A comparative policy analysis of healthcare PPPs: Examining evidence from two Spanish regions from an international perspective

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Abstract

As demand for public healthcare grows and government budgets are squeezed, many countries find policies involving private sector delivery of clinical services increasingly attractive. We take a critical analysis approach to examine the organisational and financial arrangements of healthcare PPPs from two regions in Spain. Our comparative policy analysis shows that competent learning from cross-national experience is complex because in practice it is difficult to identify specific institutional factors, evaluate operational costs, and determine whether risks have transferred. Care is needed to avoid unwarranted inferences that this policy will deliver the claimed benefits of lower costs whilst maintaining sustainable quality.

Key words: comparative policy, public-private partnerships, financial statement analysis, Spain, healthcare, Alzira model
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Introduction

In the aftermath of the financial crisis governments, facing declining budgets, have been investigating new approaches to working with the private sector to deliver public services. Whilst international attention has largely focused on large infrastructure projects in transport, rapidly increasing demand for healthcare has added pressure to marketise these services. Based on New Public Management (NPM) rhetoric, governments have been urged to transform traditional models of public healthcare provision so that they are sustainable for the future (The Global Health Group 2010).

As in other sectors, one marketising mechanism is public-private partnership (PPP), which has many forms that have adapted over time. But some healthcare PPPs represent a fundamental step up from the Public Finance Initiative (PFI) style long-term contracts generally used to provide infrastructure and/or peripheral services only. Healthcare provides the opportunity to expand into the delivery of core clinical services, thus giving the private sector access to extremely attractive revenue streams. For example, in OECD countries healthcare spending is set to rise as a percentage of GDP from 9.9% in 2010 to 14.4% in 2020 (PwC 2010). Significantly, the infrastructure element only represents 5% of this spending, so that a shift to also deliver clinical services will open up a huge market estimated to be worth $68.1 trillion (PwC 2010: 9).

1 The original paper on which this article is based was presented at the Vancouver Conference in the Public Private Partnership Conference Series CBS-Sauder-Monash, June 2013.
However, contracts that also include clinical services provision substantially shift the public sector’s role from being a provider to a commissioner of healthcare. Even though the public sector retains responsibility for and continues to fund service delivery, the private sector now has a much enhanced role through the opportunity to manage full service provision.

This article examines the case of Spain, as it has been the international leader in using this kind of model of PPP in healthcare that integrates the provision of clinical services in a contract with the private sector to finance, construct and operate a hospital building. This model may also deliver primary healthcare services. The literature refers to it as the “Alzira model”, after the name of the Valencian town in which the first such hospital was located in 1999. The Valencia region was followed by the Madrid region in 2007.

The purpose of this paper is to take a critical analysis approach to examine the organisational and financial arrangements of these healthcare PPPs in Spain. The examination of these arrangements seeks to address Hodge et al.’s (2010) call for further analysis of PPP policy performance, including investigation of the private partner perspective. This paper focuses on the financial, rather than the operational or social, performance. It draws on and extends Acerete et al.’s (2011) critical study of the “Alzira model”, by analysing financial and other information in the public domain. The approach is adapted from the organisational and financial approach used by Edwards et al. (2004) in the first extensive evaluation of the operation of PFI in roads and hospitals. The present analysis shows how the financial performance has varied over time and between the two Spanish regions. To emphasise that such variability is not specific to Spain the paper also provides a short comparison with other similar international healthcare PPPs.
However, very significantly, the study identifies differences in the model as adopted by the Valencia and Madrid regions meaning that even within Spain cross-regional comparisons of performance are not straightforward. Furthermore, we identify two highly specific aspects of the Spanish PPP environment, which affect the risks and costs of the Spanish projects in ways that are unlikely to be replicated in other countries. Therefore, we conclude that great care is needed to avoid unwarranted inferences that this policy will transfer internationally to deliver the claimed benefits of lower costs whilst maintaining sustainable quality.

The article develops as follows. Section two introduces the background to the Spanish regional cases. Section three gives details of the research method. Section four presents the evidence and findings and gives a brief comparison with other international cases. Section five provides a discussion and brief conclusion.

**Background to the Spanish cases**

Within Spain there has been considerable expansion of the healthcare PPP market. Development of PPPs has been attractive due to the need to keep debt off the government balance sheet following the Maastricht Treaty (Allard and Trabant 2008, Benito et al. 2008), combined with the right wing People’s Party coming to power in 1996. From an ideological perspective this Party wished to see greater use of the private sector in the delivery of public services. However implementation of PPPs has not been carried out in a systematic way. In contrast to Rachwalski and Ross’ (2010) finding that a special purpose agency is critical in kick-starting a PPP programme, Allard and Trabant (2008:8) instead criticise the government’s approach to PPPs as being “a ‘hands off’ search for private financing”. That is, it is an example of Boardman and...
Vining’s (2010) “rent the money” argument of giving an opportunity for cash-strapped governments to push more spending to the future. Consequently, the recommended structures for managing the policy, such as a specific PPP unit, model standardised contracts, a public sector comparator, and any method of project evaluation, are missing.

Legal changes driven by the Ministry of Health were necessary to enable the policy to be implemented, firstly to enable the separation of financing, purchasing and provision of health services, and then to enable the private sector to be involved in the provision of free and universal public healthcare. The law, which requires that a healthcare services company should be one of the members of the partnership, meant that for the first time the private sector could enter into contracts to self-manage hospitals. Some regional governments have also enacted their own legislation, thus leading to a fragmentation of PPP policy throughout the country.

The right-wing Valencian government was the first to take advantage of this new opportunity, entering into an administrative concession in 1997 with a joint venture consortium to construct and operate the Alzira hospital. The Madrid region followed with the Valdemoro healthcare contract in 2007. The policy is generally explained as an attempt to limit costs and move away from the inefficiencies of public sector employment contracts, although this is rarely achieved in practice (Acerete et al. 2009, 2010; Alonso et al. 2013).

The “Alzira model” has attracted considerable international attention and other countries have implemented similar schemes or have considered doing so. However, before drawing on the Spanish experience it is important to recognise that there are two highly specific features of the

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2 Law 15/1997, 25 April, to authorise new forms of management in the National Health System.
Spanish environment that may affect the way in which this model transfers to other countries and which may distort international comparisons of performance. Firstly, before the financial crisis, regional savings banks were closely involved in the financing and equity investment in these Spanish healthcare PPPs. These banks were originally charitable institutions, typically operating in a geographical region, and without formal owners. They were governed by a Board and a General Assembly, both consisting of representatives from different groups of stakeholders: depositors, local and regional governments, employees and founding institutions. They were non-profit making and governed by a separate Spanish law, which required them to invest their surpluses in works of social interest and other strategic actions to encourage regional socio-economic development. Representatives of the ruling political parties within a region could hold up to 50% of the votes in the governing body. This circumstance created the opportunity for the politicisation of corporate governance mechanisms (Ysa et al. 2012), meaning that politicians were able to dominate bank strategy. Contributions to regional development thus became the overriding goal for some savings banks (García-Cestona and Surroca 2008).

To understand the true risks and cost of financing of the many Spanish PPPs which pre-date the financial crisis it is essential to understand this relationship between the savings banks, regional politics and infrastructure investment that is unlikely to be replicated in other countries. As the financial crisis took effect it became apparent that this relationship may have led to some extremely risky investment decisions attributable to weak governance mechanisms and poor performance monitoring (Grifell-Tatjé 2011). Ultimately the fall-out from the financial crisis has led to the replacement of governance systems following extensive restructuring of the savings banks, which are now quite similar in nature to private commercial banks.
The second specific feature of the Spanish environment is the generous civil service contracts on which doctors and nurses are employed in public hospitals. Pay is higher than the OECD average, whilst working hours are less, and it is widely known that the Spanish public sector is bloated and unproductive (Pin et al. 2012). This environment offers scope for potentially operationalising efficiency savings on labour by the involvement of the private sector through the PPP. Acerete et al. (2011: 245) compare staff ratios between the Alzira PPP hospital and a similar-sized public hospital, reporting that the former employs 1,176 staff compared to the 1,800 employed by the public hospital. Although it is not possible to obtain the information to directly compare labour costs, Acerete et al. (2011: 542) show that in 2008 the “Alzira model” offered a saving of around 28% per head compared to public healthcare. An ex-director of Capio, a major healthcare PPP player in Spain, acknowledged that the private sector contracts of employment have worse terms and conditions, including less job security, lower pay scales and longer working hours, creating productivity increases of around 20-30% over the public sector (El País, 06/01/13). Savings of this nature may not be replicable in other countries, so expectations about the outcomes of policy transfer ought to be tested against realistic assessments of potential savings within a specific country context.

**Research method and methodology**

Our critical analysis is based on the evaluation of organisational and financial arrangements. We collect and evaluate publicly available financial and other contractual information about Valencian and Madrid healthcare PPPs. This information is then briefly compared with other international examples. In doing so we are interested in examining the effects of underlying organisational and financial arrangements on the financial performance of healthcare PPPs.
We start by considering what we would regard as desirable information to understand the financial performance of these PPPs, drawing on Shaoul et al. (2008), who recommended improved disclosure in the areas of governance and accountability mechanisms, better quality annual public sector information, better disclosure of routine information held by the public sector about the private sector partners and improved disclosure of information about business cases and project reviews. Shaoul et al. (2012) identify such information as one element of their governance-based reporting framework, without which it is not possible to evaluate whether contracts, and therefore public expenditure, are sustainable.

However this information is located within many different entities in both public and private sectors. PPPs are examples of what Miller et al. (2008:85) call “regulated hybrids”. They straddle the boundaries between the public and private sectors, being private sector entities which deliver public services paid for out of public funds, and they have organisational structures containing characteristics from both public and private sectors. This configuration of entities makes them generally problematical in terms of locating information. For example, a systematic search to establish what quantitative and qualitative information was available in the Spanish public domain quickly proved to be of limited use. There is no national PPP database, and sector information is also lacking. Spain operates a federal system of government, with each autonomous community having complete authority regarding healthcare issues. Policies therefore vary between regions. We examined the regional government websites for Madrid and the Valencian Community, however they did not show any systematic information. Instead we
used search engines and relevant government and company websites to carry out extensive, but ad hoc, searches.

We sought to analyse financial statements from both the public and private sector. Since Spain has yet to fully address issues of fiscal transparency such as those raised by the OECD (Heald 2012), financial statements for the regional governments’ departments of health and publicly funded hospitals are not publicly available. It is therefore impossible to examine payments made to concessionaires or to compare costs between public hospitals and PPPs. The departments of health do publish some factual statistical information relating to the performance of publicly funded hospitals. However the concessionaires do not publish their information in the same format, meaning that like-for-like comparison is impossible.

As regards the private sector operators, these have been constituted in two different forms. Some have been organised as joint venture-style operations (Uniones Temporales de Empresas - UTEs) which under Spanish law are not required to produce separate financial statements. The parent companies are however required to show details of the UTEs in their notes to the financial statements, based on the proportion of ownership. More recent concessions provide separate financial statements as they have been constituted as limited companies, presumably because this corporate form offers shareholders the legal opportunity to ring-fence liabilities at the level of the Special Purpose Vehicle (SPV) set up for the concession.

For financial analysis, our sample consists of five Valencian projects which all have Ribera Salud S.A. as their parent, and two Madrid hospitals (Valdemoro and Torrejón), as sufficient
financial statements to offer meaningful analysis for any others are not yet available. The earliest two are constituted as joint ventures, whilst the more recent cases are private limited companies. Relevant company financial statements were purchased from each region’s Commercial Registry Office, the latest available year being 2011.

**Empirical evidence for Valencian and Madrid healthcare PPPs**

**Organisational arrangements**

Table 1 shows the healthcare PPPs implemented by Valencia and Madrid, both ruled by the right wing People’s Party since 1995. Valencia opened the pioneering Alzira hospital in January 1999, with a long gap until the next hospital, Torrevieja, opened in 2006. The reason for the gap is unclear, as the Valencian government has been extremely pleased with the performance of Alzira, claiming that it costs around 25% less per capita than the publicly managed hospitals (Bes 2009). A further three hospitals have now opened.

Insert Table 1 about here

Madrid was later in pursuing healthcare PPPs, opening the Valdemoro hospital in 2007, Torrejón in 2011 and Móstoles in 2012. Similar to Valencia, ruling politicians claim potential savings of 25%, although there is no economically sound study to support this. Collado Villalba has been ready to open since the beginning of 2013 but remains closed, due, it is assumed, to public budget constraints (El País 24/10/2013)\(^3\). However the regional government pays €900k per month to the concessionaire for the maintenance of the infrastructure and equipment, an example of poor contracting which satisfies neither party, as whilst the regional government must pay

\(^3\) It finally opened in October 2014.
towards a service which is not delivered, the private sector partner is also incurring losses through not receiving any payment towards clinical services.

Differences in healthcare model

Differences in the healthcare model between the two Spanish regions mean that robust comparisons between PPPs in different regions are difficult. But, especially from an international perspective, it is important to recognise that these differences are not immediately obvious because reliable contract information is limited. This lack of information stands in contrast to jurisdictions such as the UK and Australia where standard contracts, albeit with some information redacted, are publicly available on government websites. The next three subsections highlight differences in relation to the contracts, the payment mechanisms and the partners.

Contract scope and duration

In Valencia, following the failure of the first Alzira contract, the contract was widened to include the full healthcare provision, both primary and specialist, within the corresponding health area of each hospital. We define this contract as an “Integral Healthcare” contract. In Madrid, the contract only includes the specialist healthcare services provided by the hospital, and we define this as a “Specialist Healthcare” contract. The reasoning behind the choices made is unclear. We have been unable to find any publicly available evidence relating to how the Valencian regional government determined its policy. In relation to Madrid, the Regional Audit Office (Cámara de Cuentas de las Comunidad de Madrid 2010) has been critical of the lack of government explanations as to its choice of healthcare provision, stating that whilst there are viability studies available to justify the need for the projects, the government has not provided any evidence to
explain how they justified both the system chosen and the form of financing it. It states that “all in all, the Administration has not provided evidence which, in terms of economy, efficiency and effectiveness, analyses the terms of the different management models, comparing them against each other as well as against a publicly funded hospital” (Our translation).

Contract duration also differs, with Valencian contracts being awarded for 15 years (extendible for five more years), whilst Madrid contracts are for 30 years.

*Capitation fee*

In both regions contracts are paid for on the basis of a capitation fee supplemented with a system of deductions for residents being treated at other hospitals and additions for patients coming in from other areas to be treated. In Valencia a single capitation fee, per year per resident in the relevant health area is payable. In Madrid, publicly available information is sketchy, but for the last three contracts awarded the capitation fee has two components: “per capita” for the clinical delivery and a maximum annual amount per person for the non-clinical services.

Details of the capitation charges for Alzira and Valdemoro, the oldest contracts in each region, are available in the online Appendix. For the Alzira contract the basis for the annual increase is linked to the increase in the general health budget for Valencia, being generous prior to the financial crisis and dropping substantially in 2010 and thereafter. The increases for Valdemoro are more volatile and we are unable to explain these.
Such a system inevitably has inherent perverse incentives. For example, managers are incentivised to “cherrypick” the most profitable medical and surgical specialities. Cost savings that internalize benefits for the private partner are encouraged, even though such savings can incentivise choices such as less expensive treatments and the prescription of medicines as an alternative to hospitalisation. There is thus a significant public interest in oversight in this area.

*Composition of consortia*

The composition of consortia differs between regions, and possibly also between Spain and other countries. Firstly, Spanish law requires healthcare PPPs to have a healthcare services company as one of the parties in the consortium that undertakes the contract. Figure 1 plots the shareholder structure of consortia that implement the contracts and the interrelationships between all of them. Healthcare services companies involved are Spanish companies Adeslas, Asisa, IDCSalud and Sanitas; DKV, which is German by origin; and Swedish Capio (although it has now sold its holding to IDCSalud). The underlying strategy for most of these companies, and their ultimate owners, has been to enter the Spanish market, if an outsider, and then work to develop that market, for example, the UK company BUPA acquired Sanitas for this reason (Lethbridge 2011).

In Madrid, three of the four specialised healthcare contracts are delivered by IDCSalud, which is now owned by CVC Capital Partners, a very large UK private equity firm. In the case of Valencia, Ribera Salud maintains a control position, as it has its origins in the Alzira contract, and it is owned by two regional savings banks now integrated into two private commercial banks. The other main parent companies of Valencian SPVs are Spanish healthcare service companies. The market is thus dominated by a relatively small number of companies who have shared out the market (autonomous regions) without involving themselves in conflict.
Secondly, regional savings banks (Bancaja, CAM) are the shareholders of Ribera Salud, which is in turn the shareholder in all of the Valencian healthcare PPPs plus one in Madrid (see Figure 1). This relationship means that the contracts between the regional governments and Ribera Salud are in substance public-public contracts, due to the domination of regional savings bank strategy by local and regional politicians prior to the restructuring of 2012/3. Furthermore, as Bankia, a major shareholder of Ribera Salud as a result of the acquisition of Bancaja, has received significant government bailout funds, this fact signals a lack of independence from the government. As Acerete et al. (2011) explained in relation to the Alzira contract, there is thus increased risk for the regional government. Consequently, the implication is that again public oversight is a concern. Indeed during their 2011 study visit to the Alzira hospital, the UK NHS Confederation expressed unease about the strength of the links between the government and Ribera Salud. The participants, whose purpose was to understand whether the model would be suitable for implementation in the UK, commented that they “were concerned that to a certain extent the representatives of the Valencia community administration were very close to the concession holders, which could reduce the effectiveness of the oversight they were providing” (NHS Confederation 2011:15).

Financial information

Our analysis first examines selected figures for the years 2008-2011 drawn from the notes to the financial statements of Ribera Salud S.A. and Capio Valdemoro S.A., in relation to the Alzira
and Valdemoro hospitals (see Table 2). Regarding Alzira, as predicted by Acerete et al. (2011, 2012), profits as a percentage of revenue are falling following the austerity cuts, as is return on equity, despite annual decreases in the amount of debt and hence finance expenses. For Valdemoro, although in the last two years the capitation fee increases are higher than in Alzira, there are losses for all complete operational years, resulting in negative equity by 2011. Its parent company has had to provide an equity loan of €78m to prevent insolvency.

Analysis of equity and debt

Table 3 shows the figures for Alzira and other healthcare PPPs with significant ownership by Ribera Salud for the year 2011 and, for comparison, Valdemoro, the oldest Madrid PPP hospital. With the exception of Alzira and Valdemoro there are extremely high levels of debt, however by 2011 it is only Valdemoro which is lossmaking. As equity is low in proportion to total capital employed, this relationship means that return on equity is very high in most of the concessions, making them attractive to private equity funds seeking to maximise shareholder value.

Operational efficiency

As the Integrated and Specialist contracts differ, and there is insufficient publicly available information to explain contracts in detail, it is difficult to examine the NPM based claim that these healthcare PPPs offer better efficiency. Indeed, Alonso et al. (2013), in their study across all types of Madrid hospital, suggest that it is management itself, not hospital model, which
determines operational efficiency. Lack of information also means it is impossible to produce a like-for-like comparison. For example, some costs are excluded from the PPP contracts and are still borne by the public sector, such as out-patient pharmacy, oxygen, transplants and transport. But as the precise details vary between contracts cost comparison is distorted. There may also be “invisible” monitoring costs paid for by the public sector. For example, at Alzira there is a commissioner appointed to monitor the contract but this cost is hidden.

Moreover, whilst there can be some labour savings due to worse terms and conditions of employment for doctors and nurses (Acerete et al. 2011), management costs can be higher. For example, at Marina Salud (Denia) management costs are €977,380, while similar costs for a public hospital total €277,638. In particular, the Marina Salud manager earns €148,570, while the salary of a manager in a public hospital ranges from €52,525 to €55,391 (El País 13/06/2013).

**Analysis of overall success**

To summarise our analysis of financial performance, whilst there is some evidence of successful delivery of cheaper healthcare in Valencia, it is due to specific circumstances that are unlikely to apply internationally. These include savings compared to public sector labour, the inclusion of primary healthcare and some cherrypicking of profitable services. In contrast, the Valdemoro contract, which excludes primary healthcare, is unable to generate any profits, even before finance expenses are paid. The profits earned by those contracts involving Ribera Salud as a partner are also affected by the close relationship with the savings banks. Notably the equity element invested by Ribera Salud, at around 25% of overall capital, is well in excess of the percentage usually invested in PPPs by the private sector partner, which tends to be in the order
of 1-10% equity to 90-99% debt. In addition, the savings banks have supplied debt at preferential rates of interest in some years below the equivalent rate of interest for a Spanish public debt 10 year bond (Acerete et al. 2011). Consequently, profits have been boosted as interest payments have been artificially low. This fact contrasts with Valdemoro’s loss-making performance, exacerbated by its much higher debt-to-equity profile.

**Analysis of public accountability**

Given that the regional governments are still responsible for the public healthcare delivered by these PPPs, we have noted above the need for proper oversight. However, once PPPs become operational, there is a lack of public accountability. There are no publicly available formal reports on performance in relation to these administrative concessions. Indeed the possibilities for monitoring are limited by the terms of the contract, as the NHS Confederation (2011:15) report explains: “in this model, the commissioner confines the contract to the specification of outcome measures and only a small number of process measures.” The NHS participants also note that the regional health department’s formal powers are more limited than is the case elsewhere, for example in the UK.

There is no systematic way of finding any scrutiny about the policy or contracts. Acerete et al. (2011), in their financial analysis of the ‘Alzira model’, were only able to find reference to that contract, for the years 1999 to 2004, in the reports from the regional auditor about the health care programs of the regional health department, by carrying out extensive searches on its website. Further information was obtained from a relevant trade union, Sindicato de Médicos de
Asistencia Pública (SIMAP), and through examining press articles. The present authors’ searches failed to find any relevant reports relating to other Valencian contracts.

Similarly, there is no systematic control at Valdemoro. In 2010, the Madrid Regional Audit office published a single control report about the budget for specialist healthcare relating to 2007. The report recommended that the regional health department should reinforce its control and in particular should guarantee that specialist healthcare at Valdemoro is delivered under conditions of “equity and equality” for all citizens. The implication of such a recommendation is that it was not being provided in this way at the time of writing.

Even where there is robust scrutiny, this may not lead to government action or even a response. For example, although the Valencian Regional Audit Office (2002) was highly critical of the government’s role in the Alzira contract renegotiation, we were unable to find any formal response to this report.

**Comparison with international cases**

Six countries, in addition to Spain, have signed PPPs that include core health care services (Global Health Group 2010). While apparently similar, the schemes have different objectives and, as in Spain, the practicalities and outcomes are variable.

The Turks and Caicos Islands (TCI) planned two small new hospitals to reduce referrals outside the Islands. This objective was achieved but these facilities are under-utilised and in terms of its financial performance the project is now described as unaffordable. The government is seeking
to increase the amounts of co-payments made by local patients, and is negotiating with its private sector partner to achieve cost reductions, although the partner has made clear that the contract is not up for re-negotiation. Therefore the government is considering encouraging health tourism by overseas patients.

Lesotho had an urgent need to replace its deteriorating main public hospital. Again this objective was achieved; however, the Lesotho contract also hit a capacity problem, albeit of a different nature, which affected financial performance. This contract specifies a maximum of 20,000 inpatients and 310,000 out-patients per year, although all patients that present will be treated so that the government could be faced with additional-to-contract costs. In 2012, the first year of operation, these limits were exceeded - 24,247 inpatients and 404,400 outpatients received healthcare (Public Eye 2013). This excess immediately triggered additional cost, but the extent of this additional-to-contract cost is not in the public domain. Of even greater concern is the contractual arrangement which does include any control mechanism over the price that the private sector can charge for providing such additional services (Lister 2011).

Although Australia has been proactive in implementing various forms of PPP, just four hospital contracts involving clinical services have been signed by three states. Joondalup has been described as the only ray of sunlight in terms of Australian contracting for hospitals (Duckett 2013), although an Auditor General’s report (Auditor General 2000) did raise a number of issues about its financial and operational performance. But Mildura, like LaTrobe and Port Macquaire before it, is to be taken back into public ownership in 2015.

The Limpopo provincial government initiated a single specialist renal dialysis project that was to be a benchmark for future South African projects. While this project was operationally
successful, especially because it reduces patient travel, no further PPPs with clinical services have been signed. The Department of Health is said to have become averse to this type of contract, so that market operators do not expect full service hospital contracts to follow (Kannegiesser 2009). The reason for this aversion is not clear but the experience of Romania, which initially planned eight renal dialysis units, may be relevant. After the initial eight renal facilities, signed with four separate contractors, the government began to roll out a nationwide renal programme. This programme has caused the public budget allocated to dialysis to increase from approximately €49.6m in 2005 to €147.6m. This must raise questions about financial sustainability at a time when competition is reducing as the market becomes concentrated. For example, a proposed merger would give the Fresenius group a 40% market share (HARE 2013).

By 2002 the Portuguese government had announced ten hospitals over two waves, but as was also the case in the TCI, Portugal hit problems related to the risks associated with providing clinical services. The Global Health Group noted that negotiations between the public and private sectors about the clinical services component caused a continuous process of advancing and retreating that earned harsh criticism from the Portuguese Court of Auditors⁴ regarding delays, the model chosen and the lack of control by the state (dos Reis Raposo, and de Jesus Harfouche 2012). De Sousa (2012) noted that banks’ involvement in Portugal was contingent upon sponsor guarantees and ceilings on corporate risk because banks were unwilling to take clinical risk. Furthermore, she argued, because the market’s capacity to absorb clinical risk was quickly exhausted the field of bidders reduced to sponsors with local clinical experience. In 2005 the Portuguese government moved to infrastructure-only contracts - just four PPPs were signed including clinical services. In the TCI the PPP’s organisation structure was mobilised to

⁴ Court of Auditors, Relatorio de auditorio 15/2009).
overcome the banks aversion to taking clinical risk. The winning bidder formed two subsidiaries. The first subsidiary held the infrastructure related risks while the second carried the clinical risk and delivered the primary, secondary, lower tertiary and emergency services. Nevertheless, despite the separation of risks the banks retain recourse to both SPVs (Smith 2008).

Organisational arrangements

While these apparently similar projects exhibit quite different characteristics and outcomes, from a public accountability perspective they do share one common feature. Typically the contract is signed with an SPV that is a subsidiary company inside a complex group structure, so that the relevant financial information is consolidated and is either not separately disclosed or is not readily accessible to the public. For example, the South African project was awarded to Clinix Renal Care (Pty) Ltd, which is a subsidiary of Fresenius Medical Care South Africa (Pty) Ltd, which is in turn a 100% owned subsidiary of Fresenius Medical Care AG & Co. KGaA. The financial arrangements of the Joondalup project are even more complex. The contract was awarded to Joondalup Hospital Pty Limited, a wholly owned subsidiary of Ramsay Health Care Limited. Together with some one hundred other subsidiary companies, these two companies entered into a deed of cross guarantee, resulting in a closed group that is able to take advantage of relief under Class Order CO 98/1418. The implication is that Joondalup Hospital Pty Limited need not prepare and lodge audited financial statements (Ramsay Health Care Limited Financial Statements June 2013). The rational for providing this relief is that the deed of cross guarantee makes the group akin to a single entity and therefore creditors and potential investors can focus on the consolidated position (ASIC 2013). However, in the context of PPP the aggregation found in consolidated accounts means that the performance of any given hospital is invisible.
Availability of financial information

Financial information in the public domain is not always consistent, verifiable or transparent. For example, many supporters’ websites suggest the Lesotho project cost US$120 million, whereas elsewhere the cost is shown as US$ 155 million (PwC 2013). The split of the US$ 32.6 million annual repayments between capital repayment, interest costs and service charges, which will increase with inflation is deemed to be too commercially sensitive to release into the public domain (PwC 2013). Consequently, there is uncertainty about how the new charges for services compare with the previous hospital’s budget of US$ 17 million in 2007/08.

In summary, the financial performance of these international projects throws out some cautionary experiences. Interestingly, governments appear reluctant to initiate new PPPs involving clinical services, even when existing projects appear to achieve their operational objectives.

Discussion and conclusion

Carrying out comparative policy analysis of healthcare PPPs in two Spanish regions, and then drawing some international comparisons, is difficult. There are differing contractual arrangements and opaque political links. Key financial information is difficult to procure, as it is usually not available from the government and is only available in a limited form from private sector reporting. This lack of information restricts opportunities for detailed cost and efficiency comparison. Monitoring takes place in relation to a limited set of outcomes, and reports are not publicly available. It is difficult to find the few ad hoc scrutiny reports that have been compiled. Overall the implication is that international comparability of healthcare PPPs is compromised.
Our comparative analysis draws four linked conclusions from the evidence presented above. First, the analysis highlights the complex nature of the organisational structures employed, making it difficult to access relevant information and to draw comparable conclusions. The opacity of financial statements means that private sector partners can obscure the effect of any opportunism. The inclusion of regional savings banks as shareholders involved in all the Valencian and one Madrid contract, and cross guarantees within groups, further complicates the financial story.

Second, our study shows that simplistic notions of success regarding these contracts do not transfer across regions in Spain, nor internationally. So whilst the Alzira contract has been profitable since 2003, and all the other Valencian contracts became profitable by 2011, Valdemoro, which follows a different model, continues to make losses. Internationally Joondalup is a rare success story. Other Australian contracts have failed and returned to public sector management, whilst Portugal has not pursued the full healthcare model due to problems writing contracts for clinical services.

Third, it is noticeable that the Valencian integrated contracts, where both primary and specialist healthcare are included in the capitation model, have performed the best, as this model best incentivises the provider to make healthcare efficient for the whole episode of care (Monrad 1995). It is unclear why other jurisdictions have failed to incorporate this important aspect of the Valencian contracts.
Fourth, there is a lack of operational stability and sustainability, made worse by the financial crisis. The Alzira contract shows declining profits, as the initially generous increases in capitation fee have been replaced by very small increases due to austerity cuts. Madrid cannot pay the clinical costs for Collado Villalba which remains closed, leading to losses for the private operator. Valdemoro continues to make losses. Internationally Lesotho and TCI already find their contracts unaffordable and Romania has trebled its budget spend on specialist renal care. The increasing presence of private equity companies in the healthcare PPP market, with their appetite for extracting value out of their investments, raises further concerns for governments about the long term stability of the market.

Internationally governments are pressing ahead with the implementation of healthcare PPPs, but this analysis challenges simplistic assumptions about cross-country policy comparisons and shows that care is needed to avoid unwarranted inferences about claimed benefits of lower costs whilst maintaining sustainable quality. Rather, these are projects that continue to carry ongoing risks for all governments.
Bibliography


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PwC, 2013, Health System Innovation in Lesotho, Health Case PPP Series No.1, PwC.


<table>
<thead>
<tr>
<th>PROJECT</th>
<th>OPENING DATE</th>
<th>PARENT COMPANIES (at start date)</th>
<th>INVESTMENT (m€)</th>
</tr>
</thead>
<tbody>
<tr>
<td>VALENCIA: PPP INTEGRATED HEALTHCARE CONTRACTS</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 1 Alzira | 1999 | -Adeslas 51%  
-Ribera Salud 45%  
-construction companies 4% | 70 |
| 2 Torrevieja | 2006 | -Ribera Salud 40%  
-Asisa 35%  
-CM Salud 10%  
-construction companies 15% | 70-80 |
| 3 Denia | 2008 | -DKV 65%  
-Ribera Salud 35% | 95 |
| 4 Manises | 2009 | -Sanitas 60%  
-Ribera Salud 40% | 90 |
| 5 Elche-Crevillente | 2010 | -Ribera Salud 60%  
-Asisa 40% | 146 |
| MADRID: PPP SPECIALIST HEALTHCARE CONTRACTS |
| 6 Infanta Elena (Valdemoro) | 2007 | -CAPIO Salud 100% | 65 |
| 7 Torrejón | 2011 | -Ribera Salud 60%  
-Asisa 25%  
-Concessia 10%  
-FCC 5% | 113 |
| 8 Rey Juan Carlos (Móstoles) | 2012 | -CAPIO Salud 99%  
-technical companies 1% | 232 |
| 9 Collado Villalba | 2014 | -CAPIO Salud 99%  
-technical companies 1% | 109 |

More detailed information is available in an on-line Appendix.
Table 2  Performance of Alzira and Valdemoro Healthcare PPPs 2008-2011

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2010</th>
<th>2009</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>€000</td>
<td>% rev</td>
<td>€000</td>
<td>% rev</td>
</tr>
<tr>
<td><strong>ALZIRA</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revenue</td>
<td>181,362</td>
<td>0.9%</td>
<td>194,316</td>
<td>1.1%</td>
</tr>
<tr>
<td>Profit before tax</td>
<td>1,636</td>
<td>0.9%</td>
<td>2,093</td>
<td>1.1%</td>
</tr>
<tr>
<td>Finance expenses</td>
<td>484</td>
<td>0.3%</td>
<td>502</td>
<td>0.3%</td>
</tr>
<tr>
<td>Profit for the year</td>
<td>1,638</td>
<td>0.9%</td>
<td>1,869</td>
<td>1.0%</td>
</tr>
<tr>
<td>Equity</td>
<td>46,631</td>
<td>0.9%</td>
<td>42,324</td>
<td>1.1%</td>
</tr>
<tr>
<td>Debt</td>
<td>5,196</td>
<td>0.3%</td>
<td>12,731</td>
<td>0.3%</td>
</tr>
<tr>
<td>Finance/debt</td>
<td>9.3%</td>
<td>3.9%</td>
<td>5.5%</td>
<td>4.3%</td>
</tr>
<tr>
<td>Debt/Equity</td>
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<td>30%</td>
<td>28%</td>
<td>47%</td>
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<tr>
<td>Return on Equity</td>
<td>3.5%</td>
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<td>6.1%</td>
<td>8.8%</td>
</tr>
<tr>
<td><strong>VALDEMO RO</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revenue</td>
<td>45,487</td>
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<tr>
<td>Debt</td>
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<td>63,710</td>
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</tr>
<tr>
<td>Finance/debt</td>
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<td>7.5%</td>
</tr>
<tr>
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<tr>
<td>Return on Equity</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
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</table>

Source: Ribera Salud S.A. and Capio Valdemoro S.A. financial statements, various years
Table 3  Performance of Valencia and Madrid Healthcare PPPs 2011

<table>
<thead>
<tr>
<th></th>
<th>Alzira</th>
<th>Torrevieja</th>
<th>Marina Salud (Denia)</th>
<th>Manises</th>
<th>Elche-Crevillente</th>
<th>Valdemoro</th>
<th>Torrejón</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>€000</td>
<td>% rev</td>
<td>€000</td>
<td>% rev</td>
<td>€000</td>
<td>% rev</td>
<td>€000</td>
</tr>
<tr>
<td>Revenue</td>
<td>181,362</td>
<td>4.9%</td>
<td>124,969</td>
<td>3.9%</td>
<td>111,039</td>
<td>5.8%</td>
<td>120,248</td>
</tr>
<tr>
<td>Profit before tax</td>
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<td>5.8%</td>
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<td>3.9%</td>
<td>4,465</td>
<td>4.0%</td>
<td>8,234</td>
</tr>
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<td>46,631</td>
<td>11,100</td>
<td>7,071</td>
<td>3,709</td>
<td>10,313</td>
<td>-8,006</td>
<td>14,082</td>
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<tr>
<td>Debt</td>
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<td>72,604</td>
<td>76,588</td>
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<tr>
<td>Finance/debt</td>
<td>9.3%</td>
<td>6.8%</td>
<td>4.9%</td>
<td>4.70%</td>
<td>16%</td>
<td>7.9%</td>
<td>6%</td>
</tr>
<tr>
<td>Debt/Equity</td>
<td>11%</td>
<td>620%</td>
<td>1,197%</td>
<td>2,550%</td>
<td>333%</td>
<td>n/a</td>
<td>544%</td>
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<tr>
<td>Return on Equity</td>
<td>3.5%</td>
<td>44%</td>
<td>63%</td>
<td>70%</td>
<td>16%</td>
<td>n/a</td>
<td>6.50%</td>
</tr>
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</table>

Source: Financial statements of companies 2011. Comparable figures for 2010 are available in the online appendix.
Figure 1. Ultimate parent companies of Spanish healthcare PPPs.

- Bancaja (Bankia)
- CAM (Banco de Sabadell)
- Ribera Salud S.A.
- L’Horta-Manises S.A.
- Sanitas
- BUPA Ltd.

- Ribera Salud UTE
- Marina Salud S.A.
- Elche-Crevillente Salud S.A.
- Torrejón Salud S.A.

- Torrevieja Salud UTE
- La Caixa

- Adeslas
- Asisa
Material for on-line Appendix

Expanded Table 1 Spanish Healthcare PPPs

<table>
<thead>
<tr>
<th>PROJECT</th>
<th>OPENING DATE</th>
<th>SPV</th>
<th>PARENT COMPANIES (as to creation date)</th>
<th>INVESTMENT (m€)</th>
<th>POPULATION</th>
<th>BEDS</th>
<th>YEARS</th>
</tr>
</thead>
<tbody>
<tr>
<td>VALENCIA: PPP INTEGRATED HEALTHCARE CONTRACTS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 1 Alzira | 1999 | Ribera Salud UTE | -Adeslas 51%  
-Ribera Salud 45%  
-construction companies 4% | 70 | 240,000 | 300 | 15+5 |
| 2 Torrevieja | 2006 | Torrevieja Salud UTE | -Ribera Salud 40%  
-Asisa 35%  
-CM Salud 10%  
-construction companies 15% | 70-80 | 155,000 | 239 | 15+5 |
| 3 Denia | 2008 | Marina Salud S.A. | -DKV 65%  
-Ribera Salud 35% | 95 | 130,000 | 240 | 15+5 |
| 4 Manises | 2009 | Especializada y Primaria L’Horta-Manises S.A. | -Sanitas 60%  
-Ribera Salud 40% | 90 | 147,000 | 241 | 15+5 |
| 5 Elche-Crevillente | 2010 | Elche-Crevillente Salud S.A. | -Ribera Salud 60%  
-Asisa 40% | 146 | 140,000 | 212 | 15+5 |
| MADRID: PPP SPECIALIST HEALTHCARE CONTRACTS |
| 6 Infanta Elena (Valdemoro) | 2007 | Capio Valdemoro S.A. | -CAPIO Salud 100% | 65 | 100,000 | 100 | 30 |
| 7 Torrejón | 2011 | Torrejón Salud S.A. | -Ribera Salud 60%  
-Asisa 25%  
-Concessia 10%  
-FCC 5% | 113 | 134,000 | 250 | 30 |
| 8 Rey Juan Carlos (Móstoles) | 2012 | Capio Móstoles S.A. | -CAPIO Salud 99%  
-technical companies 1% | 232 | 171,000 | 260 | 30 |
| 9 Collado Villalba | 2014 | Capio Collado S.A. | -CAPIO Salud 99%  
-technical companies 1% | 109 | 110,000 | 140 | 30 |
Supplementary material on PFI hospitals

Madrid also opened six new Private Finance Initiative (PFI) hospitals in 2008, which were built to fulfil an election pledge. In 2013, despite the problems of the Collado Villalba contract, the regional government has tried to extend the PPP healthcare model to these operational hospitals, carrying out the procurement process and awarding the contracts for each hospital in August.

The consortia selected were: BUPA Sanitas (Henares); HIMA San Pablo, a Puerto Rican health group (Infanta Sofía, Infanta Cristina, Tajo); UTE Ribera Salud-OHL-El Corte Inglés (Infanta Leonor, Sureste). The tender specifications required bidders to take on all the clinical staff (about 5,200 employees) and implied losses of around 4 million euro per hospital during the first three years, at least. Adding the value of the guarantee makes these very risky projects, hence initially no companies tendered. Four days before the submission date the regional government reduced the guarantee to be paid by bidders from €280 million to €28 million. After this reduction, three bidders tendered, and, as each tendered for different contracts, were all awarded the contracts for which they had bid. Various groups (including medical associations, political parties, trade unions) have appealed against the process and the Supreme Court of Madrid has suspended the awarded contracts, primarily because the change in the procedure ‘could have limited free competitive basis’ (Order of the Third Section of the Administrative Litigation Division of the Supreme Court of Justice of Madrid, in response to the Appeal Nº 787/2013, 11/09/2013).
## Winning consortia of new PPP hospitals

<table>
<thead>
<tr>
<th>PROJECT</th>
<th>OPENING DATE</th>
<th>SPV</th>
<th>PARENT COMPANIES</th>
<th>PPP CONTRACT WINNING CONSORTIA</th>
<th>INVESTMENT (€m)</th>
<th>POPULATION</th>
<th>BEDS</th>
<th>YEARS</th>
</tr>
</thead>
<tbody>
<tr>
<td>MADRID: PFI MODEL HOSPITALS to be converted to PPP specialist healthcare contracts</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 Hospital del Henares (Coslada)</td>
<td>2008</td>
<td>Hospital del Noreste S.A.</td>
<td>-Sacyr 100%</td>
<td>BUPA Sanitas</td>
<td>66</td>
<td>170,000</td>
<td>187</td>
<td>30</td>
</tr>
</tbody>
</table>
| 11 Hospital Infanta Sofía (S.S. de los Reyes) | 2008 | Hospital del Norte S.A. | -Acciona 95%  
-Crespo y Blasco 5% | HIMA San Pablo | 98 | 306,000 | 283 | 30 |
| 12 Hospital del Sureste (Arganda) | 2008 | Hospital del Sureste S.A. | -FCC Construcción  
-OHL | UTE Ribera Salud-OHL-El Corte Inglés | 71 | 125,000 | 125 | 30 |
| 13 Hospital Infanta Leonor (Vallecas) | 2008 | Hospital del Vallecas S.A. | -Begar 34%  
-Ploder 36%,  
-Arturo Grupo Cantoblanco 11%  
-Vectrinsa Gestión 10%  
-Sacyr Concesiones 100% | UTE Ribera Salud-OHL-El Corte Inglés | 94.6 | 325,000 | 324 | 30 |
| 14 Hospital Infanta Cristina (Parla) | 2008 | Hospital de Parla S.A. | | HIMA San Pablo | 87 | 130,000 | 238 | 30 |
| 15 Hospital del Tajo (Aranjuez) | 2008 | Hospital del Tajo S.A. | -Sando Concesiones 40%  
-Assignia Infraestructuras 40%  
-Instalaciones Inabensa 20% | HIMA San Pablo | n/a | 70,000 | 122 | 30 |
### Additional Table: Annual capitation fee for Alzira and Valdemoro Healthcare PPPs

<table>
<thead>
<tr>
<th>Year</th>
<th>ALZIRA Capitation fee €</th>
<th>Percentage increase over previous year</th>
<th>VALDEMORO Capitation fee €(*)</th>
<th>Percentage increase over previous year</th>
</tr>
</thead>
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<td>2003</td>
<td>379</td>
<td></td>
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<tr>
<td>2004</td>
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<tr>
<td>2005</td>
<td>455</td>
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</tr>
<tr>
<td>2006</td>
<td>495</td>
<td>8.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2007</td>
<td>535</td>
<td>8.2%</td>
<td></td>
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</tr>
<tr>
<td>2008</td>
<td>572</td>
<td>6.8%</td>
<td>330</td>
<td></td>
</tr>
<tr>
<td>2009</td>
<td>597</td>
<td>4.4%</td>
<td>339</td>
<td>2.8%</td>
</tr>
<tr>
<td>2010</td>
<td>607</td>
<td>1.7%</td>
<td>344</td>
<td>1.5%</td>
</tr>
<tr>
<td>2011</td>
<td>619</td>
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<td>380</td>
<td>10.4%</td>
</tr>
<tr>
<td>2012</td>
<td>639</td>
<td>3.2%</td>
<td>400</td>
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</tr>
<tr>
<td>2013</td>
<td>660</td>
<td>3.3%</td>
<td>432</td>
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</tr>
</tbody>
</table>

(*) Except for 2008, the capitation fee is calculated by dividing the annual budget for the hospital by the population covered.
### Additional material for Table 3  Performance of Valencia and Madrid Healthcare PPPs 2010 and 2011

<table>
<thead>
<tr>
<th></th>
<th>Alzira</th>
<th>Torrevieja</th>
<th>Marina Salud (Denia)</th>
<th>Manises</th>
<th>Elche-Crevillente</th>
<th>Valdemoro</th>
<th>Torrejón</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2010</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>5,857</td>
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<td>8,698</td>
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<tr>
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<td>4.9%</td>
<td>9.2%</td>
<td>13%</td>
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<td>79%</td>
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<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td><strong>2011</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revenue</td>
<td>181,362</td>
<td>124,969</td>
<td>111,039</td>
<td>120,248</td>
<td>108,553</td>
<td>45,487</td>
<td>21,289</td>
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<tr>
<td>Profit before tax</td>
<td>1,636</td>
<td>4,920</td>
<td>6,414</td>
<td>11,729</td>
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<td>4,529</td>
<td>5,588</td>
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<td>Profit for the year</td>
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<td>7,071</td>
<td>3,709</td>
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<td>-8,006</td>
<td>14,082</td>
</tr>
<tr>
<td>Debt</td>
<td>5,196</td>
<td>69,018</td>
<td>84,656</td>
<td>94,584</td>
<td>34,398</td>
<td>72,604</td>
<td>76,588</td>
</tr>
<tr>
<td>Finance/debt</td>
<td>9.3%</td>
<td>6.8%</td>
<td>4.90%</td>
<td>4.70%</td>
<td>16%</td>
<td>7.9%</td>
<td>6%</td>
</tr>
<tr>
<td>Debt/Equity</td>
<td>11%</td>
<td>620%</td>
<td>1,197%</td>
<td>2,550%</td>
<td>333%</td>
<td>n/a</td>
<td>544%</td>
</tr>
<tr>
<td>Return on Equity</td>
<td>3.5%</td>
<td>44%</td>
<td>63%</td>
<td>70%</td>
<td>16%</td>
<td>n/a</td>
<td>6.50%</td>
</tr>
</tbody>
</table>

Source: Financial statements of companies 2010 and 2011.