NSW NURSES & MIDWIVES' ASSOCIATION

NEW SOUTH WALES NURSES AND MIDWIVES' ASSOCIATION
In association with the Australian Nursing and Midwifery Federation

ABN 63 398 164 405
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6 February 2015

Senate Standing Committees on Economics
Parliament House
PO Box 6100
Canberra ACT 2600

Dear Committee Secretary

Incentives to privatise state and territory assets and recycle the proceeds into new infrastructure

The New South Wales Nurses and Midwives' Association (NSWNMA) is the registered union for all nurses and midwives in New South Wales. The membership of the NSWNMA comprises all those who perform nursing and midwifery work. This includes assistants in nursing (who are unregulated), enrolled nurses and registered nurses and midwives at all levels including management and education.

The NSWNMA has approximately 58,000 members and is affiliated to Unions NSW and the Australian Council of Trade Unions. Eligible members of the NSWNMA are also deemed to be members of the New South Wales Branch of the Australian Nursing and Midwifery Federation.

Our role is to protect and advance the interests of nurses and midwives and the nursing and midwifery professions. We are also dedicated to improving standards of patient care and the quality of health and aged care services.

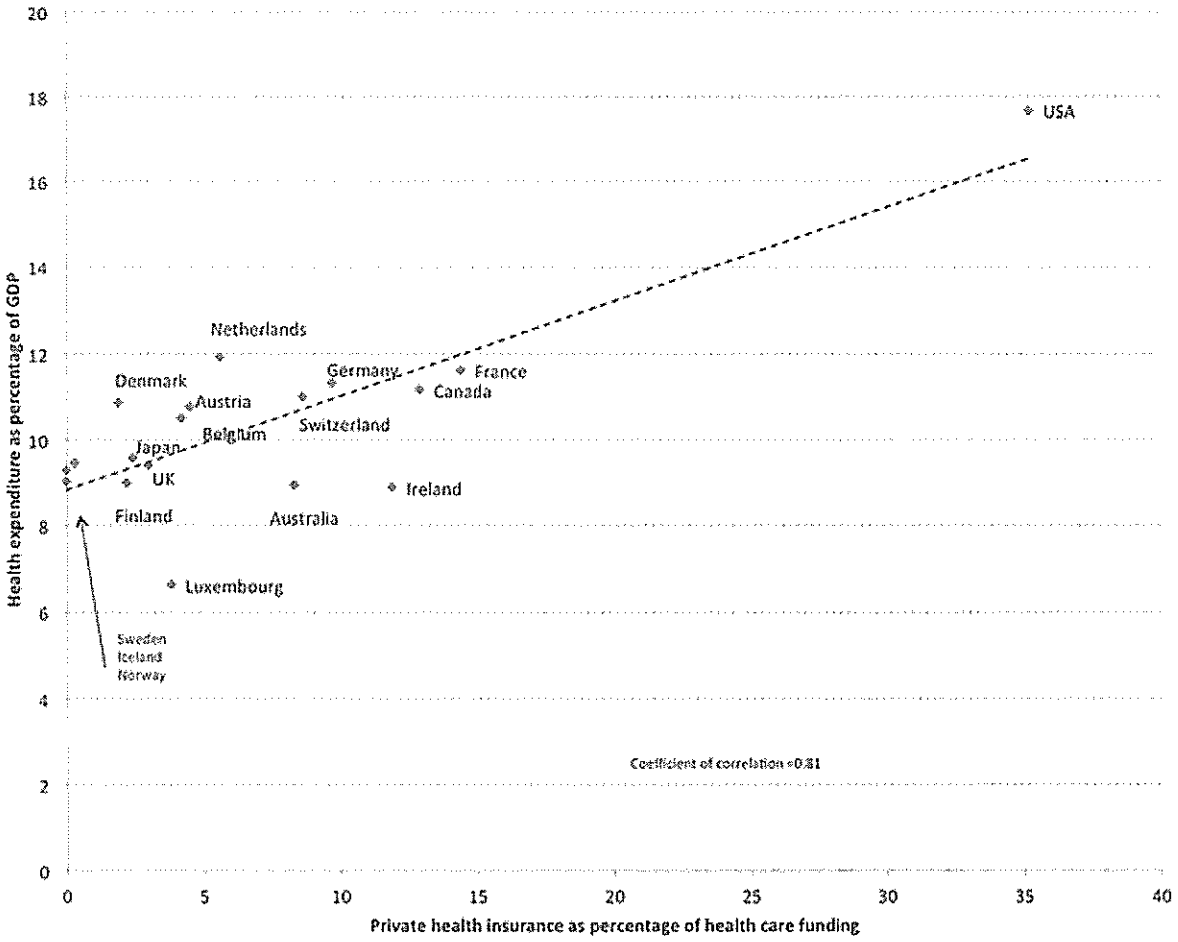
NSWNMA is committed to the notion of health as a public good with shared benefits and shared responsibilities. We believe that access to adequate healthcare is the right of every Australian and a crucial element of the Australian social compact. We are committed to publicly funded universal health insurance as the most efficient and effective mechanism to distribute resources in a manner that generally ensures timely and equitable access to affordable healthcare on the basis of clinical need rather than capacity to pay.

We believe that in a mixed public/private system, a strong publicly funded health system plays a crucial role in containing the overall rate of inflation of health costs. The private sector has a role in health as an alternative choice for Australians but everyone will lose if expansion of the private sector occurs at the expense of the public services.

We are also faithful to the principles and philosophy of primary health care: social justice, equity and self-determination, with a focus on early intervention to promote health and prevent illness.

NSWNMA rejects the notion that full or partial privatisation of health services will lead to any desirable outcomes in terms of quality, equity or efficiency. It is quite clear that the market does not drive efficiency in health.

Given the unpredictable nature of health costs, expansion of the private health insurance is the inevitable consequence of further privatisation of Australian health services. Australian and international evidence demonstrates that growth in the role of private health insurance leads to a more expensive system overall with no improvement in quality.



Source: Ian McAuley/OECD Health Expenditure at a glance 2013

The administrative costs of private health insurers including profit margin are about three times that of Medicare. Australians pay $2.5 billion per year towards private health insurers' administration fees and profits. In Australia only 84 cents in every dollar collected by private insurers is returned as benefits, the rest goes to administrative costs and corporate profits. By contrast Medicare returns 94 cents in

the dollar (McAuley, 2014). Private insurance does not contribute to efficient distribution of resources because competition among insurers renders them powerless to influence the prices demanded by providers. In contrast, a single national insurer like Medicare has the market power to put some discipline into prices and utilisation.

In NSW we are seeing very significant moves toward privatisation of previously public services. These include a range of community services in the areas of disability, mental health and palliative care. The NSW Government is also embarking on a major public/private partnership with Healthscope for the new Northern Beaches Hospital in Sydney. Full or partial privatisation is also on the agenda for the new Metford Hospital, the new Byron Central Hospital, the new cardiac catheter laboratory at Port Macquarie Hospital and support services and land at the Royal North Shore Hospital.

The Australian experience of public/private partnerships for hospitals is littered with contact failures, diminution of wages and conditions for workers, blow-outs in elective surgery waiting times and other adverse outcomes. The twin goals of improved services delivery and better value for money have not been achieved (see attached research prepared by NSWNMA Research Officer, Mr Nicholas Vanderkooi titled '*Public private partnerships for hospitals: a review of the Australian experience*').

NSWNMA recognises that Australia needs to respond to growing structural pressures in our economy. Nobody denies this. There are certainly efficiencies to be found within the health sector and many other areas of budget expenditure. But we also need to examine revenue. It is pleasing that a parliamentary inquiry is also underway examining corporate tax avoidance. NSWNMA is also working hard to begin a conversation in this country about the potential of a financial transactions tax (FTT) to support essential public services. An FTT would be a miniscule tax applied to the millions of speculative transactions that occur between financial institutions.

Creeping privatisation of Australia's healthcare system is the wrong approach to ensuring sustainability and containing costs in the long term.

Yours sincerely

BRETT HOLMES
General Secretary

Public private partnerships for hospitals: a review of the Australian experience

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NSW Nurses and Midwives Association

INTERIM RESEARCH REPORT

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Public private partnerships for hospitals

INTERIM RESEARCH REPORT

Abstract

Interest has grown in recent years as to the potential of public-private partnerships (PPPs) for delivering hospital services. In NSW the Northern Beaches Hospital Redevelopment is planned to take the form of a PPP entailing private delivery of its clinical hospital services. While the use of partnerships for hospitals is not new to Australian governments, the Northern Beaches Hospital Redevelopment will be first partnership since 2000. Pre-2000, seven partnerships were launched, with contract failure the outcome of three. Post-2000, the use of partnerships, both in policy and practice, has excluded clinical services from partnerships. With PPPs involving clinical services back on the agenda, it is timely to evaluate their effectiveness. This article explores the experience of partnerships in delivering clinical services. In particular it examines the experience of Australia's first partnership, the Port Macquarie Base Hospital. This study shows that PPPs have not resulted in greater efficiency or effectiveness. The problems with PPPs may represent either flawed implementation or a flaw in the underlying model, which while has been used successfully in other areas such as transport, has not had the same success for delivering hospital services. This may be due to the already complex task of building and operating a hospital. The conclusion will discuss the implications of both of these.

1. Introduction

During the 1990s, Australian state governments embarked on a series of public-private partnerships (PPPs) for constructing new hospitals and delivering their clinical services. The result was high-profile contract failure for three out of seven of these hospitals and large losses in terms of fees and prepayments. Since 2000, the use of PPPs has been revised in both policy and practice to exclude clinical services from partnerships.

The 2000 establishment of the group called Partnerships Victoria within the Department of Treasury and Finance (VDTF) marked a shift in Australian PPP implementation and development (Linda M. English, 2007). As the first comprehensive framework towards partnerships, a key outcome was to exclude clinical hospital services in PPP arrangements (Department of Treasury and Finance Victoria, 2000). As English (2007) notes, the guidelines also made the distinction between the two PPP models. The first PPP model involves core public services delivered by government agencies whereas infrastructure and associated ancillary services (maintenance, fittings, furniture, grounds, etc.) are delivered under contract. The second model bundles all services together including clinical services under contract. The establishment of Partnerships Victoria saw a shift in the practice of PPPs, and the Australian experience with PPPs for hospitals can be categorised into two periods: pre- and - post 2000 (Schmiede, 2005, 2009).

Pre-2000, conservative governments in the states of New South Wales, Western Australia, Victoria and Queensland launched seven hospitals involving core services delivered under contract. Post 2000, hospital partnerships have excluded clinical services.

Despite the high rate failure in these hospitals and their revised use post-2000, PPPs are back on the agenda. In NSW, which followed Victoria and excluded clinical services in PPP frameworks in 2006 (Department of Treasury NSW, 2006), guidelines have recently been modified as of December 2012 to allow private delivery of clinical services (Department of Treasury NSW, 2012). Following on, in May 2013, the NSW Minister of Health announced that the long awaited hospital for the Northern Beaches would take the form of a PPP (Jillian Skinner MP, 2013). The planned 423-bed hospital would also entail the decommissioning of the 217-bed public Manly Hospital and a reduction in bed numbers from 142 to 66 in the public Mona Vale Hospital. Queensland too saw an attempt to have the clinical services run as a PPP until its cost assessment found it was better value to have the State run the clinical services (Clare, 2013).

PPPs allow governments to provide expensive infrastructure without the capital costs. Although partnerships shift capital expenditure to the private sector, their justification relies primarily on the

claims that they provide value-for-money and result in higher quality services (Välilä, 2005). This paper aims to review these claims. This paper has four objectives. First, it seeks to review the principles of public-private partnerships. Second, it aims to describe the full sample of PPPs for hospitals in Australia. Third, the paper examines the extent to which PPPs have performed on the objectives of cost and quality, by reviewing prior literature on performance. Fourth, this paper examines whether the high rate of failure represents flawed implementation of the PPP model or whether the PPP model for hospitals is flawed.

2. The principles of public-private partnerships

PPPs are a long-term relationship between the State and a private contractor for the construction, maintenance and operation of infrastructure. The private consortium owns the infrastructure for the term of the contract and provides services. This period is usually 20 years. At the end of the contract, the hospital is transferred back to government at typically nil consideration (although the PMBH involved a buyout cost).

PPPs create new hospital assets and are often characterised as a tool to manage public sector debt (Chung, 2008; McKee, Edwards, & Atun, 2006). However the justification given for PPPs centres on their role in increasing the economy, efficiency and effectiveness of the public sector (Linda M. English, 2006). For instance, the Commonwealth's guidelines on public private partnerships put their case in the following terms:

> The aim of a PPP is to deliver improved services and better value for money primarily through appropriate risk transfer, encouraging innovation, greater asset utilisation and an integrated whole-of-life management, underpinned by private financing (Australian Government, 2008).

While PPPs may have emerged from the macroeconomic agenda, particularly during the 1990s where State governments faced large debts and economic recessions, their justification has shifted to the microeconomic, particularly on the twin claims that they provide value-for-money and deliver improved services.

Value-for-money occurs when the provision of public services occurs at a lower cost. It is assessed by comparing the costs of the public sector comparator (PSC) which is the cost of the project if it were delivered through traditional public sector procurement and management; and the net present cost of service payments paid by the State to a bidder over the life of a PPP
Value-for-money occurs when the provision of public services occurs at a lower cost. It is

assessed by comparing the costs of the public sector comparator (PSC) which is the cost of the project if it were delivered through traditional public sector procurement and management; and the net present cost of service payments paid by the State to a bidder over the life of a PPP project (both the entire construction and operation stage). If the service payments by the State to the PPP bidder are lower than its public sector comparator, this is considered value-for-money.

As English notes (2006), service provision is not just about realising lowest prices and associated efficiencies, it is also about the adequacy and quality of services provided. While PPPs are put in terms of providing higher quality services, assessing these claims is very complex (Sciulli, 2007).

3. The Australian experience of partnerships for clinical hospital services

Australia's first partnership involving delivery of clinical services was the Port Macquarie Base Hospital which commenced operations in November 1994. As with all of the partnerships, it was initiated by conservative state government. A second PPP in NSW, the Hawkesbury District Health Services, commenced operations in August 1996. In Victoria, the La Trobe Regional Hospital was launched, commencing operations in October 1998. This was followed by Mildura Base Hospital which commenced operations in September 2000. Queensland also saw two PPPs: Noosa Hospital which commenced operations in September 1999; and Robina Hospital, which commenced operations in April 2000. Western Australia saw the launch of Australia's largest and most frequently cited partnership, the Joondalup Health Campus, commencing operations in March 1998. Table 1 presents the population of Australian public-private partnerships for hospitals.

Table 1: Australian public-private partnerships involving clinical services

Project	Year	Capital Value	Beds	Operator	Location
Port Macq.	1994-2004	$40mil	160	HCoA	country NSW
Hawkes.	1994-ongoing	$47mil	127	Cath. Healthcare	outer met. NSW
Joondalup	1996-ongoing	$70mil	335	HCoA/Ramsay	outer met. WA
Latrobe	1998-2001	$56mil	257	AHC	country VIC
Mildura	1998-2015	$37mil	92	Ramsay	country VIC
Noosa	1998-ongoing	$20mil	100	Ramsay	Regional Qld
Robina	2000-2002	$48mil	192	Sisters of Charity	Regional Qld

Source: Schmiede (2009)

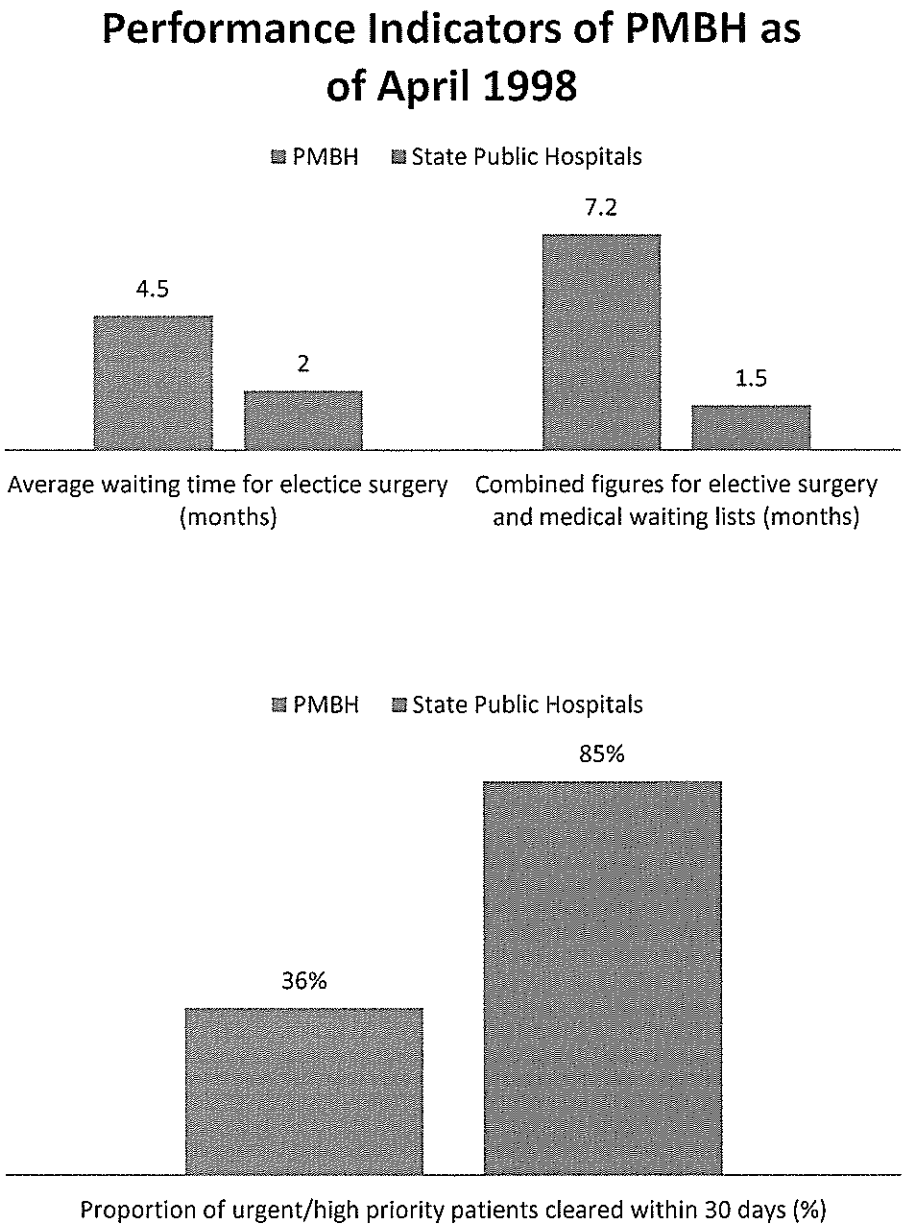
Port Macquarie Base Hospital

As the first partnership involving clinical services, the Port Macquarie Base Hospital has attracted much attraction (Chung, 2007, 2008, 2009; Cruz & Marques, 2013; Linda M English, 2008). It was initiated by the conservative Greiner government during its reforms of the public sector. In December 1992, the Department of Health NSW (DoH) entered into a 20-year contract with Mayne Nickless for the construction and operation of the Port Macquarie Base Hospital (PMBH). A subsidiary of Mayne Nickless, Health Care of Australia (HCoA), managed the hospital. The hospital was contracted to treat a mix of 80 per cent public and 20 per cent private patients. The PMBH commenced operations in November 1994.

Following ten years of operation, in October 2003 the Mayne Group proposed selling its entire Australian hospital portfolio, including the PMBH, to another private consortium. Consequently the State Government proceeded legal in April 2004 against the Mayne Group. On 31st January 2005, after 10 years of contracting public hospital services from Mayne Nickless, the Labour Government bought back the PMBH for $35million, at which point the hospital reverted to state management.

While the most obvious outcome of the PMBH was contract failure, it is worthwhile to examine the performance of the PMBH on the criteria of quality of services and value for money. On the first of these (quality of services), a number of performance indicators for the PMBH where set between the NSW Department of Health (DoH) and Mayne Nickless (Chung, 2009) which includes elective surgery waiting times. Peer hospitals for comparison were also set between DoH and Mayne. In 1998, waiting times for elective surgery at the PMBH were double state average and it was the State's worst performing hospital. Within NSW, the PMBH had the States largest number of patients with waiting times longer than a year. By 2003, at the end of its operating period, there were 333 elective patients with waiting times for surgery of longer than a year; in comparison, Coffs Harbour and Manning Base, hospitals in the same peer group, had just 7 and 5 patients respectively with waiting times longer than a year. Figure 1 & 2 below show PMBH performance.

Figure 1 & 2: Performance indicators of PMBH



Chung (2009)

The assumption that the partnership would result in lower cost turned out to be false. The cost assessment presented the partnership option as providing significant cost savings to the taxpayer; however, this did not factor in a number of costs including bargaining, administration, legal, equipment and transaction and monitoring costs. The cost assessment included some features such as the DoH compensating PMBH for all tax expenses which Chung labelled 'not much more than window dressing to make the deal look appealing' (2009, p. 80). In contrast to cost-savings presented in the assessment, the PMBH cost the State 30 per cent more to run than its public sector hospital comparators. The outcome of contract failure also presented

significant expense to taxpayers as with all contract failures, in terms of fees and buyout costs. The NSW Premier Morris Iemma described the Port Macquarie Base Hospital as "paid for twice over by the taxpayer" following its collapse and state takeover (ABC Television, 2006).

While the outcome of the PMBH was contract failure, it is not the only contact failure. Additionally La Trobe and Robina Hospital have resulted in contract failure. La Trobe Regional Hospital was initiated in 1997 when the Minister of Health entered into a 20-year contract with Australian Hospital Care for the design, construction and operation of the La Trobe Regional Hospital. It commenced operations in October 1998. After 6 months of operation, Australian Health Care approached the Liberal Government of Victoria for more funding following significant operating losses. The Government did not assist. In November 2001, the staff of Latrobe Regional Hospital transferred back into State employment and in 2002, the ownership of the hospital reverted back into state management.

The script for Robina Hospital was almost identical to that of La Trobe Regional Hospital: the hospital operator, Sisters of Charity, approached the government in the first six months of operation to alleviate operating losses and to seek more favourable contract provisions.

In both Robina Hospital and La Trobe Regional Hospital the bid was based on the assumption that greater operating efficiencies than the public sector would be achieved; indeed, this is essential for value-of-money and for the partnership to be preferable to the public sector comparable. The government did not assist and the operator continued to make operating losses. After just two years of operation, Robina Hospital reverted to State management.

4. Conclusion

Partnerships involving private provision of clinical hospital services have failed at a high rate. Far from transferring risk in the partnership, partnerships create risk. Quite rightful PPPs are labelled as risky (Duckett, 2013; Hodge, 2004). Nonetheless, PPPs will remain attractive due to their ability to transfer the infrastructure expenditure from the public to the private sector. Government who adopt PPPs in the interest of cost-savings adopt an expensive model Contract failure results in high costs to government (and taxpayers) through fees, buyout costs and the administrative transfer back to State management.

The case for PPPs relies primarily on the twin claims that they result in lower cost and higher quality services. Assessing these claims is difficult because of the complex nature of PPPs.

Operating efficiencies greater than the public sector where not achieved in either Robina or La Trobe Regional hospitals while the PMBH cost the government 30 percent more than the public sector.

There are two broad possibilities for explaining the difficulties of the PPP hospital model. The first is that the difficulties are the result of flawed implementation. The second is that the difficulties are the result of a flaw in the underlying model.

As flawed implementation, the Australian experience raises a number of lessons for future PPPs. The first is the need to strengthen cost-assessments. Unrealistic cost assessments led to the early collapse of Robina, PMBH and La Trobe. Second, there is the requirement for political consensus and broad community consultation. Political persuasions of government is often short-lived which means PPPs cross both Liberal and Labor divides; consequently, there should be some political consensus. La Trobe Regional Hospital for instance occurred operating difficulties during a change of government and faced a new Labor government which was hostile to the PPP and to the idea of bailing out a partnership or providing more favourable contract provisions. Community consultation and community census is particularly important. Mildura Base Hospital is to transfer early back to State management largely due to community pressure.

As a flawed model, the Australian experience raises a number of implications. Chiefly it suggests that the already difficult task of constructing and operating a hospital is best left to the public sector and that the additional complication of a PPP is ill-suited to enhancing the efficiency or effectiveness of public hospital services.

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