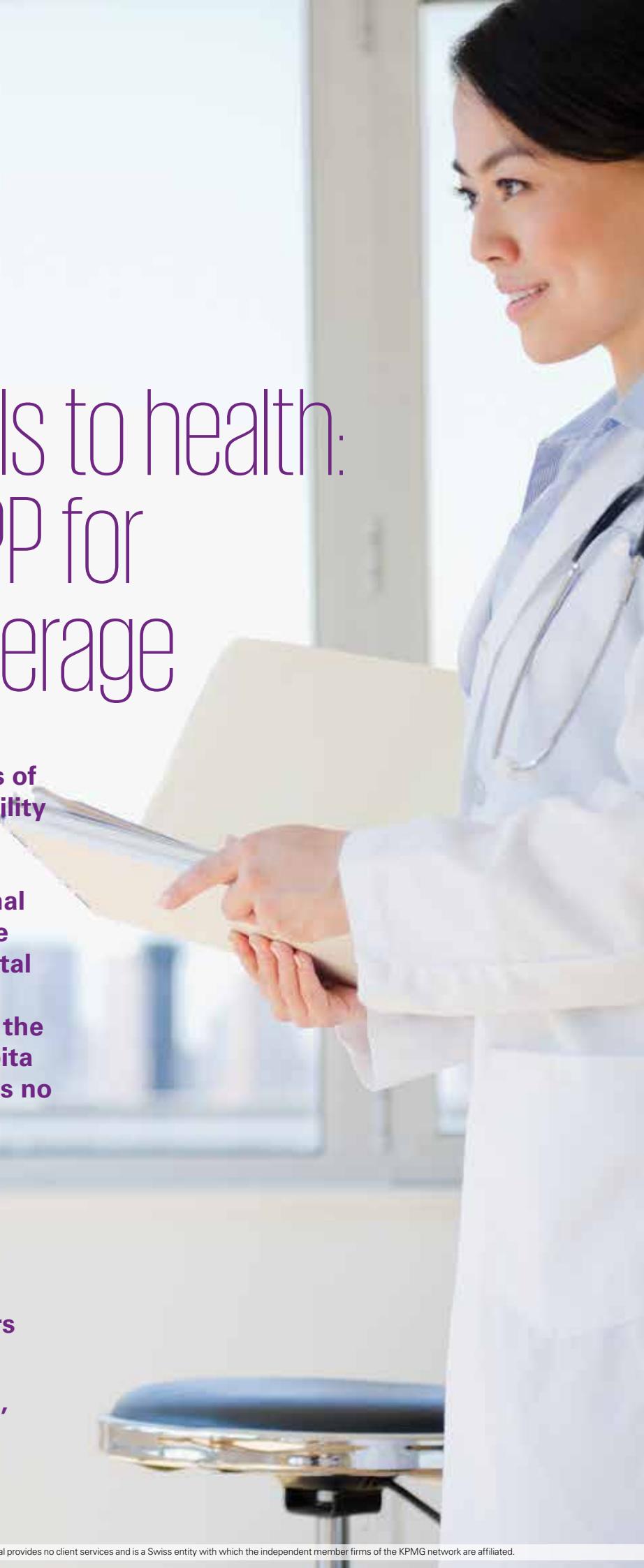
³A submission on the future directions for Public Private Partnerships, Infrastructure Partnerships Australia (2013).

4

From hospitals to health: Rethinking PPP for universal coverage

As more and more governments look seriously at PPP as a means of affordably improving the availability and quality of healthcare, there will undoubtedly be many projects that follow the traditional applications seen in high-income health systems — namely, hospital building. With low- and middle-income countries averaging half the number of hospital beds per capita in high-income countries, there is no shortage of work needed here.

However, there are signs that PPPs' contribution to UHC will not only be in 'me too' projects to build, maintain and operate hospitals. Conversations with public and private sector partners across Asia reveal an appetite to think innovatively about where else and how else the 'triple win' can be applied to developing health systems.



Three trends in particular are emerging: rethinking the kinds of **public** uses for PPPs, rethinking the types of **private** sector organizations involved, and rethinking the nature of the **partnerships** negotiated.

Rethinking 'public'

Expanding hospital capacity is a central component of many countries' UHC strategies, but by itself this will not set these systems on a sustainable path to UHC. Governments must develop stronger systems of primary and community care, resilient supply chains, IT infrastructure and telecare, and much more, as well as the health workforce capable of delivering care services to the very last mile.

Already, the public uses of PPP in healthcare are being expanded as they are taken up in emerging economies, from secondary care to many of the other key gaps that prevent countries reaching UHC, including:

Public insurance/payer functions: A number of countries have used private insurers to operate all or part of their national health insurance agencies.

— In rolling out and operating India's largest public health insurance scheme, the Rashtriya Swasthya Bima Yojana (RSBY), the government made private insurers and other third-party administrators (TPAs) responsible for enrolment, claims management, licensing providers and some of the insurance risk. While different in each state, RSBY mostly covers families below the poverty line (around 120 million enrolled persons as of 2016). Private insurers

and TPAs are typically paid per family they enroll and must cover a minimum benefit package defined by the state.⁴ Recently, many states have been significantly expanding these PPPs to bring enhanced RSBY coverage to a greater proportion of the population. Meghalaya state, for example, partnered with the insurance giant ICICI Lombard to expand RSBY to all its 3 million citizens, as well as making the benefit package almost six times as generous (from up to US\$550 per family per year, to US\$3,000). The Modi administration is currently planning to evolve RSBY into a National Health Protection Scheme. Private insurers are likely to continue having a major role in these plans, although it is hoped there will be greater incentives around effective rather than notional coverage — a recognized issue with the RSBY partnerships.⁵

- Since 2012, several Chinese cities have been piloting the use of private insurers to manage all claims under the largest state insurance program (National Rural Cooperative Medical Scheme). The intention is to demonstrate whether the private insurers — China Life, China Pacific Insurance and PICC Health Insurance — are more efficient and can therefore bring the administration cost of the scheme down.
- The Ghanaian and Kenyan governments are currently partnering with the private sector to enumerate and enroll poor and rural

households into the National Health Insurance programs to expand financial protection.

Primary and community care: Primary healthcare has historically been one of the toughest services to engage private sector providers in delivering — especially in rural areas. This is changing, however, with clinic chains and telemedicine providers approving primary care PPPs in China, India, Brazil, Russia, Romania, South Africa and Singapore in recent years. Brazil's famously primary care-led system has been one of the most enthusiastic markets to experiment with these models. As with many countries, PPPs began with hospitals, such as the 250 bed Hospital do Subúrbio in Bahia Province that opened in 2010 — the project achieved an affordable, high-quality service that was, as a result of this, swamped by very high demand.⁶ This revealed the lesson that improving hospitals in isolation was not a sustainable strategy. Several primary care deals have subsequently been signed across the country. The Alliar group are working with Bahia state and others to establish 'hub and spoke' diagnostic imaging and laboratory testing clinics across Brazil. The network professes an 'obsession' with efficiencies through scale, and is pioneering the use of remote scanners and an MRI 'Command Center' to bring diagnostics into areas where there are no radiologists, as well as reducing the costs of delivery.⁷ In 2016, the neighboring state of Minas Gerais, the city of Belo Horizonte agreed a 20-year concession deal to build, remodel, operate and maintain 77 primary care clinics, covering around a million people on low and middle incomes.⁸

⁴ http://www.rsbypay.gov.in/how_works.aspx.

⁵ Falling sick, paying the price; Sundararaman T &, Muraleedharan VR, *Economic and Policy Weekly* L:33 (2015).

⁶ Public private partnership stories: Hospital do Suburbio Brazil, International Finance Corporation (2013).

⁷ Detecting diseases with personalized radiology: Alliar, International Finance Corporation (2016).

⁸ Public private partnership stories: Belo Horizonte Primary Care, International Finance Corporation (2017).

Rethinking 'private'

Related to these much broader asks from governments, the types of private players that are operating in the PPP space are also expanding. While hospital operators have traditionally dominated in these deals, new providers — including organizations from non-health sectors — are increasingly looking to break into the rapidly expanding healthcare market. Examples of these include:



Telcos:

Universal health coverage requires reach into every community in a country, in addition to behavioral data and a means of collecting funds. Governments are good at many of these things but increasingly so too are cell phone providers, dozens of which have been making investments in the health sector in recent years. One such example is Telenor, who in June 2016

launched its first health product with a microinsurance coverage — Tonic — in Bangladesh. Utilizing its position as the country's largest telco through its partner Grameen Phone (55 million members), within 9 months Tonic had more than 5 million subscribers. The product entitles members to discounts of up to 30 percent at the more than 80 hospitals and 50 labs signed up to Tonic, as well as a 24/7 doctor-led healthline, wellness coaching and Bangladesh's first fully portable health record. Dr. Niti Pall, Medical Director to KPMG's Global Health Practice, who helped develop Tonic, says governments have much to gain from partnering with telcos and other technology partners: "While Tonic was developed as a standalone product with a fairly limited scope of benefits, to make it work we had to essentially recreate an almost complete health system based around the mobile phone. It's clear to see how these and other systems could easily be used to provide a universal, public service."

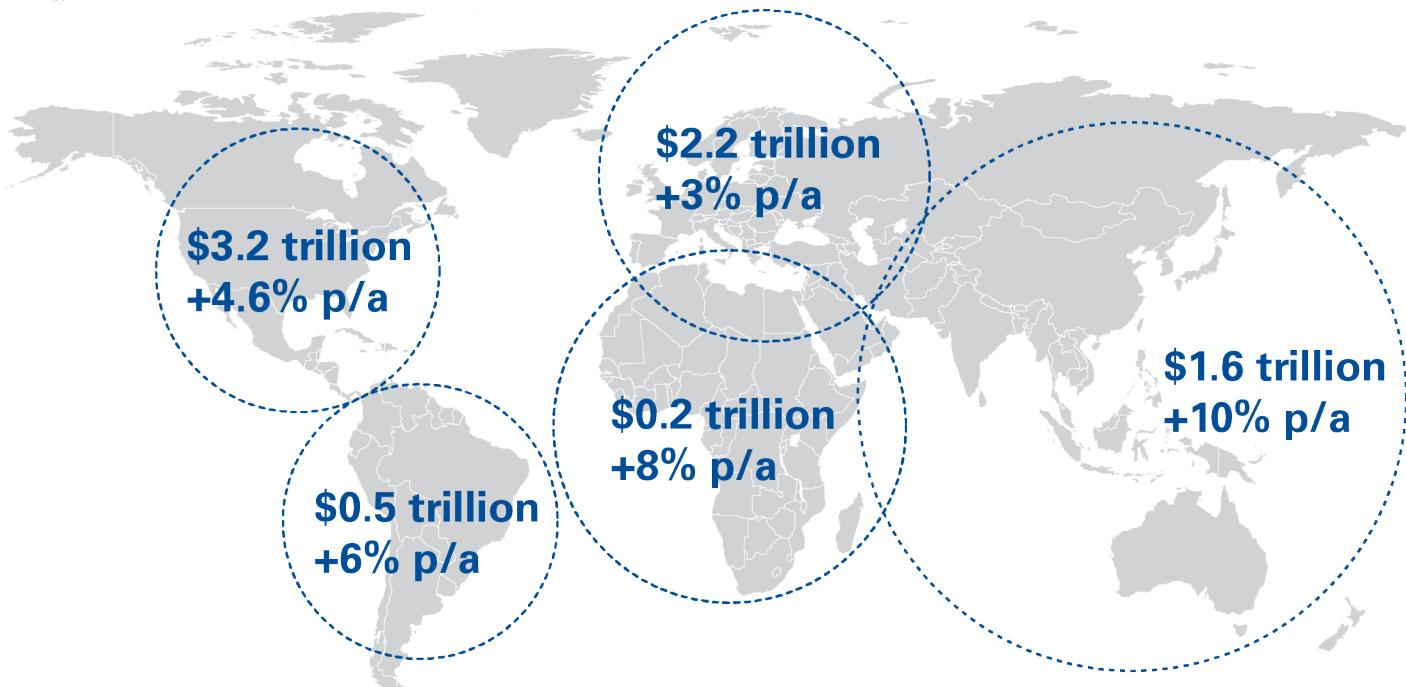


Training colleges:

A shortage of qualified health workers is one of the most common barriers to countries being able to expand coverage and achieve UHC. Private institutions offer governments the possibility of rapidly increasing training capacity, while they in turn can offer for-profit medical schools the necessary access to large public teaching hospitals. One of the longest-standing partnerships of this kind is the Melaka-Manipal Medical College (MMMC), a PPP between the state government of Mekala in Malaysia and Manipal Academy of Higher Education (MAHE) in India. For decades, thousands of Malaysian doctors were trained in India at MAHE but this came to an abrupt end in 1993 when the Indian government introduced a policy preventing foreign medical students from training there. This created a shortage of opportunities



Figure 3: Turning healthcare investment on its head: Total healthcare spending (US\$) by region and average growth rates for last 5 years



for Malaysian medical students, leading to the MMMC joint venture. MMMC's medical degree takes 5 years, with the first half spent in India and the second in Malaysia, with trained faculty from MAHE. The state government grants MMMC the use of two public hospitals and two medical centers, plus some teaching staff on a part-time basis. MAHE, in turn, manages and operates the program. Over 300 medical students graduate MMMC each year, in addition to the school providing continuing medical education and training to various other health worker cadres. Newer medical training PPPs are also emerging — several of which are also in India, such as the Shillong Medical College partnership, a 99-year concession for a 500-bed training hospital that will produce 100 doctors per year from 2020 onwards.⁹ Elsewhere in the world, Saudi Arabia has had a number of long-standing international partnerships with educational institutions, for example since 2011 King's College Hospital in London has been a major provider of nurse training for one of its largest hospitals — King Fahad Medical City.



Investors:

Following the slowdown of healthcare spending growth in North America and Europe since the global financial crisis, healthcare investors are increasingly looking to the emerging economies (Asia and Latin America in particular) for growth opportunities (see Figure 3). While many are placing bets on private facilities for wealthy patients, the boldest are seeking to capitalize on

the bottom and middle of the pyramid. The Abraaj Group's Global Healthcare Fund is one of the pioneers of this new frontier — it has commitments of US\$1 billion to invest in innovative healthcare services across Sub-Saharan Africa and South Asia. Their strategy is founded on leveraging economies of scale by creating a global platform for delivering high-quality, low-cost healthcare — both through expanding existing services and starting others from scratch. The Abraaj Group has invested in over 27 healthcare businesses to date, including in Egypt, Kenya, Nigeria, Tunisia and Pakistan. Most recently, they acquired CARE Hospitals, India's fifth largest healthcare provider, and Islamabad Diagnostics Center, a leading provider of affordable diagnostics in Pakistan. The Group's ultimate aim is, through scale, to significantly increase the capital, expertise and clinical capacity available to providers in low- and middle-income countries, providing affordable services for low- and middle-income families and become a potentially vital delivery partner to governments that wish to expand coverage.

Rethinking 'partnerships'

The distinction between 'public' and 'private' health services is blurring. With a number of 'public' health outcomes being delivered by 'private' (or not-for-profit) organizations, there is a strong trend to creating innovative partnerships.

An important trend among Western PPP models that is likely to carry forward into emerging markets is the shift towards whole population models

of care. Rather than shifting risk for one set of services in the healthcare system (e.g. primary care clinics or secondary care) these integrated PPPs give a private partner responsibility for all the healthcare needs of an area, and reward success not by activity but health outcomes. The advantages of these models are that they give the private provider the maximum freedom to find the most efficient way of treating patients, and remove the incentive to increase (or decrease) volumes into any one particular part of the system they control.

Such 'value-based' PPPs are not unique to healthcare — private sector operators of employment support contracts in the UK, US, Ireland and Saudi Arabia now routinely have the sustainable employment rates of their job seekers factored into how much they are paid by government, for example. As Dr. Niti Pall, KPMG's Global Medical Director, explains, this model is proving increasingly popular in the health sector: "More and more PPPs are including payment structures based on clinical improvement and population health, rather than simply the number of patients through the doors. While these value-based contracts can be highly complex and technical, if you get them right they create a fundamentally different kind of relationship with the private sector. No longer is their job to deliver narrow efficiencies within a particular service — instead they need to think really innovatively about redesigning entire pathways of care. It takes a very particular kind of partner to be up for that challenge, but the experience of Spain and others shows considerable rewards for success."

⁹Public private partnership stories: Shillong Medical College India, International Finance Corporation (2013).



Box 4: The Manises model: A whole-population PPP to improve health in Spain

Perhaps the most famous population-based PPP story comes from the Valencia region in Spain, which has had multiple successes in the use of the private sector to operate large portions of the health system. The region has been using population-based healthcare PPPs since 1999, when its now famous Alzira model was formed.¹⁰ The fourth of these projects, Manises, was the first to cover virtually the entire healthcare ecosystem for an urban area — including primary, secondary, tertiary and long-term care.

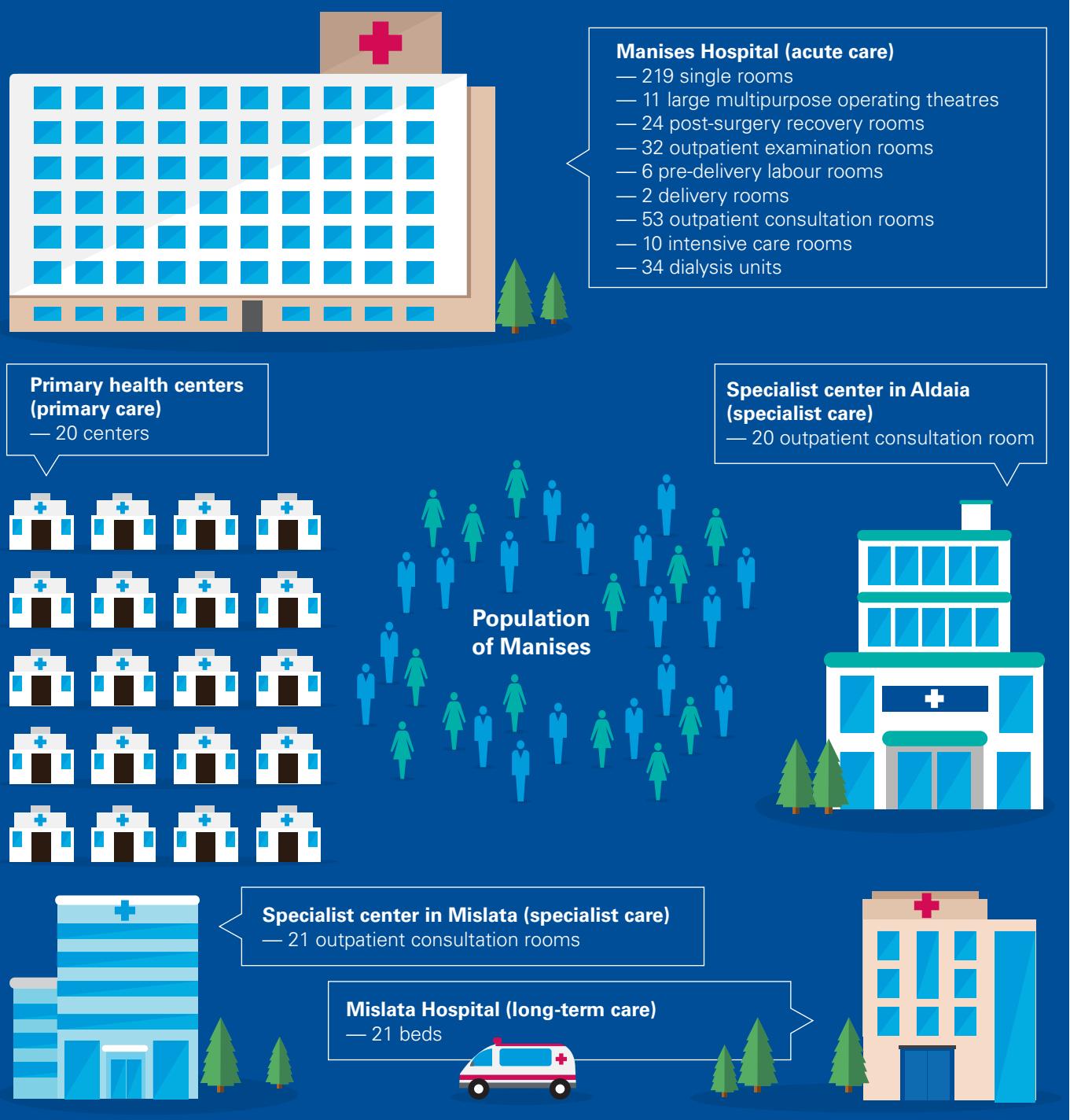
Signed in 2006, the PPP was awarded to a consortium led by Bupa Sanitas to cover a population of around 193,000 people, though they have subsequently also taken a 50 percent stake in a neighboring PPP hospital (Torrejon) that covers an additional 136,000 people. As the diagram below shows, the model covers two hospitals, 20 primary care centers, as well as two specialized care centers and a long-term care facility. Sanitas were responsible for constructing the Manises facility (which opened in 2009) and for delivering virtually all the health needs of the population in their catchment area. They are paid for each person in their registered population, regardless of how many treatments are delivered, with this figure adjusted based on an annual assessment of quality indicators (from readmissions, to management of risk factors, rates of incidents like hip fracture). This means that money follows the patient, with deductions if their patients go to outside providers and a 15 percent lower fee for any patients outside their registered population that seek care with them.

The model creates a strong incentive to provide high-quality care in the most efficient way possible, a goal that the model's outcomes suggest has happened. Compared to other public systems in Spain, waiting times for surgery are around two thirds lower (38 days vs. 120), accident and emergency department waiting times have fallen by over a third (149 minutes vs. 224), mortality is around 34 percent lower, and there are 42 percent fewer complications. Patient satisfaction is also measurably higher.

For government, the model has led to significant savings and protection from the risks that have been affecting the rest of the public system through a period of austerity. Patients are receiving better quality care and access, as well as a greater focus on prevention. From Sanitas' perspective, costs of care have been brought down significantly but not yet sufficiently to make the returns they were expecting. Inaki Ereño, CEO of Sanitas, comments that "we are incredibly proud of the integration of care that has been achieved in Manises by having a single private operator responsible for the whole pathway of care. It has allowed us to do things like integrated electronic records that follow the patient, and invest heavily in health promotion. Even so, 8 years into the contract there are still areas where we feel the 'rules of the game' are unclear and that lack of certainty has at times been a barrier to our long-term plans and profitability."

As with Hospital de Braga in Portugal (see page 11), the model's success has not dispelled public skepticism about the use of PPP in healthcare, and in recent years some Spanish regions have pulled back from plans to adopt this model themselves. One major challenge that these population-based models faced was whether the per-patient payment should be increased in line with new, very expensive treatments being added to the national benefit package. For example, there was disagreement between the government and private operators when the Hepatitis C vaccine was introduced (at a cost of around 80,000 euros per patient) as to whether this was part of their existing contract or required additional funds. This reinforces the importance of a rigorous approach to future-proofing contracts with clear processes to cope with unforeseen changes in population needs or healthcare services.¹¹

Map of the Manises model



¹⁰ Case study: Public private healthcare partnership in Valencia Spain, Reform (2012).

¹¹ The Manises Integrated healthcare model, Bupa Sanitas (2014)

5

Foresight, not fashion: What works in unlocking the 'triple win'

On the journey to making PPP projects a success, much attention gets drawn towards which model is best. Of course, selecting an appropriate contractual and funding mechanism is important, but the search for a specific structure that will guarantee better outcomes is illusory. Though fashions have seen many PPP forms rise and fall, no model is perfect. Rather, success is dependent on the skill with which any one model is adapted to reflect local circumstances.



We asked six of the most experienced leaders in KPMG's global PPP network for their top success factors that really make the difference in unlocking the 'triple win' for health.

1. Sweat the small stuff (Allan Yeo, Principal Advisor for Healthcare in KPMG Singapore, and healthcare strategy lead for Asia-Pacific)

Given that PPP deals typically have to last between 15 and 30 years, fanatical attention to detail is required over all the small particulars that could change during this time. As Allan Yeo, who previously ran several PPP hospitals in Asia explains, "Very few organizations are used to thinking on a multi-decade timescale, but when you do the list of possibilities and contingencies is vast — from new drugs and treatments, to population change, healthcare inflation, workforce capacity and all the potential areas where quality can slip. You would be amazed how many PPP hospitals are receiving double their anticipated demand just a few years into their contract — a common sign that assumptions weren't properly tested."

Factoring these considerations reliably into any deal requires a huge amount of groundwork and research, as well as absolute clarity from all parties about who is responsible for what. While mundane, some of the most important enablers of success are having proper phased checkpoints: enough time to develop bids, for a proper value-for-money analysis and for sufficient dialogue and debate between all the different parties.

2. Active market management (Matt Custance, Partner, KPMG UK)

Tendering processes and systematic procurement are an essential part of ensuring value for money and getting the benefits of competition. However, governments are often prone to 'retreat into isolation' once the process to tender for a PPP has been decided on.

"That places far too much responsibility on the market," says Matthew Custance, a Partner in KPMG UK and one of the leaders of KPMG's global healthcare PPP network. "What results from a passive approach is that no one really knows what government is looking for and the winner is the company that 'guesses best'. That's not a reliable way of finding the best partner."

Instead, he recommends an active engagement strategy from the start: "Through supporting dozens of these projects we've learned that you need to bridge the divide — dedicated time with investors, donors, debt markets, private operators and government to really get to the bottom of what problem the public sector is trying to solve and what kind of solution could work."

Relationship building is also an important part of finding private sector partners that share the same values as the public sector. Even the most watertight of contracts still needs trust and mutual understanding to function well.

3. Scaling up PPP capacity in the public sector (James Stewart, Chairman, KPMG Global Infrastructure Practice)

Even with the best technical assistance, governments need to develop strong internal capabilities if PPPs are to become a meaningful force in the drive towards universal health coverage. Many governments now looking at PPPs in health have had several years of applying them in other sectors, but it is easy to tell the difference between those that have curated and cultivated that experience and those that haven't, according to James Stewart, Chairman of KPMG's Global Infrastructure Practice. "A number of countries have prioritized the development of a dedicated, well-resourced PPP unit to support projects in whichever part of government they are needed. Those countries have tended to have a much better success rate, both in getting PPPs approved and getting value out of them." PPP units are typically responsible for a whole range of functions, including:

- making recommendations on what projects may be suitable for PPPs, and the appropriate delivery model
- establishing the legal framework and guidance under which PPPs may take place
- managing procurement alongside the relevant Ministry
- coordinating engagement with the supply-side market
- investing equity in projects.

Many countries have housed their PPP unit within an existing government ministry, for example Singapore, Brazil and Mexico, but a few have set up separate publicly-owned agencies (Portugal, and British Columbia in Canada) and in some cases the unit itself is a PPP (e.g. Partnerschaften in Germany). "The key," says James, "is whether those units are given the time and resources to invest in and retain a team strong enough to negotiate effectively with the private sector, and whether their mandate has the right balance between regulation, innovation and project support."

4. Embrace, rather than resist, the politics of PPP (Fernando Faria, Partner, KPMG in Brazil)

PPPs, especially healthcare PPPs, are inherently political. Some public skepticism and political resistance are unavoidable, and rightly so given the scale of commitment being made by government and the importance of local health services to communities.

"Europe, Asia, Africa, the Americas — wherever there have been healthcare PPPs there has been controversy — especially when they involve clinical services," explains Fernando Faria of KPMG in Brazil. "Even in countries where PPPs have been highly successful, people will always ask questions about these deals and in some cases, this has led to governments turning down demonstrable win-wins. Ultimately, it comes down to ambition — do you take the easy route and only consider low-risk, low-reward options or — assuming the





right partners exist — do you keep an open mind and try to do something really transformative.”

“Strong political will is necessary, but insufficient to overcome this,” Fernando says, “you have to pre-empt and deal with opposition constructively. These deals take years to arrange and often last for decades, so the broader their support the more future-proof they will be.”

Ensuring that the PPP process is as transparent as possible is one way to diffuse opposition. This is an area where many countries have a long way to go according to KPMG’s recent study *Through the Looking Glass*, which measured stark differences in the transparency of procurement processes across different regions of the world.¹² Asian economies scored particularly low on this measure. “Remember also that transparency doesn’t end when the deal is signed,” warns Fernando, “ongoing monitoring and evaluation reports are also important — not just for the project they are about, but to strengthen the case for future use of PPPs as part of UHC.”

5. Data systems you can trust (Dr. Niti Pall, Medical Director, KPMG Global Healthcare Practice)

“A PPP can only be as strong as the data that’s put into it,” says Dr. Niti Pall, Medical Director of KPMG’s Global Healthcare Practice, who has been responsible for healthcare PPPs in China, India, the UK, Poland and Saudi Arabia. “If a health system’s intelligence is unreliable, the chances of a ‘triple win’ are seriously reduced — at least one party is going to find out they made a bad deal because the assumptions of the arrangement turned out not to be true.”

There are many tests of a PPP deal, including: is the service quality good enough? Is it meeting demand as expected? Is it good value for money? “It’s not just about healthcare data either,” adds Niti, “at KPMG we are

increasingly using ‘real economy’ approaches to look at the value for money that PPP deals generate — these look beyond a narrow health lens to consider the impact on the local economy, employment, environment and other aspects of development.”

All these require reliable data collection systems to give a trustworthy picture,” says Niti, “and improving these is an often overlooked but necessary condition of success.”

6. From clarity of objectives to clarity of requirements (Adrian Box, Partner, KPMG Australia)

Many public health providers do what they do because it is what they have learned and/or it is what they think is right. However, these requirements are rarely written down, nor are they consistent. Furthermore, there is commonly a challenge in being able to answer the question of “why — what drives you to do this?”

When looking to contract (or partner) with a private provider for the provision of services, it is critical to fully understand the desired objectives, an ability to clearly articulate these as requirements and a detailed understanding of the factors that may drive behaviors of all parties.

As Adrian Box, one of the leaders of KPMG’s global PPP network, explains: “Without this clarity, a number of issues can arise. From the service purchaser’s perspective, an inability to clearly articulate the objectives and requirements is likely to lead to a lack of confidence and trust in private delivery. It may also lead to a commercial framework that inadvertently drives outcomes that do not meet the objectives and therefore creates dissatisfaction or service failure. From a service provider’s perspective, it is critical that they understand the objectives to tailor a solution to and critical that the framework supports positive behaviors and outcomes.”

¹² Through the looking glass: A practical path to improving healthcare through transparency, KPMG International (2017).

How KPMG can help

Whatever the stage of PPP progress — strategic planning or project implementation, traditional hospital build or innovative new model — KPMG has the skills and experience to help make the ‘triple win’ a reality.

Our global network for healthcare PPP helps public and private players alike through the entire lifecycle of healthcare partnerships, including:

- **developing a coherent strategy** — setting the right vision, goals and priorities for the healthcare sector as a whole, and articulating these to key stakeholder groups
- **shaping and evaluating specific opportunities** — selecting and preparing the right partners and specific projects to take forward, drawing on our vast global health network
- **designing partnership models** — creating the target operating models and share of risk/reward, as well as developing the values and trust

that will future-proof any agreement and deliver services that are more efficient and benefit the whole population

- **executing deals** — negotiating partnerships terms and contracts, assessing and modeling bids and securing a final agreement that works for all parties
- **implementing PPPs** — establishing the partnership, including support for transition to new arrangements and integration of existing services and organizations
- **evaluating and governing ongoing performance** — monitoring real change against the agreed plan and seeking alignment in any areas of disparity.

KPMG has recently established a Center for Universal Health Coverage (kpmg.com/uhc) as a dedicated hub for member firm clients to find advice and support for achieving ‘health for all’. Leveraging the knowledge and skills of KPMG’s 4,500 health professionals across 50 countries, the center helps governments, institutions and private organizations design and operationalize large-scale UHC programs — from introducing national health insurance, to expanding supply-side capacity, to reforming governance, redesigning financing flows, and much more.

Working together, our global expertise in PPP and UHC make KPMG the clear choice partner for health systems that wish to find whole-system solutions to the challenge of achieving ‘health for all’.



Authors and contributors



Allan Yeo

Allan Yeo is Principal Advisor for KPMG in Singapore, and leads the first healthcare strategy and deal advisory network across Asia. He has more than 28 years in the healthcare and project management industry and has been involved in the pre-development and planning, construction, project management, hospital management and restructuring of hospitals in Singapore, Malaysia and Vietnam. Allan was part of the senior management team in the restructuring of the government—owned National University Hospital to autonomous management. In the private sector, Allan was instrumental in the restructuring and turning around of three hospitals in Singapore and Malaysia. Of these, Allan listed two in Singapore. Allan also led in the negotiation and acquisition of a major tertiary care hospital in Malaysia and later tasked to manage the hospital as its Managing Director. Allan also has experience in Vietnam, taking a Greenfield hospital project from inception to completion, and into hospital management. Allan is also the Healthcare Lead for Strategy, Transaction and Finance in Asia Pacific.



Fernando Faria

Fernando is an Advisor to public and private sector clients on major infrastructure projects across the transportation, energy, water and social infrastructure sectors. Fernando has worked in Europe, Africa, the US and Latin America. Since October 2014, he has been a Partner at KPMG in Brazil infrastructure practice, based in Rio de Janeiro. Before joining the Brazilian firm, Fernando was the head of the Portuguese and Angolan KPMG infrastructure practice. From 2011 to 2014, Fernando was a member of the executive committee of KPMG's Africa Infrastructure practice. As part of his role, he contributed to developing KPMG's infrastructure practices in various sub-Saharan countries.



Matthew Custance

Matthew is a KPMG Partner in the UK based in London, specializing in major transactions in healthcare and local government. This has ranged from advice on the development of privately funded social infrastructure (e.g. PFI, LIFT, ISTCs) through assisting bidders to structure quality bids which resonate with public sector clients to advising on competitive merger processes in the NHS. Much of his work is aimed at using transactions as a means of promoting increased productivity and accountability for the government spend. Matthew has advised on government transactions for more than 20 years.



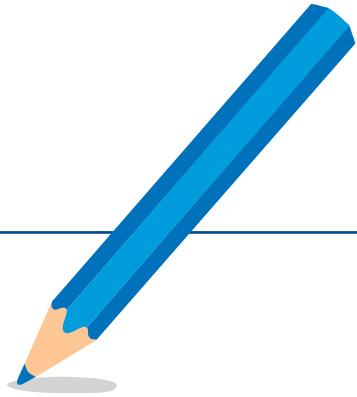
James Stewart

James joined KPMG in May 2011 as Chairman of KPMG's Global Infrastructure practice. Since joining the firm, James has visited over 45 countries to discuss their infrastructure investment plans and major projects. Prior to joining KPMG, James was based in the Treasury as the CEO at Infrastructure UK (IUK). James' role at IUK included advising Ministers on policy issues relating to the infrastructure sector and the private finance initiative (PFI) and public-private partnership (PPP) market, managing senior stakeholder engagements with the public sector, publication of a UK Infrastructure Strategy on budget day in March 2010, publication of the National Infrastructure Plan, launched by the Prime Minister at the CBI Conference in October 2010 and publication of the Infrastructure Cost Review in December 2010. From May 2000 to December 2009, James was the CEO at Partnerships UK. Prior to this role, James spent 14 years at Hambros and Société Générale. His final position was Managing Director, Project Finance, and the Global Head of Infrastructure and Environment.



Michal Jacob

Michal is an Israeli lawyer and a certified foreign lawyer by the Ministry of Justice in Vietnam. She has over 22 years of professional legal and business management experience both in Israel and Vietnam, focusing on the healthcare and life sciences sector and is currently the head of the sector at KPMG in Vietnam. Prior to joining KPMG in 2016, Michal was working with public and private (PPP) healthcare providers, regulators and insurers in Israel and was the lead advisor to the second largest Health Maintenance Organization (HMO) in the world, its hospitals and subsidiaries. Michal was involved in PPP projects and contracts under various models and scales both in Israel and Vietnam, healthcare establishments' management and structuring, supply-chain, procurement, logistics and administration, regulations and compliance, policy drafting and implementing and JCI accreditation. Michal's experience in healthcare has provided her with an in-depth understanding of PPP healthcare systems, including insurance and reimbursement plans, with a pragmatic approach to support clients in achieving the objective of improving efficiency and quality of healthcare services.



Niti Pall

Niti is a visionary senior clinician who has combined clinical practice with an entrepreneurial edge to design and deliver new models of health care around the world. A general practitioner for over 30 years, Niti helped to build up the largest chain of primary care clinics in the UK—the Modality Partnership—and held several senior commissioning roles in the English NHS. She led the formation of Health India Private Ltd, a chain of primary care clinics across India later incorporated into HCL healthcare, where she subsequently worked as Chief Medical Officer. Most recently she was Medical and Innovation Director of Emerging Markets for BUPA, where she helped to create an innovative model of micro-insurance in Bangladesh in partnership with Telenor. She established and supervised clinics in China, Saudi Arabia, Poland and Hong Kong and helped create health benefit management systems in India, Hong Kong, and Thailand. In India, she worked closely with the government and Max Bupa on RSBY a low cost health insurance scheme. Now Medical Director to KPMG's Global Health Practice, Niti leads our universal health coverage (UHC) work in Asia, as well as providing clinical leadership and primary care expertise across all work with KPMG's Center for Universal Health Coverage.



Adrian Box

Adrian Box, is a Partner with KPMG Australia and leads the Infrastructure & Projects Group in Melbourne. Adrian has extensive experience in strategic and commercial advisory and the management and delivery of large complex infrastructure, service delivery and real estate projects. Adrian's experience includes strategic analysis, stakeholder engagement & management, project implementation and leadership, procurement analysis, business case development, project structuring, tender documentation design and development, bid evaluation, contract development, transaction structuring & management and negotiation.

Adrian is also the KPMG Australia national leader for Public Private Partnerships (PPPs), having significant experience working with government and private sector bidders in relation to the majority of Australian PPPs over the past 15+ years.



Anuschka Coovadia

Dr. Anuschka Coovadia is KPMG's Head of Healthcare for Africa, and leads the firms Universal Health Coverage work across the Africa region and beyond. Qualifying as a doctor at the height of the HIV epidemic, Anuschka's initial experiences in healthcare were of a system overwhelmed by disease, denial and stigmatization. She realized that to effect true change she needed to be more than just a clinician, so started the last 15 years of her career working with governments, donors, hospital groups, pharmaceutical manufacturers, professional groups and technology firms. "I have a passion for innovation, strategy, entrepreneurship and development. I love working with people who are courageous and constantly bring fresh ideas to the table," she says. "We need this if we're to move forward, expand access to healthcare and address the critical stumbling blocks that hinder the delivery of better quality, patient-centric care. I enjoy moving across all the different components of the healthcare ecosystem - learning from people who have deep vertical experience and capabilities; and then applying those skills more broadly, in the interest of creating a better healthcare system for all Africans."



Jonty Roland

Jonty has worked with more than 25 healthcare systems advising governments on all aspects of universal health coverage. As Program Director for KPMG's Center for UHC, Jonty acts as a subject matter expert leading the Center's research program and coordinating KPMG's UHC activity across our network of health practices in 50 countries. Since joining KPMG in the UK in 2014, Jonty has worked on numerous UHC projects with governments and private sector clients around the world. His areas of expertise include comparison of different coverage models, helping countries understand their key areas of progress and gaps, quantifying the economic benefits of UHC, and strengthening delivery systems. Before joining KPMG, Jonty was Policy Director for the All Party Parliamentary Group on Global Health in the UK Parliament, and before that held various advisory and research positions in the English National Health Service and Ministries of Health in Africa and Asia. Throughout all his work runs the theme that health systems in high, middle and low income countries each have something to teach and to learn from one another.

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Contacts for healthcare services

Chairman
Global Health Practice
Mark Britnell
T: +44 20 7694 2014
E: mark.britnell@kpmg.co.uk

Argentina
Mariano Sanchez
T: +5411 4316 5774
E: marianosanchez@kpmg.com.ar

Australia
Liz Forsyth
T: +61 2 9335 8233
E: lforsyth@kpmg.com.au

Austria
Johann Essl
T: +43 732 6938 2238
E: jessl@kpmg.at

Belgium
Emmanuel De Moyer
T: +32 2 708 4486
E: edemoyer@kpmg.com

Brazil
Marcos A. Boscolo
T: +55 11 2183 3128
E: mboscolo@kpmg.com.br

Canada
Georgina Black
T: +1 416 777 3032
E: gblack@kpmg.ca

Central/Eastern Europe
Miroslaw Proppe
T: +48 604 496 390
E: mproppe@kpmg.pl

Chile
Santiago Barba
T: +562 2 798 1507
E: santiagobarba@kpmg.com

Czech Republic
Zdeněk Tůma
T: +420 222 123 390
E: ztuma@kpmg.cz

Denmark
Allan Juhl
T: +4526329418
E: ajuhl@kpmg.com

Finland
Minna Tuominen-Theusen
T: +358207603565
E: minna.tuominen-thuesen@kpmg.fi

France
Benoit Pericard
T: +33 1 55 68 86 66
E: benoitpericard@kpmg.fr

Germany
Volker Penter
T: +49 30 2068 4740
E: vpenter@kpmg.com

Hong Kong/China
Jenny Yao
T: +86 108 508 7074
E: jenny.yao@kpmg.com

India
Nilaya Varma
T: +91 98 100 85997
E: nilaya@kpmg.com

Indonesia
Tohana Widjaja
T: +62 21 574 2333
E: tohana.widjaja@kpmg.co.id

Ireland
Frank O'Donnell
T: +35 31 700 4493
E: frank.odonnell@kpmg.ie

Israel
Haggit Philo
T: +972 3 684 8000
E: hphilo@kpmg.com

Italy
Alberto De Negri
T: +39 02 6764 3606
E: adenegri@kpmg.it

Japan
Keiichi Ohwari
T: +81 3 5218 6451
E: keiichi.ohwari@jp.kpmg.com

Malaysia
Yeekeng Lee
T: +60 3 7721 3388
E: leeyk@kpmg.com.my

Mexico
Andrés Aldama Zúñiga
T: +01 55 5246 8589
E: aaldama@kpmg.com.mx

Netherlands
Anna van Poucke
T: +31 20 656 8595
E: vanpoucke.anna@kpmg.nl

New Zealand
Richard Catto
T: +64 4 816 4851
E: rcatto@kpmg.co.nz

Norway
Wencke van der Meijden
T: +47 406 39345
E: wencke.vandermeijden@kpmg.no

Philippines
Emmanuel P. Bonoan
T: +63 2 885 7000
E: ebonoan@kpmg.com

Portugal
Fernando Mascarenhas
T: +244227280102
E: femascarenhas@kpmg.com

Romania
Maria Elisei
T: +40 37 237 7800
E: melisei@kpmg.com

Saudi Arabia
Khalid Yasin
T: +96 611 874 8500
E: kyasin@kpmg.com

Singapore
Wah Yeow Tan
T: +65 641 18338
E: wahyeowtan@kpmg.com.sg

South Africa
Anuschka Coovadia
T: +27837878470
E: anuschka.coovadia@kpmg.co.za

South Korea
Kyung Soo Park
T: +82 2 2112 6710
E: kyungsoopark@kr.kpmg.com

Spain
Candido Perez Serrano
T: +34 914 513091
E: candidoperez@kpmg.es

Sweden
Stefan Lundstrom
T: +46 8 7239652
E: stefan.lundstrom@kpmg.se

Switzerland
Michael Herzog
T: +41 44 249 31 53
E: michaelherzog@kpmg.com

Taiwan
Eric K. J. Tsao
T: +88 628 101 6666
E: erictsao@kpmg.com.tw

Thailand
Chotpai boonpun Boonsri
T: +66 2 677 2113
E: boonsri@kpmg.co.th

Turkey
Raymond Timmer
T: +90 216 681 9000
E: raymond.timmer@kpmg.com

UK
Jason Parker
T: +44 207 311 1549
E: jason.parker@kpmg.co.uk

US
Ed Giniat
T: +1 312 665 2073
E: eginiat@kpmg.com

Vietnam and Cambodia
Michal Jacob
T: +84 283 821 9266
E: michal.jacob@kpmg.com.vn

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