# Public Private Partnerships in the EU

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# Executive Summary

This paper examines the role of the public private partnerships in the health care systems of three European countries – The United Kingdom, Poland and the Czech Republic.

Public private partnerships were developed in the 19th century in the UK. It was a way to finance the rapid growth of the infrastructure, such as hospitals, schools or roads. Later on, the PPP spread to other countries in Western Europe and the USA. The renaissance of the PPP came in the 1970’s of the 20th century. The PPPs provision became popular in non – European states, like Singapore, which used it to create a medical hub for the region.

Scholars have distinguished two schools of public private partnership – the public management school and the international theory school. The first one focuses on the impact of the PPPs at micro level. It describes the correlation between the public and private actors within the nation state. The international relations theory on the other hand, researches the significance of the PPP at macro level. This theory accentuates the influence of PPP on international treaty shaping.

The United Kingdom has been a leader of public private partnership implementation in many areas, including health care. For this reason, Poland and the Czech Republic have been using the experience of the UK. In both countries the PPP projects were developed within time framework and budget. However, Polish government has neither taken into consideration the opinion of the non-governmental organisations nor has it established an independent consultancy body. That might be the reason for the reluctance towards PPP among regional authorities. In case of both Eastern European countries the recent evaluation of the British experience has not been analysed. The total cost of the investment, including the cost of loans, is not included into final budget proposal. The new EU countries tend to focus on the positive side of the projects rather than examining the investments as a whole. Nevertheless, PPP seem to be an efficient way to improve the health care facilities standards and both the Czech Republic and Poland have been the leaders of the region.

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**1.0 Introduction**

Public private partnership has been present in the public services provisions of the Western world since the 19th century. These kinds of solutions were necessary to finance the match the pace of the society undergoing the industrial revolution. Throughout the years, it became an attractive way to finance public service in cooperation with the private sector. These schemes were introduced to the countries of Central and Eastern Europe at the beginning of the 21st century. The gap between the West and the East of Europe had to be closed in a quick and efficient manner. Therefore, public private partnerships seemed like a perfect solution. Public private partnerships allowed to engage private actors and helped to create civil society and they also brought additional resources required to build the necessary facilities.

Surprisingly, PPP did not become popular among Eastern European governments. Not many countries were interested in pursuing this method of contracting public services. The most active countries in the public private cooperation field are the Czech Republic and Poland. Consequently, these countries will be an example of PPP provision in the health care system. Poland is the most populated countries among the ten which joined the European Union in 2004. The Czech Republic, on the other hand, has always been one of the most stable states in the region; its GDP is comparable to the GDP of Portugal. Moreover, most of the GDP comes from the services sector (Jeneralova, 2011). These two countries, leaders in the region, will be compared in terms of PPPs provisions and implementation within the health care system in the United Kingdom. The UK has always been portrayed as a leader in implementing public private partnership into the health care system. This paper will examine the similarities between the UK and Poland and the Czech Republic. Furthermore, an example of non-European state, Singapore, will be added to the general description of PPP. Singapore, a former British colony, which adopted the National Health Service system, is an illustration of possible development of the British style of public private partnerships in the health care. Moreover, a section will be devoted to different theories concerning the PPP. The provisions will be described from both angles – the public management one and the international relations theory.

# 2.0 Methodology

The objective of this research is to find out to what extent the British PPPs solutions are applicable in the Eastern European environment. In order to answer this question, three case studies will be developed. Each of them will describe in detail the already available PPPs solutions and the plans of the evolution of public private partnerships projects in particular countries. Moreover, the criticism of the contemporary provisions will be discussed. The research will be of qualitative nature, attempting to analyse in depth the role of the public private partnerships within the health care provisions in three European countries. Following, three case studies will be developed in order to assess the nature and quality of the partnerships. For this purpose, the legislation, works of scholars and governmental information will be analysed.

## 2.1 Case studies

In order to explore how Eastern European countries modernise their health care facilities and to what extent public private partnership solutions are being implemented, three case studies will be written. Poland and the Czech Republic will serve as examples of the new EU countries and the United Kingdom will present the mature case of PPP. The materials analysed will consist of legislative acts, university papers and articles, books on theory of public private partnerships and information provided by governmental and non-governmental organisations. The case studies will reveal how successful the Eastern European countries are in implementing the public private partnerships and how similar their solutions are to the British one. Moreover, the most popular PPP operating mode will be described. The three case studies will be compared to make generalizations and to distinguish similarities and differences between the countries.

## 2.2 Literature Review

A literature review, describing the current research concerning public private partnerships, will be presented. The main objective of the review is to familiarise with the history of PPPs and to contextualise and theorise the research (Ebeling & Gibbs, 2011). The review will describe both the new public management point of view, which focuses mainly on the micro level of the PPP as well as the macro level – the influence the public private partnerships has on shaping the international treaties and agreements. This thesis will contain a narrative review; the focal purpose of this kind of a review is to synthesise and assess primary research into a descriptive analysis (Ebeling & Gibbs, 2011).

# 3.0 Literature review

The contemporary world is a constantly fluctuating organism, especially when it comes to the field of social studies. Therefore, while conducting a research concerning social matters, it is viable to define the key terms of the analysis and to determine the environment in which the research was carried out. As this paper will examine the role of public-private partnerships in the United Kingdom and two Central European countries, the Czech Republic and Poland, it is necessary to provide a clear definition of such a partnership. Moreover, the political and economic context of such agreements has to be explained.

## 3.1 Public Management Perspective

The simplest definition describes public private partnerships as “the formation of cooperative relationships between government, profit making firm, and non-profit private organisation to fulfil a policy function.” (Lindner & Rosenau, 2000). Public private partnerships mainly occur in the fields of education, medical care, infrastructure or criminal justice. The main aim of engaging private actors into public policy making is to reduce public spending. By doing so, the governments are able to avoid tax rises or cut benefits (Economist, 1998). These partnerships were relatively rare in the past but economic, cultural and social change during last 30 years made the public actors able to cooperate with the private sector in order to provide the citizens with high class facilities. The term “public private partnership” was often used alternately to the term “privatization”, but the distinction between them is very important while classifying PPPs in the public management perspective. The main difference between public private partnerships and privatization is that privatization tends to exclude any kind of connection between the public and private part. PPPs, on the other hand, presume a sort of partnership between them (Lindner & Rosenau, 2000).

The first PPPs were introduced in the 19th century in the United Kingdom and the USA. The governments franchised the rights to design, build, finance and operate schemes for power, water supply and other public utilities (Pietroforte & Miller, 2002). In the 20th century British government came back to its traditional role and expanded its direct involvement in public services. However, in the US the situation was different. In 1970 and 1980 the public sector in the USA was hugely criticised mainly for shortage of competition, low accountability to customers and political influence (Economist, 1998). The reason for the poor record of the PPPs in the US may be the lack of historical tradition for neutral civil servants. The positions in public services were often considered a political pay-off (Lindner & Rosenau, 2000). Later on, as a result of the New Public Management reform program PPPs became popular in other countries, mainly in Western Europe (Larbi, 2004). The introduction of PPPs into the public sphere led to decentralization, outsourcing of services and downsizing of local and national governments. What is even more interesting is the fact that the shift from centralised management to PPPs also took place in areas previously associated solely with a strong nation state, for instance gas, railroads, electricity, or health care. Eastern Europe adopted public private partnerships model in the transitional stage. The extended usage of PPPs resulted in reform of public services and stimulation of private activity (Devas & Horvath, 1997).

## 3.2 Five Forms of PPPs

Five different forms of PPPs can be characterized:

* Public leverage,
* Contracting out and competitive tendering,
* Franchising,
* Joint ventures and DBFO partnerships,
* Strategic partnerships (Skelcher, 2005).

In the following passages all five will be briefly described.

### 3.2.1 Public Leverage

Public leverage is strongly connected with the governmental actions. It occurs when a government creates a business friendly environment, which leads to business growth and increased economic activity. Schaeffer and Loveridge (2002) invented the term “leader-follower” to describe these kinds of activities. The government is an active factor as it is encouraging the private actors to act in a way that will benefit the public policy goals. Public leverage has been mainly used as a tool for regenerating disadvantage local groups and municipalities. Governments use infrastructure improvements, business support services, financial incentives and other measures to revitalize localities (Skelcher, 2005). The downside of public leverage is the possibility of localities to compete among each other in order to gain government support. As a result the members of the local communities are not integrating. Public leverage also takes place when private actors are realising the undertakings that otherwise would be realized by the government.

### 3.2.2 Contracting out and Competitive Tendering

A contracting out model makes a clear difference between the purchaser of a service and a provider of it. As the government is the purchaser, it has to define the nature of service in demand and determine the standards the service must fulfil. After these criteria are met, the purchaser can contract the private actor to provide utilities. Contracting out is an outcome of competitive tendering or market-testing management. This model of PPP provides a few advantages to the government. First of all, it allows to gain more efficiency, as the projects are usually better managed by private actors. Private actors are usually able to reduce the cost of the investment. Secondly, the monopoly of the public provider can be broken. Thirdly, the quality of the service might improve. The government’s perspective on the service will change as it will has to focus on the specifics of the service in need and the results it supposes to bring not on the budget. (Skelcher, 2005). In order to be successful contracting out, has to fulfil two conditions: market competition and government capacity (Van Slyke, 2003). As pointed out by Milne (1997) the market competition does not always exist. The government has to develop new skills, such as negotiation skills, service auditing or problem solving (Skelcher, 2005). By doing so, the public actor can become a “smart buyer” (Kettl, 1993).

### 3.2.3 Franchising

When a government awards a licence to a private actor in order to deliver a public service it is using a franchising tool. The income is provided to the private actor in form of user fees. The income is the factor that distinguishes franchising from contracting out; in the latter the government pays the provider for the contracted service whereas in franchising consumers pay for the service (Savas, 2000). The government’s monopoly is being relocated in this model as many potential providers may buy the franchise licence. Also the responsibility for operation is shifted to the business sector whereas the government plays the role of interest regulator. The main advantage of franchising is the transfer of risk to the private sector (Skelcher, 2005).

### 3.2.4 Joint Ventures and DBFO Partnerships

In joint ventures two or more parties work on the same project and all of them retain their independence towards each other. Joint ventures are usually managed through a partnership agreement or a special purpose vehicle (SPV). In recent years this kind of PPP has been present in public transportation systems, hospitals, roads, air traffic services, economic sector and prisons (Skelcher, 2005). It is worth mentioning that these operations are referred to as public private partnerships in the European context and Private Finance Initiative in the British one. The generic term is DBFO - design-build-finance-operate. In this case the government defines its intentions towards the public service and enters a long-term relationship with the provider. The private actor usually designs, finances and builds the service. In later stages of the project it may also maintain and deliver some of the services. The DBFO system can also be altered and it often becomes a DBO (design-build-operate) or DBF (design-build-finance) system (Pietroforte & Miller, 2002). There are three major benefits of joint ventures. Firstly, as the undertakings are operated by private factors, the financing does not add to public debt. Secondly, government specifies the project in outcome terms, which may encourage the provider of a service to introduce some innovative solutions. And thirdly, the risks of the project are shifted to private partners.

### 3.2.5 Strategic Partnership

In strategic partnership the decisions are made jointly by the public and private partner in order to achieve effectiveness for both of them (Klijn & Teisman, 2000). Strategic partnerships are of open-ended nature and involve full sharing of risks and rewards (Schaeffer & Loveridge, 2002). The underdeveloped institutional norms may lead to obstacles in implementing the strategic partnership provisions and might unable an efficient cooperation between the actors. Strategic partnership is mainly popular in the United States. It is often described as “regime theory”. According to the regime theory, government unites with business and other interest groups and form a coalition. The role of the government is to coordinate the actions and give directions to the group. These actions should result in achieving reciprocal goals for the partnership (Stoker, 1995). However, this theory cannot be translated into European context, as the differences in local governance are too big.

## 3.3 Evaluation

While evaluating the private public partnerships from a public management perspective two issues need to be taken into account. The first one claims that greater involvement of private agents may lead to increase efficiency and service quality. The second one measures the impact of PPPs on the governance and management of the public service.

Savas (2000) observed 20, 30 or even 40% cost reduction of public private partnerships provision in the USA when compared with previous arrangements. The cost reduction was a result of numerous factors, for instance reductions in staffing, alternations in employment conditions, administrative overheads and new management regimes. His findings are consistent with findings of Domberger and Hall (1997). According to them, through competitive tendering a decrease of 20% in expenditure was observed in Australia. However, other studies differ in this area. According to Walsh (1995) in compulsory competitive tendering some cost had reduced while other had increased. This fact is associated with the increase of costs during the service specification process.

There are mixed findings when it comes to public private partnerships as a stimulus for innovation. The UK prisons PFI schemes showed some innovative solutions in construction, control and monitoring of prisoners movement (National Audit Office, 1997). On the other hand, many of the projects were already submitted with detailed plans and left no independence to the contractor. The private actor suggestions were not taken into consideration during the working phase of the project.

It is hard to assess the impact of public private partnership on the service quality. It is challenging to establish a binding definition of service quality as the term is multidimensional and may be subject to personal opinions. Moreover, little research had been undertaken so far. However, some basic principles can be established. First of all, PPPs encountered some problems, for example information asymmetry, limited government capacity and regulatory capture, which may lead to quality shading. Secondly, contracting-out, franchising and joint ventures reduce the vertical integration of service. For instance, contracting-out in schools leave educational matters and janitorial service operated within different managements, even though both should contribute to well being of students (Skelcher, 2005).

## 3.4 International Relations Perspective

In recent years, PPPs also became a part of many international relations theories. Following section will deal with the IR perspective on public private partnerships. Firstly, the definition of PPPs in transnational governance will be provided. Secondly, the forms and purposes of the PPPs will be given together with a short classification.

PPPs have been put in a transnational governance environment. In order to define the role of PPPs in this habitat, it is necessary to define the term “governance”. The definition however, is very broad. In the most extensive sense, governance means all forms of controlling, producing and preserving social order, including states, markets or even networks. (Borzel & Risse, 2002). New modes of governance are in opposition to hierarchical control modes usually associated with an interventionist state. The definition of governance includes state and non-state actors collaborating together in order to achieve socially desirable goals. If we focus on this particular definition of governance, public private partnerships seem an attractive way to operate. Not only can the PPPs increase the effectiveness of public policy design and implementation, it also assure the democratic accountability of projects. As a result the international governance is given more legitimacy.

## 3.5 Historical Perspective

Public private partnerships resemble a pre-Westphalian system of overlapping public, private and religious authorities. Therefore, the state system of the 21st century should not be taken as a natural habitat of public policies. State sovereignty and monopoly to use force by state actors were established only in the 19th century (Krasner, 1999). In this context the transformation to more complex relations of global governance, including PPPs, may be a process of returning to the historical international relations. Many scholars of international relations focus their research on the question of retaining independence and autonomy by nation states. Other however, for instance Borzel and Risse (2002), claim that the research should rather concentrate on the ability of public private partnerships to solve global problems, enhance democratic participation and legitimacy of international institutions.

## 3.6 Four types of PPPs

International relations theory distinguishes four types of PPPs:

* Co-optation,
* Delegation,
* Co-regulation,
* Self-regulation in the shadow of hierarchy.

Furthermore, PPPs can also be differentiated according to purposes and functions in terms of:

* Rule and standard setting
* Rule implementation
* Service provision (Borzel & Risse, 2002).

The dependences between these factors and examples of transnational PPPs can be best depicted in a table.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Type** | *Purpose* | *Rule and standard setting* | *Rule implementation* | *Service provision* |
| **Co-optation** |  | Human rights regimes | UN Human Rights System | UN Development Agencies |
| **Delegation** |  | International Standardization Organisation (ISO) | Executive Outcomes | Humanitarian and Development Aid Sectors |
| **Co-regulation** |  | International Labour Organisation (ILO) | Various Emission Trading Schemes of Climate Change Regime | UNAIDS |
| **Self-regulation In the shadow of hierarchy** |  | Safe Harbour Agreement | Global Compact | Rating Agencies |

(Borzel & Risse, 2002).

### 3.6.1 Co-optation

A co-optation is the most common and least problematic form of public private partnership. It occurs when a non-state actor becomes a part of negotiation while shaping international agreements. As a result non-state actors may influence the international treaty making processes. Co-optation is mainly a tool at international human rights and international environment negotiations. Non-state actors provide their expertise, knowledge, moral authority and legitimacy, and, in exchange are given better access to negotiation details (Borzel & Risse, 2002). In recent years, co-optation was used for the establishment of the International Criminal Court in 1998 (International Criminal Court, 2011). Amnesty International played an important role in creating the Rome Statute (Buergenthal, Shelton, & Stewart, 2009). The co-optation has been extended into other branches of international agreements, such as international economy or international security. The International Monetary Fund or the World Trade Organisation has been participating in negotiations, especially after the outburst of world crisis in 2008.

### 3.6.2 Delegation

A delegation in international relations theory resembles the contracting out in the public management view on PPPs. State power is delegated to a non-state actor. However, from an international relations perspective, the term has broadened its meaning. In some cases, delegation may resemble a private self-regulation in the shadow of hierarchy, which will be discussed later. An example of delegation state power to a non-state actor is the International Standardization Organization. A public authority to set standard norms is delegated to a private actor, which is an expert in the field (Ronit & Schneider, 1999). This delegation may increase efficiency of a service and an acceptance of standardization outcomes. The efficiency factor is important in humanitarian sector and development aid, where non-state organisations, such as private organisations, charities, churches or INGOs, have to deal with complex emergencies. There is also a downside to this form of public private partnerships. In some Third World countries core state functions, for instance the military security is contracted out to non-state actors. The government is too weak to provide services to its citizens. (Singer, 2001/02). However, such shift of authority is exceptional and is often met with strong intervention from the Western states (Borzel & Risse, 2002).

### 3.6.3 Co-regulation

The main difference between a co-regulation and the co-optation is that in the former non-state actors are given a real veto power. The co-regulation is a joint decision making process where both sides are equal partners. The non-state actors are considered as partners in making and implementing the rules. In March 2000, the Lisbon Treaty introduced an ‘open method of coordination’, which resembles co-regulation procedures. The OMC is using ‘soft’ policy incentives in order to shape behaviours rather than legally binding methods. The OMC should be used in the microeconomic field, where the EU lacks strong, delegated policy powers. Open method of coordination should engage member governments, stakeholders and civil society in policy making (Wallace, 2010). At a transnational level, International Labour Organization is an example of co-regulation. It represents business associates and trade unions, which are equal partners in negotiations with other states.

### 3.6.4 Self-regulation in the shadow of hierarchy

An example of a private self-regulation in the shadow of hierarchy is ‘Safe Harbor’ agreement between the EU and the US. The European Data Protection Directive set stricter rules to protect the privacy of consumers than the US regulation. Therefore, the USA does not qualify as a country to which data may be exported. American companies however, require some of that data to operate. Therefore, US companies agreed to voluntarily sign a set of privacy rules formulated by the US administration (Farrel, 2002). The US-EU agreement is a ‘shadow of hierarchy’ under which US companies are able to operate. Self-regulation is usually triggered by lack of international rules and norms. Some of private sectors solutions become publicly sanctioned solutions after being enforced by national courts.

## 3.7 Role of the PPP on the international arena

Within the international spectrum PPPs have been providing solutions mainly in fields of humanitarian services and development aid. This is a result of lack of national and international organisations resources and capacity to perform any actions. Public actors have to rely on NGOs providing finance and expertise. Another incentive to share power with private actors was the introduction and emphasis on terms and processes such as “good governance”, “sustainable development” and “strengthening public society” into public policies of Western countries and international organisations (Borzel & Risse, 2002).

PPPs solutions seem to be less frequent in international rule setting and implementation. Many states are reluctant to delegate authority to private actors, particularly in areas concerned with national and international security. When it comes to security issues private actors can only hope for the co-optation model.

On the other hand, in the field of human rights and environment private actors have been incorporated more often into rule setting through voluntary agreements. There are several reasons for that. First of all, national governments failed to agree upon internationally binding and effective rules concerning environmental and human rights issues. The private actors voluntarily agreements came as a best option in that case. Secondly, nation states and international organisations realized that in order to provide best service, stakeholders have to be incorporated into decision-making and implementation processes. An introduction of the open-method of coordination may be an example of that kind of behaviour. Stakeholders not only give legitimacy to global governance but also assure that international norms are more effective in terms of problem solving (Borzel & Risse, 2002).

All of the previously mentioned PPP modes have been present in international life – either as a part of domestic affairs or a part of the history of international relations. The co-optation model is popular in domestic policy making of highly industrialized nations. The co-regulations are a characterization of most of the corporatist arrangements. A result of a deregulation and privatization in the OECD world is the delegation of state power to private actors. The deregulation/privatization waves in the 1980 limited the role of the state in public services. The private self-regulation in the shadow of hierarchy is popular among environmental policy makers. Business actors can commit to the new policy freely, which may leave them small flexibility when it comes to implementation (Borzel & Risse, 2002).

# 4.0 Public Private Partnership in Healthcare around the World – Case of Singapore

Public private partnerships have been very popular among non-European states. In this section a short description of PPPs in health care system of Singapore will be examined. Singapore has been extremely successful in implementing PPP schemes into the national health care system. Not only did it evolve from the British system, which will be characterised in the next parts of this paper, it also implemented public private partnerships into both finance and services. Of course, it has to be noted that Singapore is not as densely populated country as the United Kingdom, Poland or the Czech Republic, therefore the scale of the problem is completely different. It is, however, an interesting precedent of PPP incorporation into the health care system.

Singapore started transforming its health care system in 1980. Previously, the health care system was based on a British National Health Service scheme. This option proved not to be sustainable, therefore the government decided to move some of the cost of the service to the consumers of it. A 3M system was introduced – Medisave (1984), Medishield (1990) and Medifund (1993) (Lim, 2005). The core premises of this system were shared responsibility of the health care sector and referenced to price of health care procedures. The 3M system was supposed to decrease the unnecessary consumption of medical procedures. This arrangement has proved to be very successful over the years, especially in engaging private resources into the health care. Most of the expenditure shifted to the private sector. New forms of management had been introduced to the hospitals replacing old bureaucratic norms. Singapore had also implemented the principle of subsidiarity – most of the decisions are made on a regional level rather than central one. The patient’s satisfactory rate is reported to be 85%, approximate waiting time for an elective surgery is two weeks and average length of stay in a public hospital is five days (Lim, 2005).

The Singaporean system is now facing new challenges, such as cost containment or enduring high quality and patient safety. Moreover, Singapore would like to become a regional centre of medical excellence. Consequently, the system needs to solve existing problems and adopt the results in a quick and efficient manner.

The cost of the health care provisions has increased recently. There are several reasons for that. One of it is the maturing of the economy. The more mature the economy is, the slower the increase in GDP. Health care costs will soon exceed 3% of the GDP. Furthermore, Singapore has to confront the same problem the countries of Western Europe have to – ageing of the society. The elderly need a long-term care and the advanced medical technology, which is usually very expensive. As the 3M formula was not designed to deal with these kinds of problems, Singapore introduced new schemes – Eldercare and Elderfund (Lim, 2005).

It is worth noticing that the Singaporean health care system is highly commercialised. In fact, most of the private health care providers are listed on the Singapore Exchange (Lim, 2005). The government attracted few international pharmaceutical corporations over the years and about 200,000 foreign patients came from the region to use Singaporean health care. The implementation of an idea of Singapore as a medical hub of a region will lead to the increase in income and workplaces. The whole economy of the country will be a beneficiary of these actions. But it also can trigger negative effects. Patient’s satisfaction rates may drop down and the region may become of the over-priced medical centres, which focus rather on the income than the quality of service. The Singapore answer to the problem of maintaining high effectiveness and standards is an external regulatory scheme. The theorists do not agree on who should be responsible for auditing the services. The doctor-patient confidentiality clause restricts the right of third party monitoring. According to Lim (2005) the power of control should be given to the purchaser of the service.

The answers to the Singaporean problems can be divided into three points. Firstly, what should be introduced is competition between the health care providers. This can probably lower the costs and increase quality. Competition can provide a balance between prices and demand for the service, which is usually impossible to reach with a central planned system. The public actor can focus on policy setting and regulating rather than providing the services. Secondly, more power should be given to the consumers. Provided with sufficient information about the price and quality of the service, they will be able to make and inform decisions concerning their health. Once again, the government role would remain strictly regulatory. Thirdly, cooperation between private actors is necessary to build a regional medical hub in Singapore. The health care providers have to compete not only with each other but also with the opposition outside the country. By cooperation a common vision of evolvement can be established, which will allow to make Singaporean health care system even more attractive for foreign patients.

# 5.0 Private Finance Initiative – Case of the United Kingdom

A Private Finance Initiative, the British equivalent for public private partnership, was introduced in 1992 by the Conservative government of John Major. It began a five-year process of legal and bureaucratic changes, which main aim was to promote DBFO initiatives. The PFI suited a neoliberal agenda of the government, where a regeneration of market is achieved through ownership and market exchange (Lindner & Rosenau, 2000). The PFI also allowed going around the public sector borrowing requirement (PSBR), which was necessary to fulfil arrangements of the Copenhagen Criteria and the Maastricht Treaty (Hellowell, 2010). It also meant new infrastructure built for the voters, without having a direct impact on a budget. The left wing of the political scene accepted PFI in 1994 when Gordon Brown, Robin Cook and John Prescott published a document “Financing infrastructure investment: promoting a partnership between public and private finance” (Hellowell, 2010). A great deal of PFI financing was “off-balance-sheet” and therefore did not add to the government debt. The “off-balance-sheet” was attractive to the Labour government as well. It laid within “sustainable investment rule”, which limits the level of public sector debt to 40% of GDP. Ability to keep the net debt in limits was viewed as a measure of fiscal responsibility of the government (Hellowell & Pollock, 2009). However, recent plans of the British Office for National Statistics to redefine such investments may remove one of the most important factors in pursuing the DBFO model (McKee, Edwards, & Atun, 2006). Moreover, nowadays many economists claim that fiscal policy should not play a role in PFI decision-making process.

## 5.1 PFI in Hospitals Provisions

In April of 2009 a total of 641 PFI contracts had been signed with total nominal cost for the public sector of about £273.8 billion over the full length of these contracts (Hellowell, 2010). The largest recipient of the PFI contracts is the transport sector, followed by the defence sector. However, in health care and education the PFI schemes have also been a dominant model of investing. Between May 1997 and May 2009, 127 contracts for hospitals had been signed and 97 of them came through PFI (Hellowell, 2010). In February 2010, the UK National Health Service signed 150 PFI contracts.

In a hospital PFI project, a group of investors owns a special purposes vehicle (SPV). It manages the design, built, finance and operate (DBFO) of a hospital. The SPV usually enters a long-term agreement with the public actor. After completion of the project a special “unitary charge” is paid to the SPV. The unitary charge is made of two elements: an availability charge, which is a payment for providing buildings and equipment and a service charge which pays for provision of services. It provides the payback for shareholders and payment for maintenance services such as catering (Hellowell & Vecchi, 2012). The SPV usually enters into three types of subcontract: one with a construction company, one with facilities management company and one with banks. The lifetime of a contract is usually 30 years. (McKee, Edwards, & Atun, 2006). In a typical PFI hospital private actor provides maintenance of building, manage catering, cleaning, and laundry services. The clinical care is left solely to the public actor. Capital that SPV has to invest in the project is provided by combining “blended equity” (share capital and loans) and “senior debt” from banks. Senior debt comes in two forms: bank loans and bonds, which consist of number of financial institutions and an intermediate bond arranger (Hellowell & Vecchi, 2012).

## 5.2 Evaluation

Since the UK has a great deal of experience with Private Finance Initiatives it is possible to evaluate projects. Most of the scholars focus on cost and quality. However, other issues, such as complexity of projects, flexibility and impact on local levels, need to be mentioned and assessed as well.

### 5.2.1 Cost

Corporate bonds, mentioned above, usually receive a very lower status from rating agencies - BBB+. It is just above the junk level. Governments bonds, on the other hand, are awarded AAA level. Consequently, costs of borrowing money are much lower for governmental bonds than for private ones. This risk changes once project is completed, which allowed to refinance it at lower interest rates. The British National Audit Office has had a negative opinion on such activities and the British Treasury required that provisions had to be incorporated to share profits between the contractor and the public authority (McKee, Edwards, & Atun, 2006). Another issue concerning the cost of PFI deals with size of some of investments. The enormous size of some of hospitals already precluded some of the bidders from participation in a project. The National Health Service has had a poor reputation for maintaining its buildings. Money meant for maintenance was often reallocated to provide healthcare services. That might be the reason why buildings constructed under the PFI scheme usually are more expensive to conserve.

The Freedom of Information Act (2005) enables independent researchers to compare costs of hospitals construction within a PFI scheme and within a traditional method. By comparing two Scottish hospitals, the Edinburgh Royal Infirmary and the Hairmyrnes, it can be concluded that by using PFI cost of one hospital double. In other words, with the same amount of money and relying on traditional mode, two hospitals could have been built, not one (Hellowell & Pollock, 2009).

Nevertheless, it is hard to determine, which way of financing is more economical – the PFI or the traditional method. Pollock argued that private initiatives are remarkably more expensive. Not only the cost of borrowing money for corporate bonds is much higher, but also private companies are obliged to make profit for their shareholders (Hellowell & Pollock, 2009). However, McKee et al. mention that the life cycle view needs to be taken into account to compare higher initial costs with lower operating costs (2006). Additionally, in the PFI scheme, risk associated with an investment are included into the costs provision, whereas in the traditional scheme the same costs are passed from current to future taxpayers. The Assistant Auditor-General from the United Kingdom National Audit Office described the contemporary studies concerning the costs if the PFIs as a “pseudo-scientific mumbo-jumbo” (McKee, Edwards, & Atun, 2006, str. 892).

### 5.2.2 Quality

The quality of a project is measured by fulfilment of specifications of a project. Investors usually accept the fact that it may go over time or budget. In 2001, 76% of PFI projects were delivered on time, 79% within budget, compared with 30% on time and 27% within budget using traditional provisions (McKee, Edwards, & Atun, 2006). The main concern about the PFI arises when it comes to the quality of projects. However, the reason for poor conditions of hospitals may lay in the general British mechanisms for planning new hospitals. Public actor does not provide private partner with detailed drawings but with broad specifications, which can be interpreted in different ways. Leaving the design of hospitals to private actors, results in removing elements of it that creates more therapeutically environment. As a consequence, hospitals have been built with lack of natural light or other undesirable features. These factors cannot be contributed to private public partnerships, but to underdeveloped cooperation between the agents.

Hellowell and Pollock argue that the ability to deliver a project “on time and to budget” cannot be a measure of PFI accountability. Under the PFI, risk of extending a project in time is transferred to a private actor. It is hardly possible for project to increase in costs during the capital work period unless some major problems occur. PFI contractors include this risk in their first offer, before even starting construction (Hellowell & Pollock, 2009)

### 5.2.3 Flexibility

Demands of the health care system change constantly. It is connected with a rapid development of technologies and rising public expectations. PFI contracts, on the other hand, are usually very specific to avoid any misunderstandings between partners. Any changes to contracts are punishable. This means that many hospitals are out-of-date at the moment of their opening. New English health policies diminish the spectrum of flexibility. It is possible to design more elastic buildings, but then the design costs are higher. Any additional cost of possible future modifications will be paid by taxpayers. (McKee, Edwards, & Atun, 2006).

### 5.2.4 Complexity

PFI has proven ineffective while constructing major teaching hospitals. Teaching hospitals are complex institutions, accepting various types of patients and providing a wide range of services. Therefore, these projects involve many different stakeholders. Difficulties in reaching agreement between stakeholders led to collapse of the Paddington Health Campus in West London (McKee, Edwards, & Atun, 2006). The project was to cost £300 million and should have been completed by 2006. At the moment of collapsing of the scheme, costs had risen to £894 million. The project failed because of its complexity, unclear division of responsibilities and lack of decision from the central government whether it support the project or not.

### 5.2.5 The impact at the local level

Some studies have shown that PFI schemes hospitals have been facing major financial problems. According to the South-East London and Maudsley Strategic Health Authority (SHA) four district general hospitals have a deficit of £66 million in 2005/06 (Hellowell & Pollock, 2009). The highest losses were noticed at the Queen Elizabeth hospital and the Bromley hospital. The reason for such a big deficit is the gap between cost of availability charge and capital charges. It was recommended to reduce the “controllable costs” by reducing both staff costs and staff members.

# 6.0 Public Private Partnership – Case of Poland

In Poland, public private partnership is regulated by a legal act from 19th of December 2009. The act introduced the renormalization of rules of partnership between public and private actor. The definition of PPP is described very broadly. According to the legislature it is “common realization of a project based upon division of responsibilities and risks between public and private actor” (Banasik, 2010). This legal act is not an expanded legislation; therefore it leaves a great deal of independence for public actors.

The PPP has become an attractive alternative of cooperation. Public actor can choose the most convenient model of partnership. The risk factor can also be allocated between partners, which allows using PPP in many different projects. Once an agreement between actors has been signed it is not possible to change it. However, if any kind of force majeure occurs some alternations may be implemented into the agreement. Public private partnerships are an answer to many problems in public sector, mainly to lack of public resources, low effectiveness of projects supervised by public actors, high costs of exploitation, inefficient management and, last but not least, to change negative opinion on any form of privatisation among the society (Banasik, 2010).

## 6.1 Public Private Partnership in Health Care

Poland, as well as the United Kingdom, uses the national health services system, which encourage implementing PPP solutions (McKee, Edwards, & Atun, 2006). However, to fully understand the process and problems in implementing the PPP solution in Poland, a broader socio-economic background has to be shown. The first obstacle PPP have to overcome is a negative attitude towards any form of commercialisation of health care provisions. Local communities, trade unions, managerial and medical staff and some of politicians often express their negative opinions about PPP. Most of the health care services are and will be performed under the contract with national health service (Narodowy Fundusz Zdrowia - NFZ). Nevertheless, six projects are currently implemented in cooperation between public and private actors. These are:

* Białostockie Centrum Onkologii – services in medical imaging, MRI and X-ray computed tomography. Based on service franchising.
* SP ZOZ Szpital Wielospecjalistyczny w Jaworznie – haemodialysis infrastructure and nephrology department. Based on building franchising.
* Powiat Żywiecki – building of local hospital in Żywiec
* Gmina Karczew – building and equipment of local health clinic and commercial services. Based on building franchising.
* Gmina Kobylnica – redesign of nursing home and commercial services. Based on building franchising.
* Gmina Zabierzów – building of local health care clinic. Based on building franchising (Cieślak, 2011)

The hospital in Jaworzno was built in little over one year (the construction began on 7th of May 2009 and ended on 8th of November 2010). Due to a contract signed by a provider with NFZ patients can use the haemodialysis infrastructure without paying any additional charges. Extra workplaces were created for medical personnel. After 15 years the infrastructure will be transferred to the public partner. This hospital is the first PPP project realized in Poland.

The project of Gmina Kobylnica was built in 24 months. The private partner is responsible for construction, maintenance and management of the new centre and signing the contract with NFZ. The public actor took some of the financial responsibility – it secured part of the loan by taking a mortgage on the premises. The relationship between the actors will last for 30 years; after this period of time the hospital will be given to the public partner. During the last five years the private actor has to pay rent, and during the whole time property tax.

## 6.2 First conclusions from PPP in health care

The most common model of public private partnership in Poland is franchising. The main advantage of this type of PPP is transfer of risk to a private partner. A public one acts as a regulator of a project. In smaller projects, the private actor has usually been active at a local area. Many of public regulators are afraid of contracting unknown actors as they lack the know-how, have negative experience or are afraid of loosing control over the health care services market (Banasik, 2010). Nevertheless, public private partnerships remain an important factor in transforming health care provisions. Therefore, it is vital for the central government to promote good practices within the PPP provisions and show reluctant regional actors benefits PPP could bring.

# 7.0 Public Private Partnership – Case of the Czech Republic

Another Central European country, which has been implementing rules of public private partnerships, is the Czech Republic. The Czech government formed on 1st of July 2004 a PPP Centrum Czech Republic, an organization, which main aim is to act as a knowledge centre for implementation of PPP projects (PPP Centrum Czech Republic, 2012). The PPP Centrum offers guidance in methodology area and ensures the environment for successful realization of PPP projects. It can also suggest any necessary changes in the national legislation. The Centrum also supports the public sector by providing knowledge, advice and expertise. Therefore, the Centrum can ensure minimal risk for public actors and initiate the best practices in PPPs provision. (PPP Centrum Czech Republic, 2012).

At the same time, the Public Private Partnership Association was formed. Unlikely the Centrum, it is a citizens initiative. It was established by people active in the area of public services and investments supplied for public sector. The Association offers assistance for both public and private actors. It actively cooperates in forming rules of the PPP in order to achieve transparent principles of these kinds of investments. It aim is also to support a development of provisions by means of PPP in Czech Republic and to enhance protection of good morals and strengthening general confidence in effective forms of public and private sector cooperation (Public Private Partnership Association, 2009).

## 7.1 Organizational Chart of PPP Project Management

Economic Operator Public Sector Sponsor Regulator

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

Representatives of other

parties involved Steering Committee PPP Centrum





Project Manager





Project Team

Operator’s Financial Legal Technical

Implementation Team Advisor Adviser Adviser

(Tetrevova, 2006)

PPP project sponsor is a representative of the public sector, who is responsible for supplying a public service or infrastructure. The sponsor is responsible for an identification of needs, drawing an investment plan, defining parameters of the public service, selection of advisers, selection of the best tender and monitoring of fulfilment of agreement. An economic operator is an administrator of budget. A regulator is an independent body within the Finance Ministry of the Czech Republic. It ensures general standards are met and inspects the entire process of project preparation and implementation. A steering committee is the top governing body of a project. It is responsible for its successful implementation. It issues recommendations for the sponsor. It consists of a representative nominated by the sponsor and another two representatives of the main parties. These two representatives are appointed by the sponsor. A regulator and the PPP Centrum also have one representative. Project manager is responsible for project management; he manages a project team. The project team assists the project manager and ensures the expertise (Tetrevova, 2006).

## 7.2 PPP flag project – Central Military Hospital in Prague

The most known PPP project in the Czech Republic concerning the health care is redesign of the Central Military Hospital in Prague. The authority’s goal is to transform the Central Military Hospital into a modern medical clinic, comparable with clinics in other NATO member states. The facility will become a training spot for military and non-military physicians and should be able to accommodate and provide services to NATO soldiers. The finalization of the project is needed to introduce one-day-surgery mechanisms, which will not required an inpatient treatment. An accommodation for patients from outside Prague has to be built. A hotel-type accommodation with approximately 250 beds and few other services, for instance a restaurant or a parking lot, will be build in the area of hospital. The duration of the contract is estimated to 25 years. The private actor will bear the risks of construction and service availability whereas the Central Military Hospital and Ministry of Defence will take risk of not using the contracted availability to full extent. The operator will collect the fees directly from users (Public Private Partnership Association, 2009). The project was approved by the government in September 2007 and the construction and operation activities started in the last months of 2011. The total cost of the project is estimated to 1 billion CZK (approximately 40 000 000 Euro) (PPP Centrum Czech Republic, 2012).

# 8.0 Findings

The three case studies presented different European countries that have been implementing public private partnerships provisions within their health care systems. The case studies revealed, which institutions had been established in order to secure the efficiency of new policy modes, the nature and the costs of flag institutions, and, especially in the case of the United Kingdom, the criticism of the PFI schemes. The aim of this section of the paper is to examine the pros and cons of the PPP as well as to determine whether public private partnerships are an answer for challenges that health care systems have been facing.

All of three countries share many common denominators. The DBFO mode, or a variation of it, is the most popular one from many different forms of public private partnerships. Therefore, risk is being transferred to the private partner. The United Kingdom has been set as an example of a successful implementation of PPP models by many INGO’s and other advisory bodies (Fundacja FOR DLA PIPER Forum Rozwoju Edukacji Ekonomicznej, 2008). As the country has had a long tradition of sharing powers and risks with private sector, a critical approach towards the PFI provisions could have been developed. Whereas in Poland and the Czech Republic advisory bodies and independent researchers focus on benefits of the PPP, scholars from the UK were able to examine the long term results of public private partnerships. Their conclusions are far less enthusiastic than expected. However, none document examining British negative findings can be found on either Polish or Czech papers on public private partnerships. This is a striking notion, as the PFI schemes had been researched quite extensively. Yet, the research was centred on the positive impact of the private financed initiatives.

The Czech government has been encouraging PPP solutions in many different areas of public sector; health care is one of them. The UK example is an important reference point while constructing PPP frameworks. The Centrum PPP, an advisory organ for the public sector is based on the PUK (Partnership United Kingdom), also an advisory organ established in 1997 and reorganized in 2000 by the British government (PKPP Lewiatan, 2008). Both Czech and British government, unlikely the Polish one, invite non-governmental organisations as an expertise partner into the preparations of PPP provisions.

It is worth noticing, that the Czech Republic is not focusing its PPPs activities on health care. The flag project, the Central Military Hospital in Prague, is an exception. However, even in this case Czech approach to PPP is rather peculiar. The main aim of public private partnership part of the renovation of the Central Military Hospital is not to provide an “off-balance” accounting, but rather to provide more comfort to guests and finance the centre. The PPP agreement is not directly connected to the health care sector. The long time of implementing projects is also remarkable. Nevertheless, organisational solutions chosen by the Czech Republic resembles the UK status.

Poland, the third analysed country, also has been very active in public private partnership field. Although the health care has always been a very fragile part of domestic politics and policy making, in recent years it was possible to implement a few PPPs projects. The pace of the construction is exceptional. All of the above mentioned projects were delivered within the time limits and these were also not very prolonged.

The problem that PPP structures in Poland have to deal with is lack of non – governmental or governmental advisory bodies. Now all the expertise is provided by ministries, which are not impartial bodies. Establishing independent institutions, which main aim would be to guide public actors and to promote PPPs solutions seem as a necessary step in further development of public private partnerships.

# 9.0 Conclusion

The Czech Republic as well as Poland has undertaken many activities in order to advocate the public private partnership solutions. Taking the United Kingdom as a role model was an understandable move – all of countries rely their health care on national health services. However, no taking into consideration critical studies concerning PFI is a significant omission, which may result in obstacles in the future.

The Czech Republic has to define the nature of public private partnership investments. As we can see now, health care facilities do not lay in the main interest group of the government. However, the idea of constructing leisure facilities in the neighbourhood of hospitals seems reasonable. Therefore, the health care centres are able to finance itself and do not require full support from the government. This solution resembles the Singaporean one, where part of the costs is transferred to the user of the service.

Poland has been implementing PPP provisions and already has seen some major improvements in health care facilities. The disadvantage of the whole public private partnership system is lack of any sort of an advisory body, which would help developing local structures necessary to implement PPP. As partnerships between public and private actors are brand new ways of financing public services, additional support from the central government is required.

Public private partnership is a way to finance, design, build and operate new medical facilities. However, the quality of medical treatment itself depends solely on the quality of whole health care system. Available facilities are an important part of it, but if the Eastern European countries would like to improve general standards of it, public private partnership is not the only solution that needs to be implemented. Developing a medical hub for neighbouring countries may be a good idea to provide additional resources for the health care system.

It can be clearly seen that Poland as well as the Czech Republic still have to discover a successful way, which will allow creating an efficient health care system and providing a high patient’s satisfaction rates. However, first attempts of public private partnerships implementations have proven to be effective.

# 10.0 References

Banasik, P. (2010). Geneza partnerstwa publiczno prywatnego i aktualny stan prawny. In E. Grzegorzewska-Mischka, *Partnerstwo publiczno prywatne w kontekście EURO 2012* (pages 3-21). Gdańsk: Wydział Zarządzania i Ekonomii Politechniki Gdańskiej.

Borzel, T. A., & Risse, T. (2002). *Public-Private Partnerships: Effective and Legitimate Tools of Transnational Governance?* Berlin.

Buergenthal, T., Shelton, D., & Stewart, D. (2009). *International Human Rights in a Nutshell.* St. Paul: West Publishing.

Cieślak, R. (2011). Partnerstwo publiczno prywatne w sektorze ochrony zdrowia w Polsce.

Devas, N., & Horvath, T. (1997). Client-Contractor Splits: Applying a Model of Public Management Reform to Local Community Services in Hungary. *Local Government Studies* , 100-109.

Domberger, E., & Hall, C. (1997). Contracting for Public Services: A Review of Antipodean Experience . *Public Administration* , 129-147.

Ebeling, M., & Gibbs, J. (2011). Searching and Reviewing Literature. W N. Gilbert, *Researching Social Life* (pages 63-80). London: Sage.

Economist. (1998, October 24). A survey of social insurance: Privatising peace of mind. *The Economist* , pages 3-22.

Economist. (1998, June 13). The End of Privatization. *The Economist* , pages 53-55.

Farrel, H. (2002). Negotiating Privacy in the Age of the Internet. Analyzing the EU-U.S "Safe Harbor" Negotiation. In A. Heritier, *Common Goods: Reinventing European & International Governance.* Lanham MD: Rownan&Littlefield.

Fundacja FOR DLA PIPER Forum Rozwoju Edukacji Ekonomicznej. (2008, September). *Co zmienić by rozwinąć partnerstwo publiczno-prywatne w Polsce?* Retrieved 5 12, 2012 from http://www.for.org.pl/upload/File/raporty/Raport\_PPP\_FINAL.pdf

Gower, J. (2006). Towards One Europe? W A. S. Richard Sakwa, *Contemporary Europe* (strony 54-78). New York: Palgrave Macmillan.

Hellowell, M. (2010). The UK's Private Finance Initiative: history, evaluation, prospects. In G. A. Hodge, C. Greve, & A. Boardman, *International Handbook on Public-Private Partnerships* (pages 307-332). Cheltenham: Edward Elgar.

Hellowell, M., & Pollock, A. (2009). The Private Finance of NHS Hospitals: Politics, Policy and Practice. *Economic Affairs* , 13-19.

Hellowell, M., & Vecchi, V. (2012, February). An Evaluation of the Projected Returns to Investors on 10 PFI Projects Commissioned by the National Health Service. *Financial Accountability&Management* , 77-100.

International Criminal Court. (2011). The ICC at a Glance. Den Haag, The Netherlands.

Jeneralova, I. (2011, 8 14). *The Official Website of the Czech Republic.* Pobrano 5 15, 2012 z lokalizacji http://www.czech.cz/en/Business/Economic-facts/Development-of-Czech-economy

Kettl, D. (1993). The Mythology of Privatization for Social Services. *Public Administration Review* , 296-315.

Klijn, E.-H., & Teisman, G. (2000). *Governing Public Private Partnerships: Analysing and Managing the Process and Institutional Characteristics of Public Private Partnerships.*

Krasner, S. (1999). *Sovereignty. Organised Hypocrisy.* Princeton NJ: Princeton University Press.

Larbi, D. (2004). *The Changing Role of Government: The Reform of Public Services in Developing Countries.* Basingstoke: Palgrave Macmillan.

Lim, M. (2005, August). Transforming Singapore Health Care: Public-Private Partnership. *Annals Academy of Medicine* , 461-467.

Lindner, S. H., & Rosenau, P. V. (2000). Mapping the Terrain of the Public Private Policy Partnership. W P. V. Rosenau, *Public Private Policy Partnerships* (pages 1-19). Massechussets Insitute of Technology.

McKee, M., Edwards, N., & Atun, R. (2006, November). Public-private partnerships for hospitals. *Bulletin of the World Health Organization* , 890-896.

Milne, R. (1997). Market-Type Mechanisms, Market Testing and Market Making:A Longitudinal Study of Contractor Interest in Tendering. *Urban Studies* , 543-549.

National Audit Office. (1997). *The PFI contracts for Bridgend and Fazakerly Prisons.* London: HMSO.

Pietroforte, R., & Miller, J. (2002). Procurement Methods for US Infrastructure: Historical Perspectives and Recent Trends. *Building Research and Information* , 425-434.

PKPP Lewiatan. (2008, 2 20). *Czas na PPP.* Retrieved 5 12, 2012 from http://pkpplewiatan.pl/dla\_mediow/informacje\_prasowe/1/czas\_na\_ppp

PPP Centrum Czech Republic. (2012). *PPP Centrum Czech Republic*. Retrieved 5 1, 2012 from http://www.pppcentrum.cz/index.php?lang=en&cmd=page&id=1113

Public Private Partnership Association. (2009). *Asociace Pro Podporu Projektu Spoluprace Verejneho A Soukromeho Sektoru*. Retrieved 5 1, 2012 from http://www.asociaceppp.cz/

Ronit, K., & Schneider, V. (1999). Global Governance through Private Organizations. *Governance* pages, 243-266.

Savas, E. (2000). *Privatization and Public-Private Partnerships.* London: Chatham House.

Schaeffer, P., & Loveridge, S. (2002). Towards an Understanding of Types of Public-Private Cooperation. *Public Performance and Management Review* , 169-189.

Singer, P. (2001/02). Corporate Warriors. The Rise of the Privitized Military Industry and Its Ramifications for International Security. *International Security* , 186-220.

Skelcher, C. (2005). Public-Private Partnerships and Hybridity. W L. E. Ewan Ferlie, *The Oxford Handbook of Public Management* (pages 347-370). New York: Oxford University Press.

Stoker, G. (1995). Regime Theory and Urban Politics. W D. Judge, & G. Stoker, *Theories of Urban Politics.* London: Sage.

Tetrevova, L. (2006). Theoretical and Practical Ascpects of PPP Projects. *Vadyba/Management* , 105-110.

Van Slyke, D. (2003). *Sharing Power: Public Governance and Private Markets.* Washington DC: Brookings.

Wallace, H. (2010). An Institutional anatomy and Five Policy Modes. W H. Wallace, M. Pollack, & A. Young, *Policy-Making in the European Union* (strony 69-107). New York: Oxford University Press.

Walsh, K. (1995). *Public Services and Market Mechanisms: Competition, Contracting and the New Public Management.* Basingstoke: Macmillan.