Spanish healthcare Public Private Partnerships: the 'Alzira model'

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Abstract

Global infrastructure reports suggest that, in the wake of the fiscal crisis, healthcare Public Private Partnerships (PPPs) are seen as a growing area as governments switch attention to social welfare projects. Spain is unique in having had a PPP hospital in operation for over a decade which is funded through a capitation fee. This paper takes a critical approach to evaluate the project, with our analysis showing that the original project could never have been viable and that the renegotiation of the contract has been costly to the government. We call into question the role of the Spanish savings banks in financing this type of project, which has now been replicated with further hospitals in Spain and Portugal, as well as in developing countries such as Lesotho.

Key words: PPPs, healthcare, hospitals, Spain

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1. Introduction

Internationally, healthcare costs are increasing, due to, amongst other things, advances in medical and technological treatments, an ageing population, changing public expectations and evolving patterns of diseases, whilst at the same time government budgets are in decline. Consequently, as part of the global movement towards involving the private sector in the financing, construction and delivery of public services, the use of public private partnerships (PPPs) in the healthcare sector has contributed to the global PPP market being worth $55.5 billion by 2009 (Project Finance, February 2010).

This increase in the marketisation of health has created an opportunity for medical insurance, private healthcare and construction and facilities management companies to expand their remit into the delivery of healthcare services to the public through PPP mechanisms funded by government payments, especially in the UK, Italy, Spain and Portugal, where the national health services are funded through general taxation (Barros and Martinez-Girault, 2009). Indeed, although the market is dominated by transport projects, social infrastructure, including healthcare projects, is seen as an attractive pipeline for infrastructure investors (DLA Piper, 2009; Project Finance, March 2010). In the case of Spain, this fits with its macro- level rationale that PPP projects provide additional investment which otherwise the state could not afford or would have to delay for many years (Vázquez, 2006; Vilardel, 2005)[1].

As the PPP policy matures, the models have become more complex. In relation to healthcare, most accounting literature has focused on hospital PPPs, notably the UK Private Finance Initiative (PFI) model whereby the private sector finances and constructs a hospital building and then delivers the service and maintenance functions

[1] In contrast to this, the UK government claims a micro-level justification - that PPP will deliver greater value for money (VFM) over the whole life than public sector procurement despite the higher cost of private over public finance. The Australian (Victoria) rationale has changed over time (Blanken and Dewulf, 2010; English, 2005) and is now a combination of both funding related principles and the need to demonstrate VFM.

over a period of around thirty years. This model is also in use in Spain, Italy, Mexico, South Africa, France, and Australia. However there are also many other models using private finance (IFC, 2009; McKee *et al.*, 2006), for example, franchising, BOO (build, own, operate) and BOOT (build, own, operate, transfer), the contracting out of clinical services, such as the UK's Independent Sector Treatment Centres (ISTCs) and similar schemes in Romania and Peru, as well as management contracts in Brazil.

This paper considers the case of a PPP model which goes still further – not only does the private sector finance, construct and operate the hospital building, but it also delivers the clinical services as well. The unique feature to this contract is that the public sector role is reduced to being that of a commissioner of healthcare, as it funds healthcare services by paying the provider a capitation charge derived from the public health budget. The first hospital to use this model was the La Ribera hospital in the town of Alzira, in the autonomous region of Valencia, Spain, and this approach has become known as the 'Alzira model'.

The objective of this paper is to carry out a detailed case study of the development of the 'Alzira model'. We analyse the financial statements and compare the empirical evidence to the available narratives about the model, to determine the information gap between the rhetoric, which declares this project to be a success story, and the financial reality.

The information gap that we find is very significant because since its inception in 1999, further hospitals following the 'Alzira model' have opened in the autonomous Spanish regions of Valencia and Madrid as well as a related variant in Portugal, where the model is split into two separate contracts, one covering clinical activities and soft facilities, and another covering infrastructure operations (Barros and Martinez-Girault, 2009).

Some proponents, such as the Global Health Group based at the University of California, claim that such a model is well suited to the funding of healthcare in developing countries as it overcomes the problems of both financing the replacement of obsolete infrastructure and the delivery of clinical services. Lesotho in southern

Africa and the Turks and Caicos Islands of the Caribbean have now pursued this model for the provision of publicly available hospitals and health centres.

The paper is organised as follows. The next section reviews the literature evaluating healthcare PPPs and problematic issues arising from them. Section three introduces our theoretical framework. Section four describes the background to Spanish healthcare and section five sets out our research method. Section six describes the project structure and provides the empirical analysis of the Alzira case. Section seven draws out the implications of our study of the 'Alzira model', offers our conclusions regarding the future use of the 'Alzira method' and briefly considers the implications for international settings.

2. Problematic issues concerning healthcare PPPs

A review of the existing literature shows that global evaluation of healthcare PPPs is patchy, with overview studies such as Grimsey and Lewis (2004, 2005) providing little specific comment on healthcare. Thompson and McKee (2004) identify and describe, but do not evaluate, how different countries, including the UK, Italy, Spain, Ireland, Portugal and Greece, are using or considering the use of PPP for hospitals. Although, for example, Portuguese PPP hospitals have been operating since 2007, we have been unable to find any studies which evaluate them. Well over a decade after the first PFI projects went operational in the UK, there continues to be a lack of project evaluation. The UK National Audit Office (NAO), which scrutinises public spending on behalf of the UK Parliament, commented in a reflective report on PPPs that:

> '*We have yet to come across truly robust and systematic evaluation of the use of private finance built into PPPs at either a project or programme level.*' (NAO, 2009, Paragraph 13)

Although the UK's Office of Government Commerce (OGC) initiated a review process to evaluate the implementation of PFI projects, these are not in the public domain and their purpose remains unclear (Edwards *et al*., 2004). Although there is internal benchmarking of costs within the UK National Health Service (NHS), this

information is confidential, and therefore there is little specific post-implementation evaluation evidence that is publicly available (Broadbent *et al.*, 2003; Edwards *et al.*, 2004). This is echoed in relation to the ISTCs, where the UK NHS requirements for data collection and reporting are not being met, meaning that the policy cannot be evaluated (Pollock and Godden, 2008; Pollock and Kirkwood, 2009).

Thus, although many countries are using PPPs for healthcare, international studies of PPPs such as Hodge and Greve (2007) lament the lack of sufficient research on the outcomes of the PPP policy in practice and call for an increase in rigorous assessment of PPP projects. Despite this, there are a number of areas where the existing literature on PPP, in general, and hospitals, in particular, raises themes relevant to the procurement and operation of the 'Alzira model'.

Firstly, there are cost related issues. Cost savings were expected from lower labour costs and higher productivity (Grimshaw *et al.*, 2002). However, as the public sector has relinquished direct control over costs, there has been 'contract drift'. Private sector costs have moved upwards, leading to increases in the PPP charges (Edwards *et al.*, 2004; Grimshaw *et al.*, 2002; Shaoul *et al.*, 2008b; Whorley, 2001). This has been partly due to long term contractual 'lock in' (Lonsdale, 2005) as monopoly power reduces the contractors' incentive to produce good performance (Lonsdale and Watson, 2007). Furthermore, the public sector partners have had to implement bureaucratic practices, some of these invisible, to manage and monitor the contracts (Broadbent *et al.*, 2003; Edwards *et al.*, 2004), which again makes projects more expensive than the original expectations. Overall Shaoul *et al.* (2011) suggest that both the public and private sectors underestimated the cost of partnership working.

Secondly, there are issues around risk and risk transfer possibly because of an over-emphasis on quantitative risk, with other types of risks and uncertainties being downplayed (Broadbent *et al.*, 2008). The UK evidence shows that in early contracts, commercial operators had an advantage in contract negotiations because the public sector lacked experience of risk management (Hood and McGarvey, 2002), although over time this improved (Sussex, 2003). Risk sharing between partners can be ambiguous as its allocation may be unclear and therefore its transfer is uncertain, leading to the potential for operational disputes (Edwards *et al.*, 2004). Such a

situation led to problems in Victoria, Australia, where payments to two hospitals had to be increased so that the private operators would continue the contracts (Senate Community Affairs References Committee, 2000).

Furthermore, there is evidence in relation to UK and Spanish PPP roads that contracts may have been designed to mitigate risks to the private sector (Acerete *et al*., 2010), demonstrating that these contracts need political support (DLA Piper, 2004). This is expensive for the state to provide when it pays on behalf of the user, moreover, the state bears the risk when things go wrong. Similarly, with ISTC contracts, the UK NHS retained the demand risk that fewer procedures than expected would be performed and has had to pay the ISTCs for the total procedures contracted for, whether or not they were carried out (Pollock and Godden, 2008).

A third, related, issue is premature contract termination or state intervention. In Victoria, Australia, the La Trobe Regional hospital, which included the transfer of clinical services, was taken back into public ownership at substantial cost when the private sector partner became non-viable after making large losses. It had failed to understand the implications of the funding model, which left it unable to provide the level of services required (English, 2005) so intervention became inevitable. Although as yet there has been no early termination of a UK PFI hospital, an additional £50 million in 2005-6 alone was provided specifically to help hospitals, of which some were PFI hospitals, in serious financial difficulties meet their costs. A specific example is that of the Queen Elizabeth II hospital, Woolwich, where the trust's finance director said that PFI had added £9m extra to annual costs, and that this meant the deal had locked the trust into an annual deficit (PwC, 2005). To date hospitals have not been allowed to fail, but whether such support can continue under public sector budget cuts is questionable.

A fourth issue is that literature dealing with capitation payments as a model for funding healthcare indicates that there needs to be integration of both primary and specialised healthcare. With capitation there is an incentive to make health care efficient for the whole episode of care (Monrad, 1995). Funding hospitals through capitation promotes the integration of primary and secondary care because integration promotes prevention and avoids the use of more expensive care procedures. Likewise,

when capitation is linked to one category of care only, such as outpatient care, there may be an incentive either to underprovide or to refer unnecessarily to higher echelons in the health system (Carrin and Hanvoravongchai, 2003).

Finally, publicly available financial information may be very limited and opaque. To start with, it is hard to find robust figures in the public domain relating to the capital value of projects. Shaoul *et al.* (2008a) found that it is 'extraordinarily difficult' to get information about PPP projects and that frequently capital values vary across websites, meaning that it is impossible to know which provides the most reliable figure. Additionally, claims of commercial confidentiality make financial analysis of PPP policy very difficult (Edwards *et al.*, 2004; Pollock and Godden, 2008; Shaoul *et al.*, 2008a). It is difficult to obtain copies of the Full Business Cases where the financial details of the contract have not been redacted (Shaoul *et al.*, 2008a). Even in Victoria, Australia where Partnerships Victoria routinely place their PPP contracts online, the financial information is still redacted. Edwards *et al.* (2004, p223) conclude that: *'the inadequate financial reporting of and lack of accountability for PFI serves to obscure what the government does not wish to reveal.'*

In the light of these five key issues, we turn now to explaining our theoretical approach.

3. Theoretical framework

The use of private finance to deliver public healthcare services is part of the New Public Management (NPM) agenda, which has sought to create markets and improve public sector efficiency (Hood, 1991).

Our framework is based on the work of Froud *et al.* (2006) who use a 'narrative and numbers' approach to highlight discrepancies between management narratives, performative initiatives and business strategy. They state that:

> *'if we consider company narratives, the promises of management can be backed by performative initiatives but often do not accord with subsequent financial numbers…the financial numbers are crucially important because*

they are not a function of the tale that management spins' (Froud *et al*. 2006, p5)

Whilst Froud *et al.* (2006) apply their approach to management strategy in giant firms and their requirement to deliver shareholder value, our concern is in understanding whether the use of private finance in healthcare is able to deliver public value to citizens and taxpayers.

Froud *et al.* (2006) scrutinise the relationship between the narrative and the numbers. They examine how the different levels of narrative fit together. This may be at company level, in terms of the management discourse, at industry level, in terms of brokers' and investment analysts' reports, or other sector-level reports, or at the meta-level, the so-called 'grand narrative', which in our case is the way in which NPM claims to deliver efficiencies and cost savings to the public sector. However they caution that (p.129):

> *'Narrative is never a function or product of a social position, but some voices are louder because of the actor's structural position…the idea of narrative as voice is also fundamentally misleading because it encourages a very limited concept of performance as vocalization not enactment.'*

As well as creating narratives, management is also about doing (Thrift, 2001), that is, the performative, and Froud *et al.* (2006, p.130) argue that the narrative and the performative fit together in 'unstable, unique configurations', or discrepancies, which need to be critically interrogated. Here Froud *et al.*(2006, p.99) use numbers to explore the discrepancies between promises and outcomes. In our study we use numbers and financial analysis techniques to explore whether there are discrepancies between the NPM rhetoric that states that private sector efficiency leads to more cost effective healthcare delivery and actual performance in the case of the 'Alzira model'.

We apply Froud *et al.*'s (2006, p.131) two step relation between narrative and numbers. They argue that firstly '*narrative is often understood through the opposition of fact and fiction, fact and value, so that a narrative is something which is 'made up*'. Secondly, they consider if numbers can be facts, claiming that '*financial numbers are socio-technically constructed in ways that often allow several different narratives to*

find empirical support' (Froud *et al.,* 2006, p.133). We extend their approach to consider in relation to the 'Alzira model' what the underlying numbers are and how they are used, as well as examining whether there is any numerical basis for the claims made by the NPM rhetoric employed in relation to the project.

4. Background to Spanish Health Care

Internationally the Spanish National Health System (NHS) is well regarded. For example, its organ donor system is an international reference model and the WHO placed Spain seventh in an international ranking of healthcare (Sanchez Bayle and Beiras Cal, 2001). During the Franco regime it was a means-tested system that moved from covering around 20% of the population in the 1940s to around 80% of the population in the 1970s. The adoption of a democratic Constitution in 1978, followed by the General Health Law in 1986, brought the creation of a universal healthcare system. 2002 marked the completion of the gradual transfer of health care responsibilities from the central Ministry of Health to the autonomous regions.

Within each autonomous region the Spanish NHS operates as a two-tier system as shown in Figure 1 (Ministry of Health & Social Policy – Health Information System of the SNS, 2010). Each region is divided into health areas, which are further divided into basic health zones. Each health area has a designated hospital for specialist care, both inpatient and outpatient. Primary health care centres are located in the community within each basic health zone, and offer readily accessible basic healthcare services.

Insert Figure 1 about here

Health financing is part of the mainstream regional financing system (Lopez-Casasnovas *et al*., 2005). Central government imposes some legal and financial restraints, and the Ministry of Health retains a coordinating and governance role, although Lopez-Casasnovas *et al*. (2005, p.S222) regard this as weak. Accountability is achieved politically through the regional parliaments, with an increase in fiscal accountability after the 2002 changes through establishing a floor on health expenditure (Lopez-Casasnovas *et al.*, 2005). Devolution has meant that the

autonomous regions will show differences in health expenditure due to differences in clinical practices and health care priorities.

Whilst previously Spain was able to deliver a satisfactory healthcare system at a cost lower than the rest of Europe, in recent years costs have increased, which is significant in relation to the first Alzira contract formula. A new allocation formula was implemented in 2002, coincidentally at the time of a contract change in our case study, which led to a significant increase in total healthcare expenditure from 7.3% of GDP in 2002 to 8.1% of GDP in 2003 (OECD, 2009). By 2008, total health spending accounted for 9.0% of GDP in Spain, equal to the average of OECD countries, although Spain ranks below the OECD average in terms of health spending per capita, with spending of €2,072 in 2008 (adjusted for purchasing power parity), compared with an OECD average of €2,185. In Spain, 72.5% of health spending was funded by public sources in 2008, very close to the average of 72.8% in OECD countries (OECD, 2010).

Ongoing reform of healthcare takes a number of forms across the 17 autonomous regions. In relation to primary healthcare, there is increased use of outsourcing for diagnostics and day surgery. In some regions there are consortia between the public and the not-for-profit sector to run hospitals. More recently, more freedom has been given to individual hospitals through the use of mechanisms including Public Health Companies, Public Health Foundations and Foundation Hospitals. There has been increasing use of the PFI hospital model, as well as further hospitals using the 'Alzira model'.

5. Research method

We examined both narrative and numerical data in relation to the 'Alzira model'. For narrative information, we firstly examined the material available on the Ribera Salud website (<http://www.riberasalud.com>), as this was extensive and included the book *Alzira Model 1999-2005* (Bosch, 2005). The Sindicato de Médicos de Asistencia Pública (SIMAP), the local medical trade union, provided a contrasting view including evidence regarding labour statistics as well as access to the book *For the*

sake of our health? The privatisation of healthcare services[2] (Lister *et al.*, 2010). Then we searched both academic e-journal collections and business information databases such as *Factiva*, which gave us access to relevant business and news publications, including Spanish newspapers and trade journals such as Project Finance. We also carried out internet searches to locate other relevant documents relating to public healthcare and the use of Public Private Investment Partnerships (PPIPs) worldwide.

The contract specifications were not accessible, as they are only available during the invitation to tender period. The references we make to the contract have therefore been gleaned from disclosures by Ribera Salud S.A., news items, evidence from SIMAP supplemented by personal communication and the limited published studies about this project.

For numerical information we obtained data relating to both *Ribera Salud Unión Temporal de Empresas* (RSUTE) and the public sector. Under Spanish company law there is no requirement to publish the financial statements for this type of joint venture, and so it was not possible to obtain the actual financial statements of RSUTE. However, under Spanish Generally Accepted Accounting Principles (GAAP), the parent companies must show in a note to the accounts the relevant share of this type of joint venture under proportional consolidation. Therefore, we obtained the financial statements of the parent companies Ribera Salud S.A. and Adeslas S.A. from the relevant regional Registrar of Companies for the years 1998 -2008 (1997 was not available but was shown as a comparison in 1998). We used the figures from the notes to Ribera Salud S.A., dividing them by the percentage of participation (45%) by Ribera Salud S.A. in the joint venture to re-create the financial statements of RSUTE. We were then able to use these figures to carry out financial analysis of the profitability and cost of finance of RSUTE.

The public sector data have been obtained from official surveys produced by the Spanish NHS Health Information System and the Valencian Autonomous Region Department of Health (VDoH). The Regional Audit Office of Valencia, which

[2] *¿Por nuestra salud? La privatización de los servicios sanitarios*

supervises the expenditure budgets of the Programmes of Healthcare Assistance of the VDoH, reported on RSUTE for the period 1999 to 2004, however, since 2005 we found no further reference to RSUTE in any Regional Audit Office reports.

Overall, in common with other PPP studies, we encountered the usual problems of a lack of public access to data, aggregation of data and poor availability of financial information in the public domain about hospitals

The numerical evidence is a story of two halves – the first contract from hospital opening until 2003 and then the second contract, for which we have evidence from 2003 to 2008. Although the two contracts were operating for complementary periods during 2003 (RSUTE from 1st January 2003 to 31st March 2003 and RSUTE II from 1st April 2003 to 31st December 2003), there are some distortions in this year's figures which we are unable to adjust for.

6. The Alzira Public Private Investment Partnership model

Our case study is a PPIP whereby a ten-year contract was entered into in 1997 between the Valencian government and RSUTE, a joint venture special purpose vehicle (SPV), to construct a hospital and manage both the clinical and non-clinical facilities in the town of Alzira. The RSUTE shareholders were firstly, the medical insurance company Adeslas S.A. (51%), as the technical provider of health services required by the procurement terms for taking on the project. It was closely linked to the Spanish regional savings banks, its majority shareholder being Agbar S.A., who in turn had La Caixa, the leading Spanish savings bank, as one of its controlling shareholders. Secondly, the regional savings banks Bancaja, CAM and Caixa-Carlet by means of a jointly-controlled entity –Ribera Salud S.A.- (45%), which was the financial partner for this project. Finally the construction companies Dragados and Lubasa each took a 2% holding.

Insert Figure 2 about here

The project was to be funded by a capitation fee of €204 per resident *per annum* in the relevant health zone, payable by VDoH, and rising by the consumer prices index (CPI) each year.

The contract was awarded in 1997 and the hospital opened on 1 January 1999. Following losses, the contract was terminated in March 2003, being immediately replaced by a second contract awarded to *Ribera Salud II Unión Temporal de Empresas* (RSUTE II) in what was effectively a refinancing deal. This second contract widened the remit to manage not only the La Ribera hospital as before, but also the primary healthcare of the surrounding health area.

6.1 Establishing the first contract (RSUTE)

The Valencian regional government, ruled by the right wing Partido Popular, was the first region to take advantage of the 1997 Spanish Law (Ley 15/1997) that first permitted PPP structures to be legally used in Spain, thereby enabling public healthcare to be privately financed[3]. The rationale was that this would save money for the VDoH. The city of Alzira was chosen because it had no existing hospital. In the first year the annual payment for the 230,000 residents of the catchment area was €47 million. The initial contract was for ten years with the possibility of renewal for a further five years, after which the buildings would revert to government ownership, although no details were given as to how the extension of the contract would be determined.

The RSUTE consortium submitted the only bid and health officials commented that it was a very tight deal. As a comparison, MUFACE[4] were working on a figure of €301 per person for their healthcare benefits (Cinco Dias, 29/04/1997), whilst healthcare expenditure in hospital and specialist care services per covered person in the Autonomous Region of Valencia public healthcare system amounted to €362 (Ministry of Health and Social Policy - Health Information System of the SNS, 2008).

It is difficult to find a reliable figure for the original capital value of the hospital. It is recorded in RSUTE's balance sheet as €60.3m, 86% more than what El País (24/01/2003) quotes as being a preliminary estimated investment of €32.4m, and

[3] For further information on the implications of this in relation to the Spanish public sector being able to access private finance for public infrastructure work see Benito *et al.* (2008, pp.968-9).

[4] MUFACE -acronym of *Mutualidad General de Funcionarios Civiles del Estado*- is a public entity of the Spanish central government that manages the social security benefits (health care, retirement benefits, grants for children, etc.) for central government Spanish civil servants.

different to the €63.2m quoted by the Regional Audit Office of Valencia in its 2002 report[5]. Our literature review showed that such discrepancies are common when undertaking financial analysis of PPPs.

6.2 Contract operation

A Joint Committee was set up with members drawn from both RSUTE and the VDoH to oversee the working of the contract, with a Commissioner appointed by the VDoH to act as the link between the two partners. The Commissioner is a civil servant paid by the VDoH[6], and therefore represents the type of 'invisible' monitoring costs referred to by Shaoul *et al*. (2011) which increase the cost of partnership working. His role has a number of specified oversight duties, including oversight of and administration in relation to movements of patients between health areas, action on activity statistics, customer complaints, equipment and its maintenance, VDoH tenured staff, and enquiries from the Joint Committee. He has oversight of the continuing strategic programme of development for new services offered by the hospital (<http://www.ribera10.com/pages/cont/index.php?destino=1&id=4> [accessed 04/05/10]). However there is no publicly available evidence that (a) these are carried out satisfactorily or that (b) problems raised in relation to the working of the contract are acted upon. There is also a management committee and a board of directors for RSUTE (Tarazona Ginés *et al.*, 2005), in respect of which similar points can be raised.

The right wing government's decision to adopt the 'Alzira model' was criticised from the start by the Spanish Socialist Workers' Party (PSOE) who were against any move towards privatisation of healthcare, and by trade unions who were concerned that the concessionaire's pursuit of profit would be detrimental to both healthcare and jobs (Cinco Dias, 29/04/1997).

As a privately managed hospital, the Alzira hospital introduced a new contract of employment. Terms and conditions were worse than the government tenured scheme,

[5] Fiscalización de los Programas de Asistencia Sanitaria de la Consellería de Sanidad ['The Financing of Medical Care Programmes by the Department of Health']

[6] Boletín Oficial de la Comunidad Valenciana [Official Gazette of the Valencian Government] (Nº 3,416), Agreement dated 11th January 1999. We also confirmed this in a personal communication with SIMAP.

with less job security, lower pay scales and longer working hours, although the hospital claims that doctors' mean income is 25% higher than Spanish NHS doctors (http://www.hospital-ribera.com/english/alzira_model/04.htm [accessed 21/07/10]). Doctors and nurses already practising in the health area were given the opportunity to either keep their tenured position or transfer to the new contract. Nearly all tenured personnel decided to remain on the public tenured scheme. Those who decided to switch were those who were working in less attractive locations as well as those doctors who were offered management positions, and therefore higher salaries. Interim tenure employees whose employment was not exclusive to one location were put under pressure to accept a contract at the Alzira hospital[7].

In addition the private sector management invested heavily in technology to demonstrate management efficiency and to offer a better level of service and greater flexibility than in public hospitals, for example, using the internet for booking appointments. They also changed working practices and introduced longer working hours, in order to boost productivity (http://www.ribera10.com/pages/cont/index.php?destino=1&id=2 accessed 04/05/10).

6.3 The role of the Spanish regional savings banks

An explanation of how the Spanish regional savings banks operate is crucial to our examination of how the 'Alzira model' has worked in practice, given their involvement as major investors in the project (see Figure 2). They are non-profit making financial entities, governed by a separate Spanish law, which are intended to invest their surpluses in works of social interest and other strategic actions to encourage the socioeconomic development of their territorial region of action. Their governing bodies include representation by different groups of stakeholders: depositors, local councils, regional governments, staff and founding institutions (see Figure 3). Representatives of the ruling parties in local councils and regional governments can hold up to 50% of the votes in the General Assembly, so there is a close link between local and regional political control and these financial institutions, therefore creating the opportunity for politicians to dominate bank strategy as there

[7] This information was provided through a personal communication with SIMAP.

are few restrictions as to how banks can earn their surpluses[8]. This strong political influence has meant that regional savings banks 'overextended themselves by financing local projects of dubious value' (FT, 12/06/09), as happened, for example, in the case of Caja Castilla La Mancha, which was taken over in March 2009 by the Spanish central bank following liquidity problems relating to its investment in the Ciudad Real airport, described as a 'monument to financial folly' (FT, 25/02/11).

Insert Figure 3 about here

It was clear early on that this was a risky project for the regional savings banks. Bancaja and CAM, whilst based in the Valencian region, are both in the top twenty listing of Spanish banks. However Caixa Carlet, a much smaller town savings bank, (which, due to political links between the regional savings banks and the regional/local government, would have been obliged to invest in the project despite it being disproportionate to its size) invested in RSUTE at the same level as the other two banks. Apart from its poor profitability, this investment was too large in proportion to Caixa Carlet's asset base. It subsequently failed and was absorbed by Bancaja in September 2001 (Orbis database), following an audit by the Bank of Spain that found its operating costs were too high and its speed in collecting payments too slow. In addition, the audit found the 15% investment in the La Ribera Hospital to be an excessive risk (Expansión, 28/12/2000). This did not spread the risk because Bancaja merely increased its shareholding in Ribera Salud S.A. to 30% of the investment.

The way in which the construction of the hospital was financed shows the close relationship of the regional savings banks to the project. Ribera Salud S.A. took out two loans totalling €19m from its parents Bancaja and CAM, that it, in turn, lent to RSUTE[9]. Adeslas also took out two loans totalling €25m for financing the construction of the hospital, although in this case, there is no explicit reference that these loans were completely lent to RSUTE. Again, the lender was the parent

[8] This has been the structure for the last 25 years, but in 2010 the structure of Spanish savings banks was reorganized, one objective being to professionalize the governing bodies. The new regulations only permit the public administrations to provide a maximum of 40% of the members of the governing bodies and these members can no longer hold a political post.

[9] This information was disclosed in the notes to the accounts of Ribera Salud S.A.

company, Agbar S.A., a subsidiary of La Caixa. In addition to this long term debt, La Caixa, CAM and Bancaja (along with BBVA, one of the top Spanish corporate banks) are also short-term creditors of RSUTE.

6. 4 Financial analysis of RSUTE

Financial analysis of the first contract from inception to its termination in 2003 (see Table 1) shows that in these years whilst fluctuating operating profits are recorded, overall the contract is loss making. The values shown for 2003 include termination payments which are further discussed below. Five reasons may be identified to explain the losses up until 2002.

Insert Table 1 about here

Firstly, at a time when Spanish expenditure on healthcare was below the rest of Europe, the annual capitation fee of €204 was below other Spanish benchmark figures, being 32.1% less than the MUFACE figure of €301 and 43.6% less than the Valencian healthcare expenditure for hospital and specialist care of €362. So this initial fee was very optimistic, even acknowledging that in the early years of the contract, the Alzira hospital might not carry out the most specialist and potentially most expensive treatments in comparison to Valencian public hospitals as a whole. As we have been unable to access initial cost estimations we cannot comment further but it seems that there are striking similarities to the La Trobe hospital, Australia, where underestimation of costs and a lack of understanding of the funding regime left the private contractor unable to deliver the clinical services required (English, 2005).

In addition, whilst the annual capitation fee rose from €204 to €233 between 1999 and 2003 based on the CPI, an increase of 14%, the comparable Valencian healthcare expenditure rose from €362 to €465, an increase of 28%. This implied the need for enormous efficiency savings at Alzira (see Table 2).

Insert Table 2 about here

The second issue relates to patient usage. As the first PPP hospital in Spain, there was initial general hostility in the area, and it took time to get the primary health centres to

switch patients to La Ribera. As the Spanish NHS uses a formula whereby the money follows the patient, this meant that Alzira had to pay 100% of the cost if patients from the health area attended other hospitals. Whilst figures for 1999 are not reported, this amounted to €2.6m in 2000 and €3.0m in 2001, around 5% of the capitation fee received in each year.

A third reason is that in hospitals, like other public services such as education, labour represents a very high proportion of total value added (see Table 3). This makes it structurally difficult to generate free cash flow, which is not a problem when public services are publicly financed, as there are no providers of finance to be reimbursed. However, with private entities such as RSUTE, interest must be paid to the financiers and so there is pressure to cut labour costs in order to increase cash flow available for interest payments. Such circumstances create social conflict. It has been difficult to calculate labour share of value added for Alzira, due to the way in which total labour costs are reported in the notes to the financial statements (see notes to Table 3) and so we can only state that it falls from 77.6% in 2000 to 75.3% in 2001. Comparable figures for public hospitals are not available, but the fact there were wage disputes, for example, there were union protests that RSUTE refused to implement the wage increases passed by the VDoH (El País, 27/01/2003), indicates that the Alzira management were actively trying to keep wage levels down in order to generate sufficient value added to cover interest payments.

Insert Table 3 about here

Fourthly, Spanish GAAP, which has been influenced by lobbying from the powerful infrastructure companies (Stafford *et al.*, 2010), requires a reversion fund to be set up under special regulations which only apply to infrastructure projects. Here, an amount equivalent to the net value of the assets on reversion to the public administration is allocated over the life of the contract, being charged against profit and credited to the reversion fund, a long-term non-distributable reserve. The reason for this is that, at the end of the contract period, in theory at least, the main investment in the hospital will revert to public ownership. With the creation of the reversion fund, it means that at the end of the contract period there is an amount available equivalent to the net value of the infrastructure assets, therefore protecting shareholder wealth. In the case of the

Alzira hospital, once it opened in 1999, annual allocations were made to the reversion fund, which, whilst only amounting to 3.5% of operating expenses for the period 1999-2002, have wiped out any profit on the contract as they have amounted to 198% of operating profit over the same time period. This was worse than expected because the initial capital cost of the hospital was higher than anticipated.

Acerete *et al.* (2009) show a contrasting experience in the case of Spanish toll roads. Here the Spanish government accepted that the tariff should be set high enough to cover this annual reversion transfer on top of other operating and financing costs, thus committing road users to pay enough to have fully paid for the asset over the life of the concession, which is somewhat less than the life of the asset. However, unlike the toll roads where the contract terms range from thirty to sixty years plus, the Alzira contract is very short at only ten years, meaning that a much larger proportion had to be allocated each year. In addition the roads concessionaires were able to increase their incoming cash in ways that were not possible in the Alzira contract.

Fifthly, the lack of cash being generated from operating activities and the increase in capital investment required compared to the original estimate meant that more finance had to be raised, so that the debt: equity ratio increased year on year from 3.0 in 1998 to 10.4 in 2002 (see Table 4). This greatly increased the risk to the savings banks. Between 1998 and 2001, the years when RSUTE made an operating profit, in each year the interest expense was greater than operating profit, contributing to the non-viability of the project.

Insert Table 4 about here

However, the fact that RSUTE was financed mainly by group debt (Bancaja and CAM, the shareholders of Ribera Salud S.A., and La Caixa, the ultimate parent of Adeslas) meant that the project seems to have benefited through receiving these loans at preferential rates. Table 4 shows the interest rate on debt in 1999, the first full year of the contract, to be 4.1%, rather less than the interest rate of 4.94% for a comparable Spanish public debt 10 year bond taken out in that year. Although interest rates rose to 5.5% and 5.9% for 2000 and 2001 respectively, the interest rate of 4.5% calculated for

2002 was once again lower than 4.94%. Without this beneficial interest rate, the losses incurred on the overall contract would have been even higher.

6.5 Termination of RSUTE and the drawing up of RSUTE II

In December 2002 the VDoH approved the arrangements for the termination of RSUTE and its replacement by RSUTE II. There are a number of anomalies in relation to this. Firstly, it was not necessary to legally terminate RSUTE as it would have been possible under Spanish law to just extend the contract on the grounds that it needed to be put back onto a sound economic footing.

Secondly, the financial arrangements in relation to the termination and reletting of the contracts have been criticised by the Regional Audit Office, which commented that neither the original contract nor the contract specifications included compensation for lost profit in the case of termination of the contract by mutual agreement and that the method used to calculate the compensation was not appropriate for this type of contract (Regional Audit Office of Valencia, 2002). The Valencian government paid RSUTE a sum of €69.3m on termination, which consisted of €43.3m for the purchase of the infrastructure assets at their written down value, and €26m compensation for lost profit. This latter figure was calculated by taking €75.3m, the final agreed amount of investment made by RSUTE but one which cannot be traced back to its balance sheet, and multiplying it by 6%, a rate intended for industrial returns not healthcare projects, for 69 months (the remaining life of the contract) and is therefore far from robust. Under Spanish GAAP this amount is shown under extraordinary items (extraordinary revenues less extraordinary expenses) in the RSUTE summarised income statement for 2003 (see Table 1).

Finally, RSUTE II paid the government a premium of €72m for the new contract, which included taking over the infrastructure assets just bought back by the government. It could afford to do this thanks to the payment of €69.3m which the government had just made to its predecessor, which had the same parent entities. Such a huge amount could be considered as a way of discouraging other bidders, therefore guaranteeing that it won the new contract.

The controversial nature of the first contract termination and the reletting of the contract attracted significant criticism from opposition groups (El País, 07/11/02). The nationalist Esquerra Unida's view was that this was a political cover up – the Alzira hospital had not achieved expectations despite the fact that the VDoH had made every effort possible to send patients to Alzira. Esquerra Unida saw the rescue package and new contract as having just the one purpose of increasing business for the concessionaire. The leftist Bloc Nationalista Valencià political group commented that the inclusion of €43.3m in the Department's budget to pay for the the hospital's assets was clear evidence that the economics of the scheme were unfeasible, and this was a manoeuvre to hide the liquidity problems that had already been evident when Caixa Carlet failed in 2001. Cinco Dias, the left wing newspaper, alleged that the Valencian Government had withheld information relating to a secret €26m transfer to Alzira hospital as compensation for lost profit, despite the fact that the company was making losses, and that the VDoH had then gone on to create a much more advantageous contract for RSUTE. However, the Valencian government responded that although the "rescue" (its word) cost €69.3m in total, because the government was able to let the new contract to the same concessionaires for €72m, in actual fact the government gained €3m (El Mundo, 18/12/2003).

6.6 Operation of RSUTE II

The terms of the new contract (Alzira Model II: 2003-2018) were very different to the first, as the contract covered primary as well as specialist healthcare (245,000 inhabitants, 30 health centres, two outpatient clinics in addition to the original hospital).

A number of conditions were stipulated in the contract. Residents were able to choose their preferred hospital in the vicinity; if they chose to go to another hospital, then the Alzira hospital had to pay 100% of the cost (see Figure 4). The annual internal rate of return was to be capped at 7.5%. Other penalties were also established – a 12.5% discount on the capitation fee when the portion of patients attending from outside the area exceeded 20% of the budgeted capitation, rising to a 25% discount when 40% was exceeded, thus serving to reduce the Alzira hospital's incentive to take out-of-

area patients. Finally, if patients from other areas attended the Alzira hospital, this was only funded at 80% of the capitation fee (Tarazona Ginés *et al.*, 2005, p.86).

Insert Figure 4 about here

The capitation fee for 2003 increased from €234 under the old contract to €379 for the new contract, an increase of 62%, to take account of the extra primary healthcare services coverage. More significantly, the annual increase was no longer linked to the CPI but to the much more generous percentage yearly increase in the Valencian health budget, making it much more beneficial to RSUTE II. For the years 2004 to 2008, the average annual increase in capitation fee was over 80% of the average annual increase in the Valencian health budget, and in 2004 and 2005 it increased by more than the percentage yearly increase for the overall Spanish health budget (see Table 2). As a result, the savings benefit in comparison to the costs of public healthcare has been severely eroded. However, if we do a straightforward comparison between the Alzira contract and the per capita figure for the Valencian region, on the face of it the contract continues to offer healthcare services around 28% cheaper than the public sector (see Table 2). We discuss the validity of this percentage further in section 6.7 below.

At the same time the concession has become increasingly profitable – with return on equity rising steadily from 1% in 2004 to 8.8% in 2008 (see Table 4). Whilst the cap in place on the concession states that the Internal Rate of Return should not exceed 7.5%, the consortium claims that the actual rate is 1.6% (Bes, 2009), and there will be in addition a further €68m investment in local health centres and hospital improvements during the concession period (http://www.ribera10.com/english/alzira_model/01.htm, [accessed 04/05/10]). RSUTE II continues to benefit from the low interest rate on debt being charged by the Spanish regional savings banks. This ranges from 4.3% to 5.2%, with the exception of a rate of 8.3% in 2007, however this latter figure is distorted due to the repayment of debt in this year.

There are further human resources challenges attributable to the hospital achieving its greater efficiency with lower salaries, with fewer workers and with longer working

hours (Bes, 2009). We calculate that the labour share of value added has risen significantly in comparison to the first contract to around 85% (see Table 3). Figures produced by SIMAP show that the collective agreement for the fixed salary of Alzira staff is 90% of the fixed salary of VDoH's tenured staff, although the actual salary paid can vary dependent on the type of shifts worked[10]. In addition SIMAP's studies show that there is a shortage of 42 doctors in the hospital plus a further shortage of 29 doctors to cover the primary care area[11,12]. We have been able to compare the Alzira hospital to another similar sized hospital at Elda, also in the Valencian autonomous region (see Table 5), which confirms that in 2008 in relation to all clinical staff the Alzira hospital is operating on staff to bed and staff to admissions ratios that are substantially lower[13]. Whilst some of the difference will be due to better productivity at Alzira, where the hospital prides itself on its technological improvements and its longer opening hours, the fact that there are ongoing staff disputes, including a doctors' strike in 2007, indicates staff dissatisfaction with their working conditions. Finally, the union claims that the stressful working conditions have led 40 out of 400 doctors to resign since 2007, a figure disputed by the director of Alzira who claims the figure is closer to 20 and that departures are driven by a general shortage of doctors in Spain (Bes, 2009).

Insert Table 5 about here

6.7 Evaluation of RSUTE II

Since the new contract began, the hospital has gained a place amongst the top twenty Spanish hospitals in a number of categories (Tarazona Ginés *et al*. 2005, p.88), and has gained university hospital status. But it remains controversial. Whilst particular areas of success are highlighted such as the prompt scheduling of surgery and the guaranteeing of epidurals due to better availability of anaesthetists than in public

[10] http://www.simap.es/20razones.htm [accessed 26/07/2010]
[11] http://www.simap.es/Estudio_Ribera.htm [accessed 26/07/2010]
[12] We have tried to confirm this by comparing the working hours of staff at the Alzira hospital with working hours in public hospitals, but due to differences in shift patterns between the two systems this has not been possible.
[13] In addition, SIMAP indicates that the number of beds at Alzira can increase depending on the admission needs, with instances where the number of beds has been 30% over the official capacity, making these statistics even worse. See for example http://www.levante-emv.com/secciones/noticia.jsp?pRef=2009022100_19_558381__Comunitat-Valenciana-hospital-Ribera-trabaja-limite [accessed 01/08/10].

hospitals (Bes, 2009), Benedito (2010) claims that this latter point is only true because this service has been deliberately restricted at other local hospitals so that patients will wish to attend the Alzira hospital instead.

The claims around lower costs remain particularly contentious and like-for-like comparisons are difficult. So, whilst Pere Ibern, Professor of Economics at the University Pompeu Fabra, Barcelona claims there have been savings in construction costs, and management is more efficient (Cinco Dias, 19/11/2009), this claim is countered by Antonio Cabrera, secretary of the Federation of Health and Socio-sanitary Sectors of the Spanish national trade union Comisiones Obreras (CCOO), who claims that the Alzira hospital does not carry out the most specialised clinical services. This claim is supported by the Valencian Federation of Neighbourhood Associations, who argue that the 'Alzira model' hospitals '*earn their profits through the reduction of healthcare quality, reduced wage costs and in "freeloading" in relation to the range of services offered in comparison to those by the public hospitals*' (El Mundo, 20/04/10), for example, focusing on the most profitable medical and surgical specialities whilst lacking others such as caring for HIV patients and referring those with chronic disorders to other hospitals (Benedito, 2010)[14]. There are also a number of areas where the costs are still borne by the VDoH, specifically out-patient costs for pharmacy, oxygen therapy, prosthetics and transport (Benedito, 2010).

Furthermore, although the Alzira hospital has now been open for twelve years, and despite more than one million people now being dependent on this model for their healthcare due to the replication of the model throughout the Valencian autonomous region, there has still been no independent evaluation of how well it works (El País, 24/6/10). Moreover, Vicente Ortún, director of the Centre for Research in Economics and Health at Pompeu Fabra University, claims that the level of transparency is very low, with it being easier to get data on commercial enterprises than on public hospitals (El País, 24/6/10). However such a lack of accountability is the norm throughout the Spanish public health sector. The emphasis is instead on soft information such as

[14] However, we have compared the specialist services available at the Alzira hospital with those of La Fe hospital, the top hospital in the Valencian region, finding that there are very few services not offered at the Alzira hospital, thus disproving this latter point.

satisfaction surveys, where the government states that users are more satisfied with the Alzira hospital than with public hospitals – Cabrera, secretary of the CCOO, comments that this will obviously be the case as users will always prefer a local hospital, and the 'hotel' style rooms (Cinco Dias, 19/11/2009). In any case the 91% approval rating is not much higher than the average 85% satisfaction reported for Spain's NHS as a whole (Bes, 2009).

Our evaluation of the available numbers leads us to the conclusion that the second contract is not such a good deal for the VDoH as the narrative claims. Although the capitation fee is around 28% less than the budgeted cost per head for Valencian primary and specialist healthcare, these two figures are not comparable and it is impossible to make the necessary adjustments to make a like-for-like comparison. There are areas of invisible costs, such as the Commissioner employed by the VDoH to monitor the contract; there are areas of savings where Alzira does not have to pay for items such as transport and out-patient costs which are incurred overall by the VDoH; there are very profitable areas, such as some surgery and maternity cases, where Alzira seems to benefit from taking in additional cases. There is also the question as to whether patient care is properly managed, given the apparent shortfall of medical staff in comparison to the regional average. Finally, it is apparent that risk transfer has not been achieved, given the readiness of the VDoH to bail out the first contract and the close political links between the regional savings banks and local and regional governments.

6.8 A 'narrative and numbers' analysis

We have shown in our numerical analysis above, particularly in relation to the failure of RSUTE, that there is no financial success story here. Instead we have found evidence giving further support to the issues raised in our literature review. Firstly, our analysis demonstrates rising costs and invisible and uncosted bureaucratic management practices. The index used for annual price rises is now much more favourable for RSUTE II, and the percentage difference between the *per capita* annual capitation fee and the annual amount spent on public healthcare by the Valencian government is diminishing year by year (with the exception of 2006).

Taking risk transfer and contract termination together, clearly risk transfer did not take place, as the government stepped in to terminate the first contract with a favourable outcome for the parent entities of RSUTE in the awarding of RSUTE II on more advantageous terms. In contrast to the literature showing the high cost of private compared to public finance we have shown that both SPVs have benefited by being financed by the politically-connected regional savings banks. Finally we have noted our difficulties in finding relevant and robust financial information.

Our numerical evidence, particularly in relation to the failure of the first contract and its replacement by a second, contrasts with the success stories given by the published narratives that set up a frame of action and expectation (Thrift, 2001). For example, we were particularly surprised to read the following glowing report in the Adeslas 2003 Management Report in relation to the termination of the first, failed, contract and the issue of the second contract as its reference to '*good results'* offers such a contrast to what the figures actually show:

> '*The Department of Health, having verified the good results of the concession, at the end of 2002 proposed to [RSUTE] that it be liquidated in anticipation of holding a new bidding competition that would include primary as well as specialist care. The firms involved in [RSUTE] accepted this offer, but in their desire to continue a truly emblematic project, they entered the new competition and were successful in being awarded the contract.'*

Rather there is evidence that the language of numbers is used deliberately to make the case for private management of public healthcare as the efficient way forward:

> '*This book, the inheritor of a codified world, is full of data. Measured in a thousand different ways and presented using every kind of available groupings. This data reinforces, as a successful model, the private management through administrative concession of a public service such as health. High rates of activity combined with excellent quality indicators and outstanding investments are three of the many numbers (once again numbers) that attest to the validity of this model of management, our "Alzira Model"'*. (de Rosa, Managing Director of La Ribera Health Area 11, Foreword, Bosch, 2005).

Further assertions are made by hospital management in relation to NPM rhetoric on efficiency, with the claim that the hospital makes '*Better use of public resources: More efficiency, more activity, better service'*, achieving this through introducing '*modern management tools in a "slow" and bureaucratic environment.*' (http://www.ribera10.com/english/alzira_model/04.htm, [accessed 01/08/10]).

The superiority of NPM is then echoed by the Minister of Health for Valencia, who emphasises that the 'Alzira model' is '*an excellent formula for facing up to the problems of financial support for the current healthcare system'* (El Mundo, 28/04/10). But as these narratives do not draw on the underlying numbers there is a clear disjuncture between numerical fact and narrative fiction.

7. Discussion and conclusions

Our purpose was to carry out a detailed case study of an under analysed form of PPP in public healthcare – the 'Alzira model'. Although there are problems of aggregation and availability of data in the public domain, we have used a 'narrative and numbers approach' to analyse the success or otherwise of the 'Alzira model' within the Valencian healthcare environment.

We have shown that RSUTE was never viable. RSUTE II became viable due firstly to the way in which the contract area was changed and enlarged. The difficulties of the first contract, which only covered specialised health care, and the profitability of the second contract, which included both primary and specialised health care, should not be surprising, as from the literature dealing with capitation payments as a model for funding healthcare we can deduce that both levels of care should be integrated. Secondly, RSUTE II benefited from the capitation fee increase calculation being changed to link to public health budget increases.

These significant changes meant that RSUTE II, now in receipt of a higher level of funding, was able to cover the beneficially low interest payments to its financiers, the regional savings banks, and even to generate a small profit for its owners, by making adjustments around labour costs and offering the more lucrative specialities. It remains to be seen whether this strategy will work for the remainder of the contract

life, given the size of Spain's financial crisis and its likely effect on cutbacks to public healthcare expenditure over the next few years.

An important difference between the Spanish case and elsewhere is in the role of the regional savings banks, which are non-profit making, with a social obligation to invest in the regional community. There is political involvement as regional politicians sit on the banks' governing body and, as we have shown, this can mean that banks make poor investment decisions which can, as has been the case for Caixa Carlet and Caja Castilla La Mancha, lead to bank failure. In the Spanish context it is therefore not surprising that the banks have been very supportive of the 'Alzira model'. They have not only provided significant additional financing when the first contract encountered liquidity problems, despite the lack of viability of the investment, but also lent at a favourable interest rate, at times below the average for an equivalent Spanish public debt bond.

But this political agenda has been ignored in the NPM rhetoric presented by the Valencian government and the private sector partners which focuses solely on the 'Alzira model' as a success story, claiming that it is: cheaper to deliver than traditional public sector healthcare; good for patients and staff; and affordable for the taxpayer. Thus the 'Alzira model' is being portrayed through a particular performative frame – that of the superiority of NPM techniques in delivering a better quality service. However, when we apply Froud *et al.*'s (2006) 'narrative and numbers' approach to critically examine the underlying numbers, we find discrepancies between the NPM-style narratives given to explain management action, and the actual performance.

This contract on the surface seems to be about providing good quality healthcare for Valencian residents that is presented as being cheaper than that provided by the public sector system, although the extent to which the PPIP is cheaper cannot properly be evaluated due to a lack of financial accountability. However, we argue that this portrayal hides an important agenda that the political will was to create a market for PPP healthcare over the long term. When the first contract failed, the hospital could have been handed back to the government, as happened with the La Trobe Hospital in Australia. Instead the Valencian government and the members of the consortium

sought to replace the failed contract with an alternative that would be more likely to deliver a politically successful outcome that would have further market consequences. This intention is made clear by Bes's (2009) hospital director who states that the consortium '*hopes that its model will be taken up in other parts of Spain*', thereby making explicit the desire to replicate this model and to establish a private healthcare market in Spain. Elsewhere participants in early PPP contracts, for example the UK (Shaoul *et al*., 2007), have agreed to poor contracts to establish markets that will prove lucrative in the future. In the case of Spain, the market in healthcare is being established with support from the right wing Government of Valencia, thus following in the tradition of the Spanish Government which in earlier decades helped toll road concessionaires establish a market in the toll motorway sector (Stafford *et al.*, 2010).

Similarly, a long piece in El Mundo (13/01/2003) explicitly refers to the long term market opportunities for the regional savings banks Bancaja and CAM to extend the 'Alzira model' across Europe, with this reference to working with the German insurance company DKV and Portuguese banks in developing the Portuguese market:

> *'The objective is not only that Spain, Bancaja and CAM maintain links with Caixa Xeral and Banco Espirito Santo in Portugal to develop the model in that market, where DKV is the second private insurer. The composition of the UTE which wins the competition will not change… but the Valencian savings banks have ceded part of their capital in Ribera Salud to the Portuguese in exchange for being allowed to invest in the Portuguese hospitals which will follow the same model. This link is very valuable to DKV…'*

A critical analysis of the underlying financial reality of the 'Alzira model' disrupts the NPM discourse of success. This model is not a true partnership between the public and private sectors, but rather a political partnership between the regional government and the regional savings banks. It is this political relationship which locks in the savings banks as indirect long term shareholders in the UTE, rather than their investment in the concession as proponents of this model claim (Kinlaw, 2008). Within Spain, Ribera Salud S.A. has become the main player in the PPIP market. It has been successful in winning another four Valencian hospital contracts paid for by capitation fee, in each case partnering with a health insurance company. In a further consortium with Adeslas, it has also been awarded a contract in Madrid. Its strength

as a player in the healthcare market can be measured by the fact that it no longer needs to partner with health insurance companies, instead seeing itself as the specialist healthcare member of a further consortium set up to bid for a hospital PPP.

There are wider global implications for this. The 'Alzira model' has been replicated in Spain and more recently in Portugal as well as in developing countries. Evaluation of these other contracts needs to establish whether our findings in relation to Alzira are also repeated in these other cases. Whilst the other Spanish and Portuguese cases may be subject to the same benign political regime, this is unlikely to be the case for other countries, particularly developing countries where stricter criteria will be imposed by organisations such as the World Bank and where private sector partners will not be bound by close political relationships. Thus risk transfer and affordability could become issues.

Organisations such as the Global Health Group based at the University of California are actively promoting the 'Alzira model'. As well as the concerns raised by Jean Perrot of WHO's department of Health Systems Financing that developing countries would struggle with such complex projects (Bes, 2009), we would add our concerns that this model, if applied in a true commercial environment, will not prove viable or affordable in the long term.

Bibliography

Acerete, B., Shaoul, J. & Stafford, A. "Taking its toll: the cost of private roads in Spain", *Public Money and Management*, Vol.29 No.1, 2009, pp.19-26.

Acerete, B., Shaoul, J., Stafford, A. & Stapleton, P. "The cost of using private finance for roads in Spain and the UK", *Australian Journal of Public Administration*, Vol.69, No. S1, 2010, pp. S48-S60.

Barros, P.P. & Martinez-Giralt, X. "Contractual design and PPPs for hospitals: lessons for the Portuguese model", *European Journal of Health Economics*, Vol.10, 2009, pp. 437-453.

Benedito, J. "La experiencia valenciana de las concesiones administrativas en la sanidad pública", in *¿Por nuestra salud? La privatización de los servicios sanitarios*, pp. 97-110 (Madrid: Traficantes de Sueños, 2010).

Benito, B., Montesinos,V. & Bastida, F.J. "An example of creative accounting in public sector: the private financing of infrastructures in Spain", *Critical Perspectives on Accounting*, Vol.19, No. 7, 2008, pp. 963-986.

Bes, M. "Spanish health district tests a new public-private mix", *Bulletin of the World Health Organisation*, No. 87, 2009, pp. 892-893.

Blanken, A. & Dewulf, G. "PPPs in health: static or dynamic?" *Australian Journal of Public Administration*, Vol.69, No.S1, 2010, pp. S35-S47.

Bosch, M. (ed) *Modelo Alzira 1999-2005* (Ribera Salud UTE Ley 18/82 La Ribera Departamento 11 de Salud, 2005).

Broadbent, J., Gill, J. & Laughlin, R. *The Private Finance Initiative in the National Health Service: Nature, Emergence and the Role of Management Accounting in Decision Making and Post-Project Evaluation*, (London: CIMA, 2003).

Broadbent, J., Gill, J. & Laughlin, R. "Identifying and controlling risk: the problem of uncertainty in the private finance initiative in the UK's National Health Service", *Critical Perspectives on Accounting*, Vol.19, 2008, pp. 40-78.

Carrin, G. and Hanvoravongchai, P. "Provider payments and patient charges as policy tools for cost-containment: How successful are they in high-income countries?" *Human Resources for Health*, Vol. 1, No.6, 2003. Available at: http://www.human-resources-health.com/content/1/1/6

DLA Piper, *European PPP Report 2004*, (London: DLA Piper, 2004).

DLA Piper, *European PPP Report 2009*, (London: DLA Piper, 2009).

Edwards, P., Shaoul, J., Stafford, A. & Arblaster, L. *Evaluating the Operation of PFI in Road and Hospital Projects (ACCA Research Report No 84*, (London: Association of Chartered Certified Accountants (ACCA), 2004).

English, L. "Using public-private partnerships to achieve value for money in the delivery of healthcare in Australia", *International Journal of Public Policy*, Vol.1, No. 1-2, 2005, pp. 91-121.

Froud, J., Johal, S., Leaver, A. & Williams, K. *Financialization and Strategy*, (London and New York: Routledge, 2006).

Grimsey, D. & Lewis, M. *Public Private Partnerships*, (Cheltenham: Edward Elgar, 2004).

Formatted: English (U.K.)

Grimsey, D. & Lewis, M. "Are public private partnerships value for money? Evaluating alternative approaches and comparing academic and practitioner views." *Accounting Forum*, Vol.29, 2005, pp345-378.

Grimshaw, D., Vincent, S. & Willmott, H. "Going privately: partnership and outsourcing in UK public services", *Public Administration*, Vol.80, No. 3, 2002, pp. 475-502.

Hodge, G. & Greve, C. "Public-private partnerships: an international performance review", *Public Administration Review*, Vol.67, No.3, 2007, pp. 545-558.

Hood, C. "A public management for all seasons?" *Public Administration*, Vol.69, No. 1, 1991, pp3-19.

Hood, J. & McGarvey, N. "Managing the Risks of Public-Private Partnerships in Scottish Local Government", *Policy Studies*, Vol.23, No.1, March, 2002, pp.21-35.

International Finance Corporation, *Supporting the Development of Public Private Partnerships in Health and Education***,** IFC Infrastructure Advisory Department November 2009, www.info.worldbank.org/etools/PPPI-Portal/docs/events/HealthandEducation.pdf Text Version accessed 24/05/10

Kinlaw, H. *Public-private investment partnerships in health systems strengthening*, Report on Wilton Park Conference 909, 2008. Available at: www.wiltonpark.org.uk/documents/conferences/WP909/pdfs/WP909.pdf

Lister, J., Hellowell, M., Pollock, A., UNISON, Álvarez Edo, D., Benedito, J., Serna, R. & Gómez Liébana, J.A. *¿Por nuestra salud? La privatización de los servicios sanitarios*, (Madrid: Traficantes de Sueños, 2010).

Lonsdale, C. "Post–contractual lock in and the UK Private Finance Initiative: The Cases of National Savings and Investments and the Lord Chancellor's Department", *Public Administration*, Vol. 83, No. 1, 2005, pp. 67-88.

Lonsdale, C. & Watson, G. "Managing contracts under the UK's private finance initiative: evidence from the National Health Service", *Policy and Politics*, Vol.35, No.4, 2007, pp.683-700.

Lopez-Casasnovas, G., Costa-Font, J. & Plana, I. "Diversity and regional inequalities in the Spanish 'system of health care services", *Health Economics*, Vol.14, 2005, pp. S221-S235.

McKee,M., Edwards, N & Atun, R. "Public Private Partnerships for Hospitals", *Bulletin of the World Health Organisation*, November, 2006, pp. 890-896.

Ministry of Health and Social Policy - Health Information System of the SNS, *Health Expenditure Analysis Task Force Report*, 2008. http://www.msc.es/en/estadEstudios/estadisticas/sisInfSanSNS/finGastoSanit.htm [accessed 16/07/2010]

Ministry of Health and Social Policy - Health Information System of the SNS, *National Health System of Spain*, 2010, http://www.msps.es/en/organizacion/sns/libroSNS.htm [accessed 16/07/2010]

Monrad Aas, I.H. "Incentives and financing methods", *Health Policy*, Vol.34, 1995, pp. 205-20.

National Audit Office, *Private Finance Projects.* A paper for the Lords Economic Affairs Committee, (London: National Audit Office, 2009).

OECD, *OECD Factbook 2009: Economic, Environmental and Social Statistics* *www.oecd.org/* [a*ccessed 08/05/2010]*

OECD, *OECD Health Data 2010,* www.oecd.org/spain, [a*ccessed 01/07/2010]*

Pollock, A., & Godden, S. "Independent sector treatment centres: evidence so far", *British Medical Journal*, Vol.336, 2008, pp. 421-4.

Pollock, A., & Kirkwood, G. "Is the private sector better value for money than the NHS? A Scottish case study", *British Medical Journal*, Vol.338, 2009, pp. 1108-1111.

PwC. *Queen Elizabeth Hospital NHS Trust*, (PwC, London, 2005).

Regional Audit Office of Valencia [*Sindicatura de Cuentas de la Comunidad Valenciana*] Reports about the health care programs of the Valencian Health Department, 1999-2004, http://www.sindicom.gva.es/ [accessed 20/07/2010]

Sanchez Bayle, M. & Beiras Cal, H. " The People's Campaign against Health Care Counter-Reforms in Spain", *Journal of Public Health Policy*, Vol. 22, No. 2 , 2001, pp. 139-152.

Senate Community Affairs References Committee, *Healing our Hospitals*, (Canberra, Commonwealth of Australia, 2000).

Shaoul, J., Stafford, A. & Stapleton, P. "Evidence based policies and the meaning of success: the case of a road built under Design Build Finance and Operate (DBFO)", *Evidence and Policy*, Vol. 3, No. 2, 2007, pp. 159-179.

Shaoul, J., Stafford, A., Stapleton, P. & McDonald, P. *Financial black holes: accounting for privately financed roads in the UK*, (Edinburgh, Institute of Chartered Accountants of Scotland, 2008a).

Shaoul, J., Stafford, A. & Stapleton, P. "The Cost of Using Private Finance to Build, Finance and Operate Hospitals", *Public Money and Management*, Vol. 28, No. 2, 2008b, pp. 101–108.

Shaoul, J., Stafford, A. & Stapleton, P. "NHS capital investment and PFI: from central government responsibility to local affordability", *Financial Accountability and Management*, Vol.27, No.1, 2011, pp.1-17.

Stafford, A., Acerete, B. & Stapleton, P. "Making concessions: political, commercial and regulatory tensions in accounting for European roads PPPs", *Accounting and Business Research*, Vol. 40, No.5, 2010, pp.1-22.

Sussex, J. "Public-private partnerships in hospital development: lessons from the UK's 'private finance initiative'", *Research in Health Care Financial Management*, Vol.8, No.1, 2003, pp.59-76.

Tarazona Ginés, E., de Rosa Torner, A., & Marín Ferrer, M. "La experiencia del "Modelo Alzira" del Hospital de La Ribera a La Ribera-área 10 de salud: la consolidación del modelo", *Revista Administrativa Sanitaria*, Vol.3, No.1, 2005, pp. 83-98.

Thompson, C. & McKee, M. "Financing and planning of public and private not-for-profit hospitals in the European Union", *Health Policy*, Vol.67, 2004, pp. 281-91.

Thrift, N. " "It's the romance not the finance that makes the business worth pursuing": disclosing a new market culture", *Economy and Society*, Vol.30, No.4, 2001, pp. 412-432.

Valencian Health Department *Evolución del Presupuesto y del Gasto per cápita*, 2009, Valencian Health Department, http://www.san.gva.es/cas/inst/homeinst.html [accessed 16/07/2010]

Vázquez, P. *Copagos, nuevas formas de gestión y PFIs: Ganar en responsabilidad sanitaria*, Economic and Social Committee of the Regional Government of Madrid, 2006, [accessed 26/07/2010]

Vilardel, M. *Documento del Grupo de trabajo para la racionalización y la financiación del gasto sanitario*, Catalonian Department of Health, 2005, http://www.icf.uab.es/informacion/noticias/marco.pdf [accessed 26/07/2010]

Whorley, D. "The Andersen-Comsoc affair: Partnerships and the public interest", *Canadian Public Administration-Administration Publique du Canada*, Vol.44, No.3, 2001, pp.320-345.

Table 1 Summarised income statements for RSUTE and RSUTE II

RSUTE 1998-2003

	2003 €'000	%	2002 €'000	%	2001 €'000	%	2000 €'000	%	1999 €'000	%	1998 €'000	%
Revenue	20,022		77,949		75,898		66,249		54,492		0	
Depreciation and amortisation	(1,422)	(7.1)	(5,604)	(7.2)	(5,356)	(7.1)	(4,982)	(7.5)	(3,561)	(6.5)	(46)	
Reversion fund	(698)	(3.5)	(2,622)	(3.4)	(2,473)	(3.3)	(2,378)	(3.6)	(2,067)	(3.8)	0	
Other operating costs	(17,082)	(85.3)	(70,370)	(90.2)	(64,765)	(85.2)	(57,271)	(86.5)	(48,324)	(88.7)	373	
Operating profit/(loss)	820	4.1	(647)	(0.8)	3,304	4.4	1,618	2.4	540	1.0	327	
Finance income	0	0.0	1,153	1.5	462	0.5	9	0.0	23	0	88	
Finance expense	(658)	(3.3)	(2,822)	(3.7)	(3,358)	(4.4)	(2,458)	(3.7)	(1,595)	(2.9)	(519)	
Profit/(loss) after finance	162	0.8	(2,316)	(3.0)	408	0.5	(831)	(1.3)	(1,032)	(1.9)	(104)	
Extraordinary items	*24,580	122.8	(4)	0.0	(2)	0.0	(9)	0.0	0	0.0	0	
Prior year adjustments	(9,698)	(48.5)	(342)	(0.4)	(828)	(1.1)	(80)	(0.1)	0	0.0	0	
Profit/(loss) for the year	15,044	75.1	(2,662)	(3.4)	(422)	(0.6)	(920)	(1.4)	(1,032)	(1.9)	(104)	

* Includes extraordinary revenues of €25,982m, representing the compensation for loss of future profits paid on contract termination

RSUTE II 2003-2008

	2008 €'000	%	2007 €'000	%	2006 €'000	%	2005 €'000	%	2004 €'000	%	2003 €'000	%
Revenue	175,549		159,549		143,089		127,864		117,876		82,796	
Depreciation and amortisation	(8,122)	(4.6)	(8,720)	(5.5)	(7,829)	(5.5)	(7,167)	(5.6)	(5,718)	(4.9)	(3,782)	(4.6)
Reversion fund	0	0.0	(640)	(0.4)	(716)	(0.5)	(576)	(0.5)	(653)	(0.6)	(498)	(0.6)
Other operating costs	(162,947)	(92.8)	(147,427)	(92.4)	(129,782)	(90.7)	(117,070)	(91.5)	(108,805)	(92.2)	(75,645)	(91.3)
Operating profit/(loss)	4,480	2.6	2,762	1.7	4,762	3.3	3,051	2.4	2,700	2.3	2,871	3.5
Finance income	342	0.2	244	0.2	142	0.1	76	0.1	80	0.1	129	0.2
Finance expense	(887)	(0.6)	(624)	(0.4)	(691)	(0.5)	(1,009)	(0.8)	(1,244)	(1.1)	(1,384)	(1.7)
Variation in FV of FI	(29)	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Profit/(loss) after finance	3,935	2.2	2,382	1.5	4,213	2.9	2,118	1.7	1,536	1.3	1,616	2.0
Extraordinary items	0	0.0	720	0.5	(1,713)	(1.1)	(11)	0.0	49	0.0	(224)	(0.3)
Prior year adjustments	0	0.0	14	0.0	13	0.0	(881)	(0.7)	(1,272)	(1.0)	0	0.0
Profit/(loss) for the year	3,907	2.2	3,116	2.0	2,513	1.8	1,224	1.0	313	0.3	1,391	1.7

Notes:

1. Sources are the Ribera Salud S.A. notes to the financial statements, various years
2. Figures for 1998 cover the end of the construction phase for RSUTE
3. In 2003 RSUTE terminated March and RSUTE II started in April
4. In 2008 Spanish GAAP changed from national financial reporting standards to International Financial Reporting Standards (IFRS).

Table 2 Comparison of capitation charges to Valencian healthcare expenditure for both contracts

RSUTE	Annual capitation charge €	Increase (%)	Increase of Valencian Gov. health expenditure % (1)	Increase of Central Gov. health expenditure % (2)	CPI %	Valencian healthcare expenditure # Hospital and specialist care services (2) €	Difference between capitation charge and Valencian healthcare expenditure (%)
1999	204.34				2.9	362.2	-43.6
2000	210.27	2.90	7.1	8.01	4.0	379.1	-44.5
2001	218.68	4.00	6.1	7.29	2.7	397.0	-44.9
2002	224.58	2.70	10.1	8.05	4.0	422.5	-46.8
2003	233.57	4.00	6.8	11.37	2.6	464.9	-49.8

RSUTE II	Annual capitation charge €	Increase (%)	Increase of Valencian Gov. health expenditure % (1)	Increase of Central Gov. health expenditure % (2, 3)	CPI %	Valencian healthcare expenditure # Hospital and specialist care services and primary healthcare services(2, 3) €	Difference between capitation charge and Valencian healthcare expenditure (%)
2003	379					586.6	-35.4
2004	413	9.00	13.0	8.1	3.2	619.0	-33.3
2005	455	10.14	12.1	8.38	3.7	645.7	-29.6
2006	495	8.79	10.7	10.04	2.7	737.0	-32.9
2007	535	8.08	10.4	9.06	4.2	753.2	-28.9
2008	572	6.92	7.2	7.68	1.4	796.3	-28.2

(1) Source: *Evolución del Presupuesto y del Gasto per cápita*, Valencian Health Department, http://www.san.gva.es/cas/inst/homeinst.html [accessed 16/07/2010]

(2) Source: Years 2000-2005: Health Expenditure Analysis Task Force Report, Health Information System of the SNS, Ministry of Health and Social Policy; http://www.msc.es/en/estadEstudios/estadisticas/sisInfSanSNS/finGastoSanit.htm [accessed 16/07/2010]

(3) Source: Years 2006-2008: National Health System of Spain, 2010. Madrid: Ministry of Health and Social Policy, Health Information System of the SNS; http://www.msps.es/en/organizacion/sns/libroSNS.htm [accessed 16/07/2010]

Table 3 Labour share of value added

	RSUTE II		RSUTE	
	2005 €'000	**2004 €'000**	**2001 €'000**	**2000 €'000**
Value Added				
Net sales	127,864	117,876	75,898	66,249
Supplies	(59,264)	(56,738)	(29,758)	(26,067)
External services	(6,176)	(5,596)	(2,596)	(2,876)
Other net operating revenues	1,574	1,665	1,576	898
Sub-total	63,998	57,207	45,120	38,204
*Adjustment for payment to personnel subcontracted from the VDoH	9,400	9,704	2,064	2,226
Total value added	**73,398**	**66,911**	**47,184**	**40,430**
Labour expenses				
Labour expenses from income statement	53,098	47,793	33,449	29,162
*Add payment to personnel subcontracted from the VDoH	9,400	9,704	2,064	2,226
Total labour expenses	**62,498**	**57,497**	**35,513**	**31,388**
Labour share of value added	**85.1%**	**85.9%**	**75.3%**	**77.6%**

Source: Ribera Salud S.A. Notes to the Financial Statements, various years

Notes:

1. Value added has been calculated by deducting external goods and services from sales.
2. In the financial statements, some personnel costs have been included in supplies because they are accounted for as subcontracted staff supplied by the VDoH. We have therefore adjusted the amounts for Value added and Labour expenses accordingly for the years 2000, 2001, 2004 and 2005 because these are the only years where the note giving the breakdown of supplies has been provided.

Table 4 Finance ratios

RSUTE

	2003 €'000	**2002 €'000**	**2001 €'000**	**2000 €'000**	**1999 €'000**	**1998 €'000**
Total interest paid	**658**	**2,822**	**3,358**	**2,458**	**1,595**	**519**
Total debt	**46,827**	**62,373**	**57,010**	**44,805**	**38,930**	**25,753**
Total equity	**21,829**	**5,996**	**7,940**	**7,648**	**7,822**	**8,457**
Interest rate on debt	*1.4%	4.5%	5.9%	5.5%	4.1%	2.0%
Debt/equity ratio	2.1	10.4	7.2	5.9	5.0	3.0

Source: Ribera Salud S.A. Notes to the Financial Statements, various years

* The contract terminated during 2003. However we do not have sufficient detailed information to accurately adjust for the termination in our calculation.

RSUTE II

	2008 €'000	**2007 €'000**	**2006 €'000**	**2005 €'000**	**2004 €'000**	**2003 €'000**
Total interest paid	**887**	**624**	**691**	**1,009**	**1,244**	**1,384**
Total debt	**20,642**	**7,533**	**13,253**	**22,251**	**26,189**	**74,580**
Total equity	**44,196**	**40,293**	**37,184**	**34,669**	**31,227**	**10,720**
Interest rate on debt	4.3%	8.3%	5.2%	4.5%	4.8%	*1.9%
Debt/equity ratio	0.5	0.2	0.4	0.6	0.8	7.0
Profit for the financial year	3,907	3,116	2,513	1,224	313	1,391
Return on equity	8.8%	7.7%	6.8%	3.5%	1.0%	13.0%

Source: Ribera Salud S.A. Notes to the Financial Statements, various years

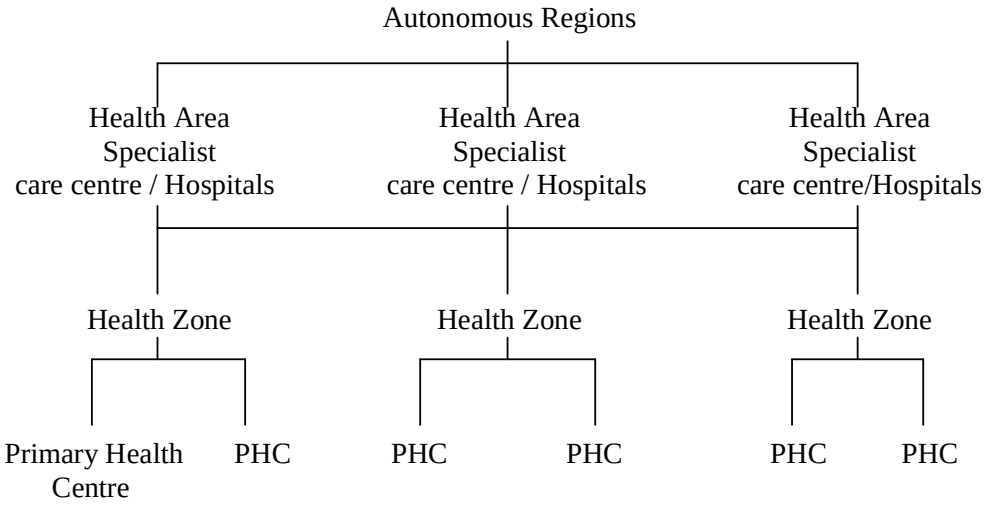
* The contract started during 2003. However we do not have sufficient detailed information to accurately adjust for this in our calculation.

Table 5 Comparison of staff ratios between the Alzira and Elda hospitals

YEAR 2008	Alzira			Elda		
Population	250,000			230,000		
Number of beds	300			352		
Total number of admissions	21,945			17,783		
		Per bed	Per admission		Per bed	Per admission
Doctors	317	1.05	0.0144	499	1.41	0.0280
Other medical staff	654	2.18	0.0298	919	2.61	0.0516
Non-medical staff	205	0.68	0.0093	382	1.08	0.0215
Total staff ratio	1,176	3.92	0.0536	1,800	5.11	0.1012

Sources: Performance Report Department of Health of Elda (2008)
Annual Report Department of Health of La Ribera (2008)

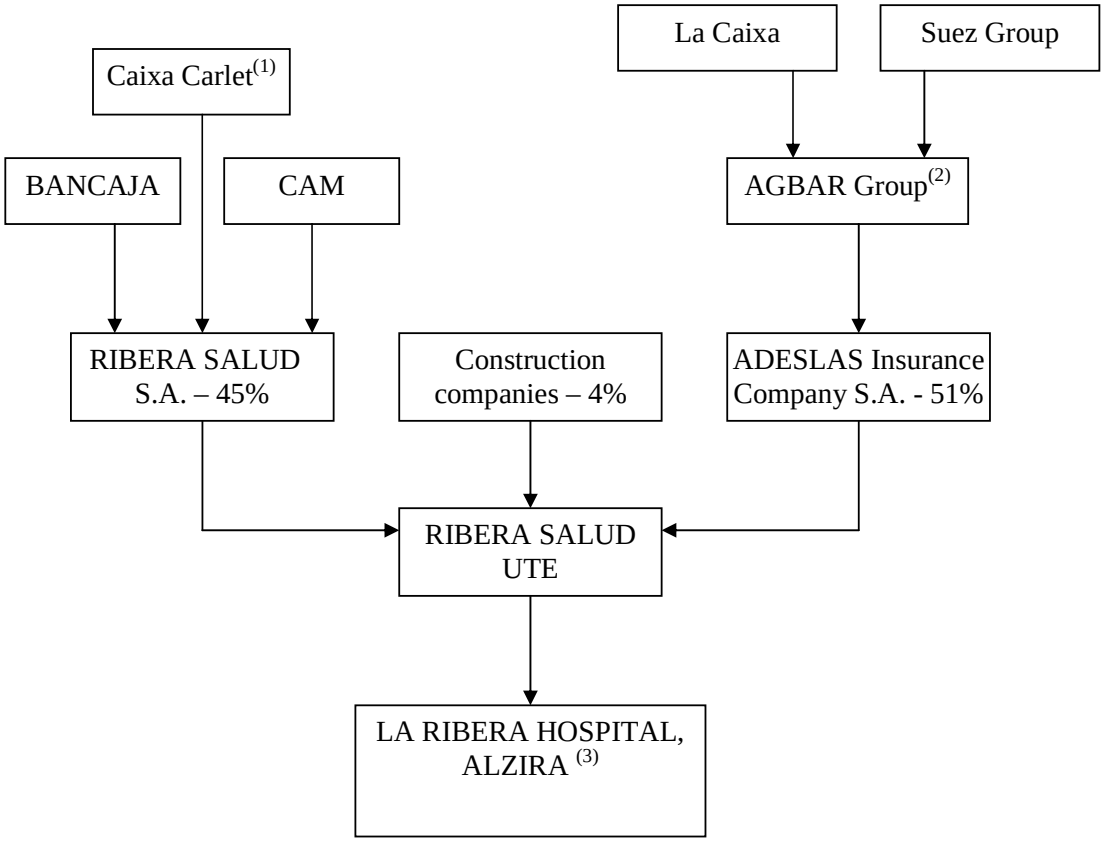
Figure 1 The Spanish Healthcare System



Residents are allocated to a PHC – there is no choice of PHC but residents can choose their GP within the PHC.

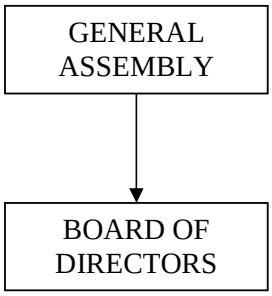
Residents only can attend a specialist medical centre if they are referred by the GP. In Spain, the responsibility for healthcare falls on the autonomous regions. There are two different systems in operation. In the first one, residents are allocated to a hospital according to their residence through their PHC, but they can attend any hospital in their health area (or even in other areas, e.g., if they are on holiday or they are living temporarily in another city) if they need to use the hospital's emergency services. In the second one, residents are able to choose which hospital they attend. This is the case for the Alzira health zone, for example, a resident that lives in the Alzira Hospital's health zone and needs specialist hospital treatment can decide to either be treated in the Alzira hospital or to be referred to any other public hospital in the Valencia region.

Figure 2 Structure of Ribera Salud Unión Temporal de Empresas (RSUTE)



(1) It merged with Bancaja in 2001.
(2) It has reduced its participation in Adeslas, but it continues being the main shareholder.
(3) For RSUTE II this was extended to also include Healthcare Services for Area 10

Figure 3 Structure of Spanish regional savings banks' governing bodies



Note: The General Assembly is responsible for the savings bank's supreme governance and decisions. This body is made up of a number of members that represent the social interests and stakeholders of the savings bank's region of activity. In relation to the savings banks connected to RSUTE, the percentages of stakeholder representation are as follows:

STAKEHOLDER GROUP	BANCAJA (%)	CAM (%)	LA CAIXA
Depositors	33	36.1	36.3
The Autonomous Government	25	25.0	--
Local councils	25	23.9	21.2
Employees	12	13.3	12.5
Founding and community-interest institutions	5	1.7	30.0
TOTAL	100	100	100

Sources:
Bancaja: http://informesanuales.bancaja.es/ing/informes/informe_anual_apartado.aspx?id=10&idtipo=1&ida=100&idsuba=2005&IDnoPagina=317&anyo=2009 [accessed 28/02/11]
CAM: https://www.cam.es/EN/inversores/CorporateGovernance/Paginas/Asamblea-General.aspx [accessed 10/02/11]
La Caixa: http://portal.lacaixa.es/infocorporativa/gobiernocorporativo_en.html. [accessed 10/02/11]

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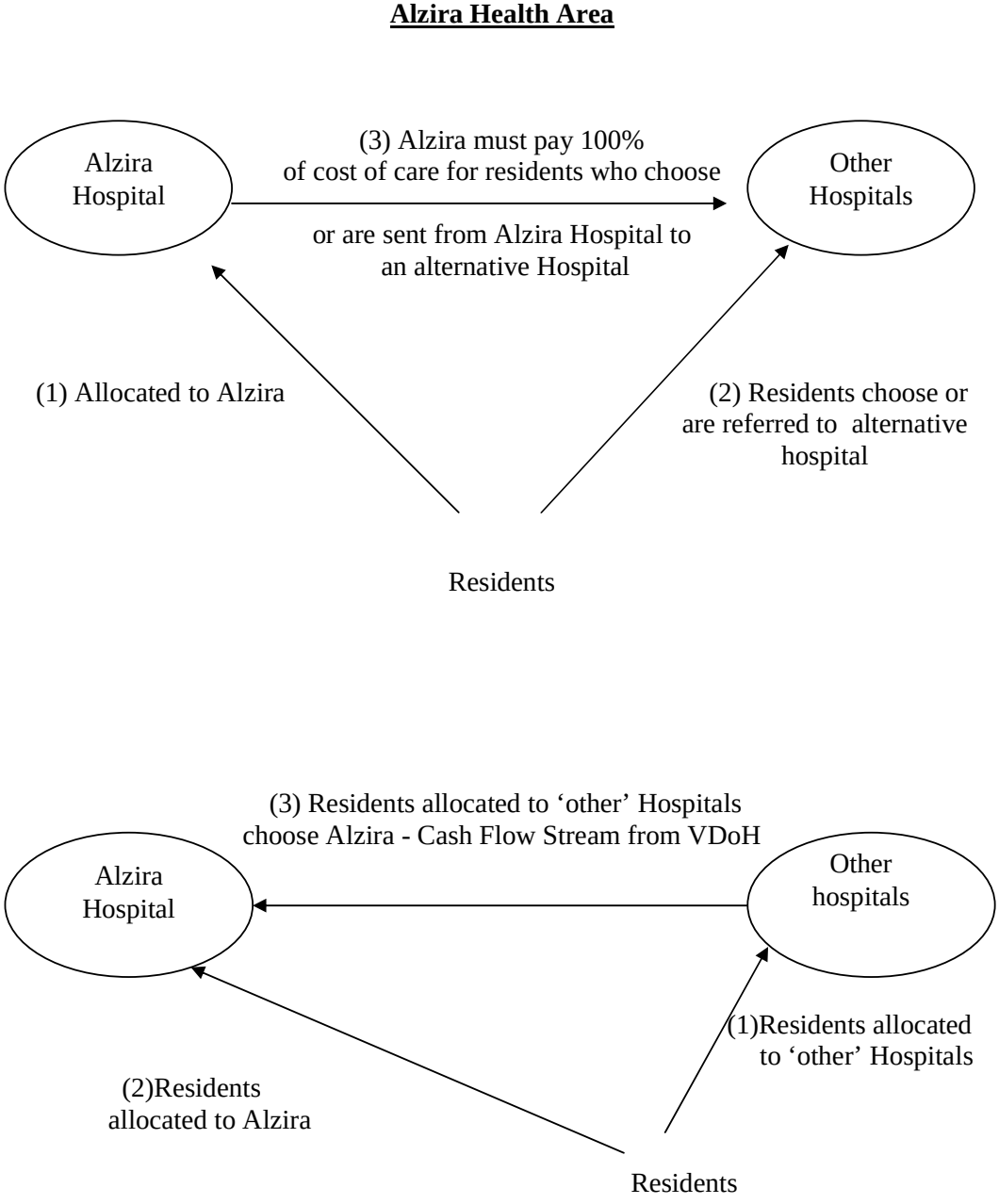
Amongst other duties, the General Assembly is responsible for defining the general strategy of the savings bank's action plan; approving, managing and executing its annual budget; and approving, where applicable, the management of the Board of Directors, the Annual Report, Balance Sheet and Income Statement as well as the allocation of any surplus for the proper purposes of the savings bank.

Figure 4 Patient and cash flows in relation to the terms of the second contract (RSUTE II 2003 onwards)



The full cost payment from 'other' hospitals to Alzira is capped to reduce Alzira's incentive to take out of area patients. Discounts of 12.5% and 25% apply when out of area patients exceed 20% and 40% of budget capitation respectively.