



THE MCKELL INSTITUTE

# Risky Business

**The pitfalls and missteps of  
hospital privatisation**



NOVEMBER 2014

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# Executive Summary

**The health burden in Australia is enormous. Each year there are 9.4 million hospitalisations across the nation's 1338 hospitals. This costs \$42 billion each year and grows at an expected 3 percent each year. The efficiency with which this task is met should be of importance to every taxpayer and every consumer of healthcare, though an equally important consideration is whether the purported efficiency gain from privatisation in any form to offset any potential decline in service quality.**

This report has investigated the ownership structure of the health system and identified that privatising public assets is a business fraught with risk, especially when it relates to healthcare. This report highlights the need for greater consideration by policymakers of the risks relating to the privatisation of public hospitals and hospital services. This report has critically examined an array of case studies from earlier privatisation attempts – some successful and others not – and has determined that privatisation attempts have rarely been able to deliver on their purported benefits for taxpayers, government and especially patients.

This report highlights findings by the Productivity Commission which demonstrate that public hospitals in NSW and Victoria are more cost efficient than their private counterparts by more than 3 percent and 4 percent respectively. This is despite public hospitals operating in far greater numbers in rural and regional areas (traditionally much more expensive to service) and despite their high-cost responsibility for providing accident and emergency room services. Although some hospital services are more efficient when provided by the private sector, the significant risks highlighted by earlier privatisation attempts should be enough to make any government carefully reconsider the purported merits of privatisation within the hospital network.

This report also examined a recent trend in hospital ownership structures and the allocation of responsibilities within privately run but publicly owned hospitals. This report notes a concerning trend in which private operators are able to pick and choose only the most profitable services to run, leaving the public sector the unenviable task of undertaking the more costly and difficult work. This allows private operators to capture a large share of operating revenue while exposing taxpayers to greater risk and higher costs.

This report also finds that the flow on impact from changes to staff morale and capacity is rarely considered by policy makers when considering privatisation or outsourcing. In previous cases of unsuccessful hospital privatisation and outsourcing attempts, patients and staff both lamented a substantial decline in service quality. This in turn was responsible for a significant decrease in the reputations of both the hospital and the government.

# Recommendations

## **RECOMMENDATION 1:**

### **The introduction of national data sets to more effectively determine the performance of Australian hospitals**

One of the difficulties in assessing the performance of various hospitals is the multitude of different data points that each hospital or jurisdiction is required to report on. Comparing 'like-with-like' becomes increasingly difficult, leading to competing claims over project efficiencies. This paper would propose that governments work together to establish a single national set of agreed reporting figures.

Additionally, ensuring regular performance reporting for both service delivery and financial efficiency measures is imperative to measuring the success of any privatisation attempt, and must be written into every partnership agreement.

## **RECOMMENDATION 2:**

### **The creation of bipartisan efficiency standards for newly privatised hospital services**

In too many instances the "success" of a privatisation has been defined as parity with the public system. This fails to accurately price the heightened exposure to demand risk absorbed by the Government as part of the established expectation that governments will be called upon to bail out financially failing private operators. In order to assess the success of privatisation, a clear margin of improvement that exceeds the existing status quo needs to be identified and agreed upon. Were these benefits more easily identifiable from the outset of any agreement, bipartisan cooperation would be easier to achieve.

## **RECOMMENDATION 3:**

### **Improved efforts to reduce government risk**

Given that State governments do continue to be exposed to a high degree of demand risk when contracting a private organisation to provide healthcare services, the financial and service benefits that offset that should be clearly defined in any future potential partnership agreement. Too many previous case studies have demonstrated the damage that can be caused by poor partnership agreements, with substantial financial costs inevitably shifted back to governments as private operators walk away from their contractual obligations.

Critically, privatisation should not be undertaken in a haphazard or hurried manner. The careful consideration of partnership agreements, as well as the economic and social impacts of privatisation, must take place before any decision is made in order to ensure that hospitals can continue to offer quality health services in an efficient manner. The risks involved in privatisation – to government, patients, healthcare workers and taxpayers – is far too great to do anything but.

## **RECOMMENDATION 4:**

### **Further research into methods to reduce overall government exposure to privatisation risks**

As government is likely to continue providing essential healthcare services – as shown by its near-total responsibility for services that the private sector currently does not consider financially viable to operate – it is important that policy makers acknowledge that government will continue to absorb ultimate demand risks in social infrastructure projects, even if they are partially privatised.

Accordingly, this report recommends further research into the appropriate pricing and allocation of risk in public private partnership, including possible means to transfer a greater proportion of risk back to private partners.

## **RECOMMENDATION 5:**

### **Increased use of alternative efficiency measures to improve the provision of public hospital services**

Policymakers should understand that privatisation, rather than being a panacea to all issues facing a hospital, is just one small option within a broad suite of possible reforms that could substantially improve hospital services and finances, including management change, workplace flexibility, and technological innovation and improvements. Many of these policies not only avoid the risks inherent in the privatisation of hospital services, but can also be implemented in a more collaborative framework with hospital staff, minimising the impact on morale and the ability of staff to perform their most essential duty – helping the nation's sick.



# Introduction

**The privatisation of Australia’s public assets has been a contentious issue in Australian politics for many decades now. The results of the broader privatisation agenda has been mixed. Whilst some privatisations have delivered significant benefits to both the government and the Australian community, others have delivered nothing but heartache and a costly bill for Australian taxpayers.**

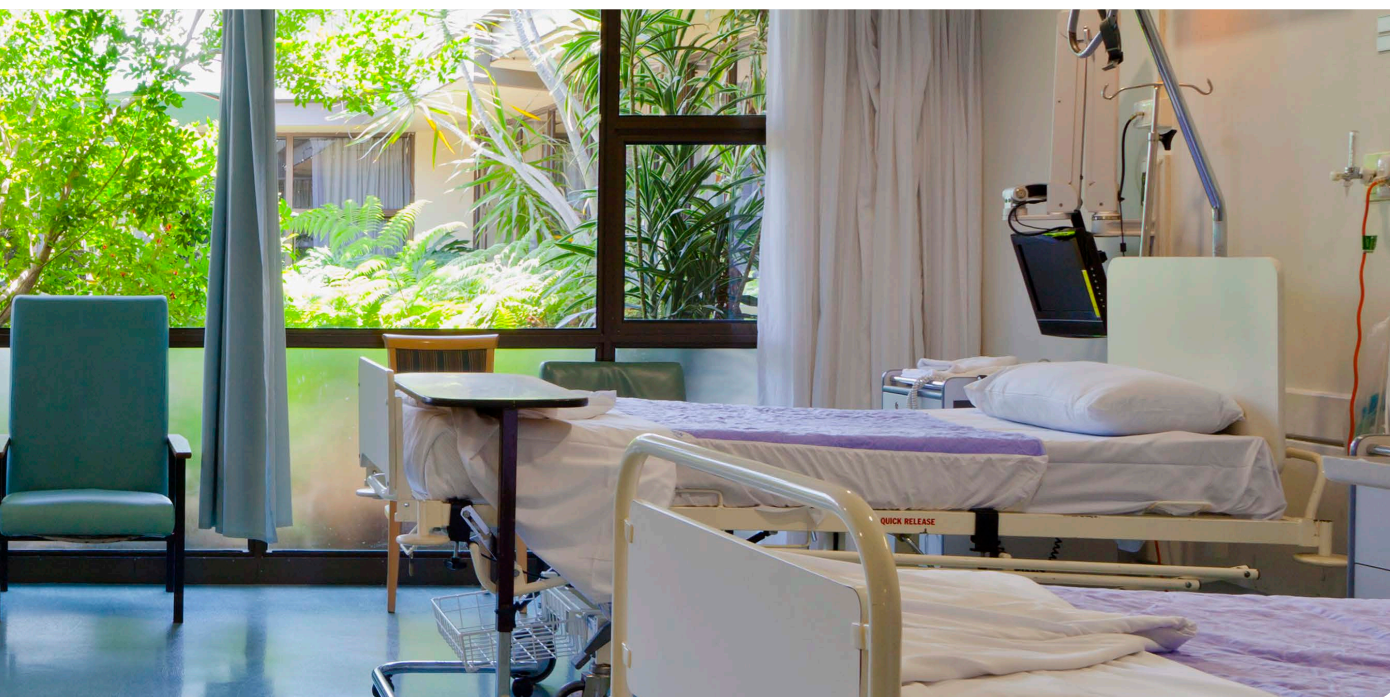
Recent experience would suggest that there is no one-size fits all approach which can be adopted when considering the potential privatisation of public assets. Despite this, many politicians continue to vigorously pursue the extensive sale of public assets. Fiscal prudence demands that policy makers consider the privatisation of public assets on a case-by-case basis and not on the basis of a broader political ideology.

This report investigates the privatisation of health assets within Australia’s public hospital network. It aims to provide a deeper understanding of the benefits, disadvantages and potential pitfalls associated with privatisation in Australia’s public health network. To achieve this, the paper will examine both successful and unsuccessful

examples of earlier privatisation attempts in order to better equip policymakers with the information necessary to make decisions in the best interests of the public, patients, healthcare workers and the healthcare industry as a whole.

Following the 2013 Federal Election, the Abbott Government has undertaken a strong push for the privatisation of both Commonwealth and State and Territory assets. The New South Wales Government has also provided explicit support for the greater of privatisation public hospitals and hospital services. Following his appointment, Premier Mike Baird declared that the NSW Government would “continue to look for ways to transform and improve health care.”<sup>1</sup> Premier Baird pointed the privatisation model used in Western Australia –





where non-clinical staff are privately employed and public hospitals are privately built and managed – as a “fantastic opportunity” to give NSW patients “the best possible services”.<sup>2</sup>

The privatisation of hospital assets and hospital services is notably more problematical than the privatisation of other state-owned assets. Specifically, the decision to pursue privatisation within the healthcare sector can often expose the government to additional risks. As an essential service, ensuring appropriate access to adequate healthcare – whether via public or private entities – remains a core responsibility of the state government. If a privatisation attempt goes awry, the ramifications for government can be disastrous and exorbitantly expensive for the taxpayer. After analysing the process of privatising public hospitals and measuring the purported benefits against potential risks and costs, this report seeks to develop a range of recommendations to assist in the effective management of Australia’s public hospital and health system.

Section One outlines the current state of the hospitals network in Australia, with a specific focus on NSW and the composition of public and private assets and services.

Section Two summarises the supporting arguments for privatisation as a concept, specifically focusing on the contended benefits for the healthcare system.

The justifications for privatisation are tested in Section Three, by using case studies to examine the successes and failures of recent hospital privatisation projects in various Australian states. As will be demonstrated, the assumption that the private sector can deliver cost savings and an increase in service performance, regardless of the specificities of the project, have often resulted in an increased cost to government and a drop in service quality for patients. Additionally, an array of other negative unintended consequences can also result from poorly managed privatisation projects.

Lastly, Section Four provides recommendations for a more effectively and efficiently managed hospital network in Australia. Rather than basing decisions about Australia’s healthcare system on assumptions rooted in economic arguments of efficiency, the evidence examined within this paper strongly validates that concise and exhaustive planning must inform the management of Australia’s healthcare system.

# A snapshot of Australia's health sector

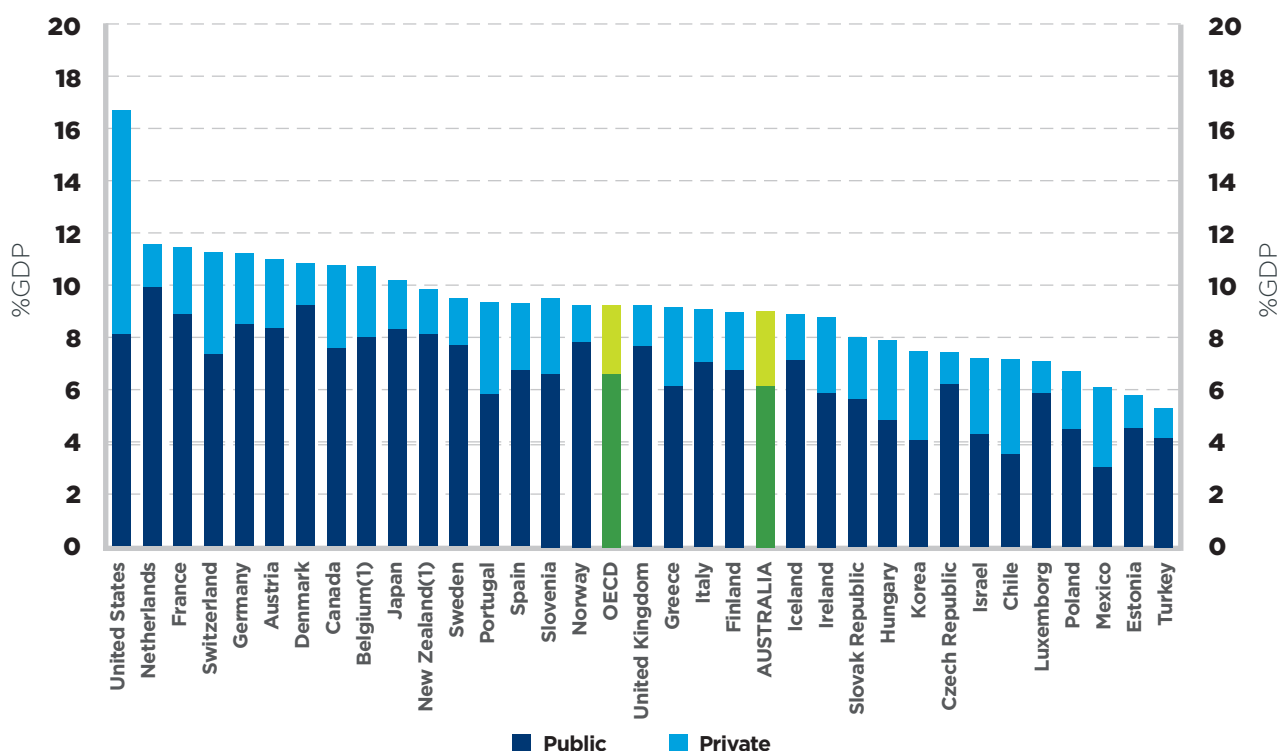
During 2012-13, there were nearly 9.4 million hospitalisations across Australia's 746 public and 592 private hospitals, with 3 out of 5 of these patients admitted to a public hospital.<sup>3</sup> Australia's public hospitals provided over 7.9 million emergency services, responded to nearly 225,000 childbirth cases, and looked after patients for an average length of 5.6 days.<sup>4</sup>

By global standards, our health system provides remarkably good value. In 2011-12, Australia spent 9.1 percent of GDP on health – slightly below the OECD average and lower than other developed nations such as the Netherlands, France, Switzerland, Germany and the United States (see table 1 below). Despite spending less than most other OECD nations, Australia has the sixth highest life expectancy rate amongst all 34 OECD countries, and the 22nd and 28th-lowest mortality

rates from cancer and cardiovascular diseases respectively.<sup>5</sup>

These high standards have been maintained despite the distortionary impact of the Global Financial Crisis – spending on health increased in Australia by over 5 percent in real terms during 2011-12, compared to a meagre 1 percent average increase across OECD nations.<sup>6</sup>

**TABLE 1:** HEALTH EXPENDITURE (PUBLIC AND PRIVATE) AS SHARE OF GDP, OECD COUNTRIES, 2012 OR LATEST YEAR



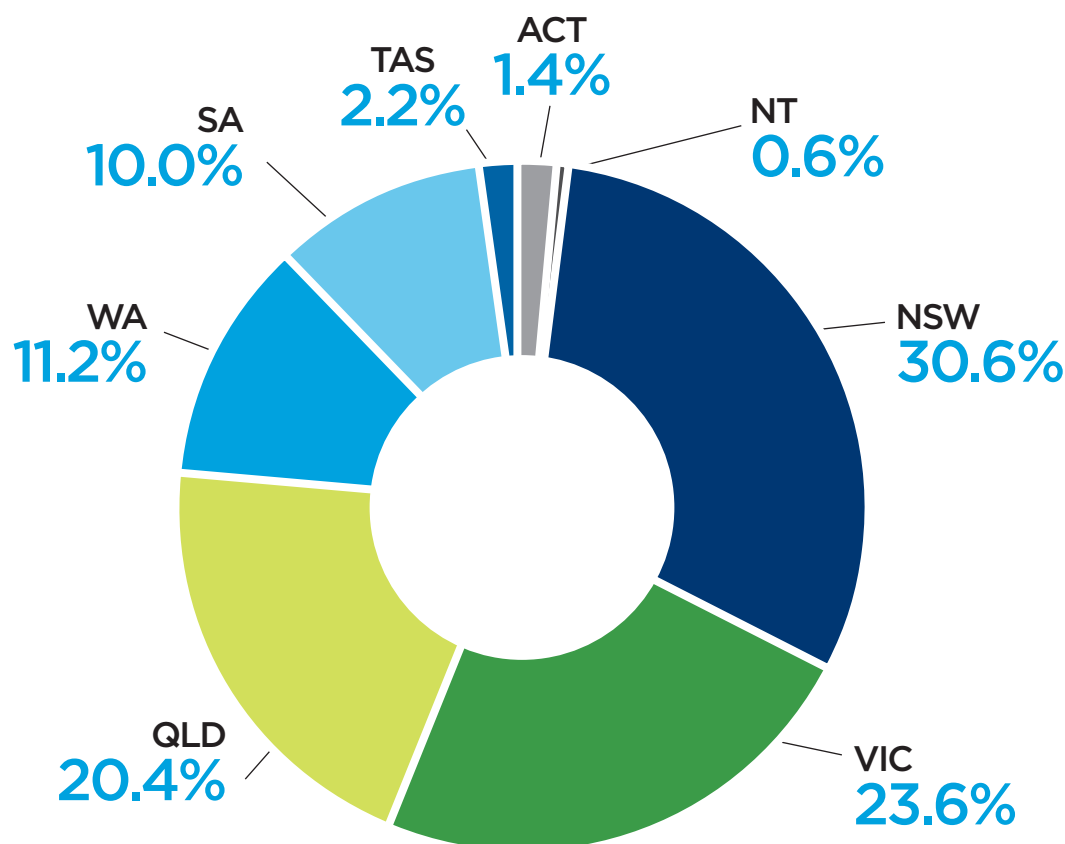
Australia's universal health system is one of the world's best in terms of service delivery and value-for-money. This is a large contributing factor to Australia's status as one of the world's most attractive nations in which to live. The Economist Intelligence Unit's Liveability Index frequently awards Australia's major cities with a perfect score of 100 in healthcare, which it directly attributes to our high levels of availability and quality, as well as our strong performance in other healthcare indicators.<sup>7</sup>

Nevertheless, changing demographics and the rising cost of modern health technologies and services means that the cost of providing healthcare to Australians is now set to increase in coming years – a challenge that all governments must inevitably address.<sup>8</sup>

To provide these invaluable services to the Australian community, public hospitals collectively required nearly \$42 billion in funding in 2012-13 from the Australian Government, State and Territory Governments and non-government sources such as private health insurers and self-funded patients.<sup>9</sup> During this same period, overall staff numbers increased by an average of 2.7 percent per annum, with the proportion of salaried medical officers increasing by 4.8 percent each year.<sup>10</sup>

The cost of healthcare is likely to rise as the health sector continues to expand, with a predicted nationwide annual growth rate of 3.0 percent per annum between 2014-2019.<sup>11</sup> New South Wales has the largest share of hospitals in the country,<sup>12</sup> indicating that the state will likely need to bear the brunt of continuing increases in the cost of healthcare.

**TABLE 2:** PERCENTAGE OF HOSPITAL ESTABLISHMENTS BY STATE





Users of Australia's hospitals are predominantly the elderly, with individuals over 65 years comprising approximately 50 percent of total hospital patients and accounting for 39 percent of industry revenue, despite this demographic comprising just 14.2 percent of the nation's population.<sup>13</sup> This overrepresentation occurs primarily because elderly Australians are more likely to be affected by chronic and terminal illnesses, requiring an increase in visits to general hospitals for the former and more intensive palliative care for the latter.<sup>14</sup>

The overrepresentation of elderly Australians requiring hospital care is expected to increase in the decades to 2049-50, as is the overall cost of health in Australia. According to the Federal Government's 2010 *Intergenerational Report*, health spending is estimated to increase as a proportion of GDP from 4.0 percent in 2009-10 to 7.1 percent by 2049-50. This will be a direct consequence of the nation's ageing population – real health spending on over-65s is expected to escalate by seven-fold and twelve-fold for Australians aged over 85 years.<sup>16</sup>

Such a dramatic rise in health spending is of considerable concern to Australian State Governments, primarily because public demand for government services is expected to increasingly outstrip the revenue collected by the states.<sup>17</sup>

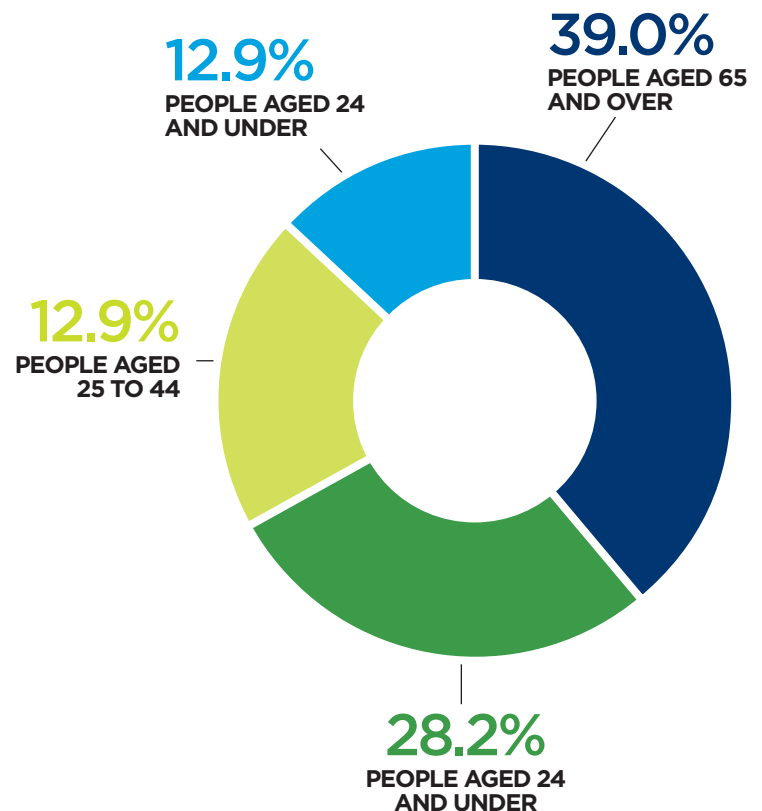
While economic reform is not discussed in this paper, it should be noted that the Commonwealth Government's recent changes to National Partnership and National Agreement payments is expected to place significant additional pressure on State Government health budgets.

In NSW, the state government has experienced a \$2.2 billion reduction in grants funding for recurrent programs over the next five years, including a \$1.1 billion reduction in National Health Reform funding.<sup>18</sup> The Baird Government has calculated that the long-term impact of changes to national partnerships will see federal hospital funding plummet from 40 percent to just 14 percent of total costs.<sup>19</sup>

At the same time that state governments are grappling with a reduction in federal government

**TABLE 3: HOSPITAL PATIENTS BY AGE<sup>15</sup>**

**Major market segmentation (2013-14)**



national partnership funding, the Abbott Government has also announced a new 'asset recycling' program to financially incentivise the privatisation of state owned assets. Under this 'asset recycling' initiative, any state or territory which sells an asset and spends the proceeds of that sale on new infrastructure is rewarded with an additional 15 percent contribution towards the cost of that infrastructure.<sup>20</sup> For fiscally challenged state governments concerned about the long-term decline in federal contributions for public hospitals, the asset recycling initiative provides a further incentive to privatise these hospitals. Consequently, it should not be surprising that the states have become increasingly enticed by privatisation as a potential solution to addressing their long term health funding challenges.

**TABLE 4:** NUMBER OF PUBLIC AND PRIVATE HOSPITALS BY REGION, 2009<sup>a</sup>

REGION <sup>b</sup>	PUBLIC HOSPITALS	PRIVATE HOSPITALS		
		DAY HOSPITALS	OTHER <sup>c</sup>	TOTAL
Major city	164	233	203	436
Inner regional	205	31	64	95
Outer regional	234	7	18	25
Remote	79	—	—	—
Very remote	81	—	—	—
Unable to be classified <sup>d</sup>	5	--	--	--
Australia	768	271	285	556

**a.** September 2009 **b.** Regional classifications are based on the Australian Standard Geographical Classification **c.** 'Other' comprises private acute and psychiatric hospitals. **d.** Unable to be classified due to missing postcodes. Nil or rounded to zero. -- Not applicable

## Public and private hospitals – an even match for services and costs

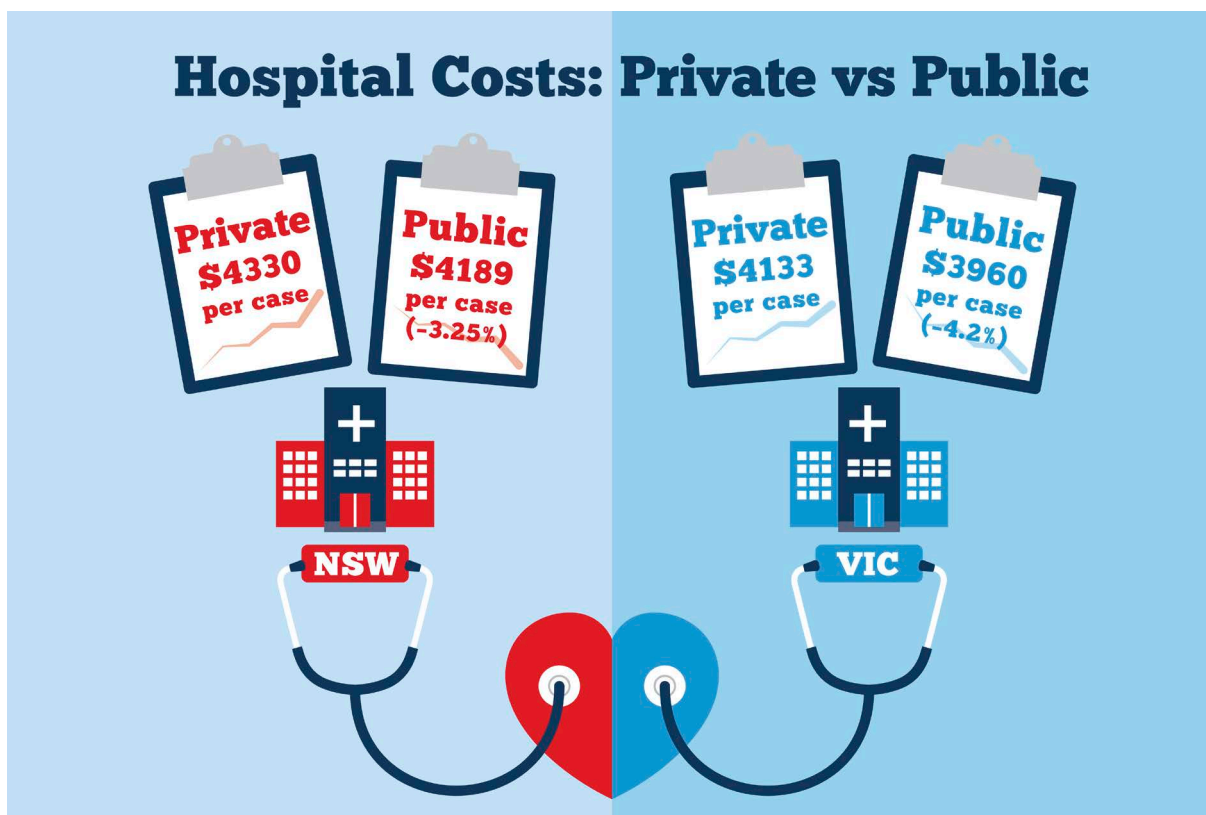
There exists a widespread view within the Australian community that private hospitals are superior to their public counterparts. These perceptions are not supported by existing evidence and research into the quality of healthcare provided respectively by the public and private sectors.

While observers note that private hospitals generally possess a stronger reputation for having better amenities and shorter waiting lists for some types of elective surgery,<sup>21</sup> the broader question of overall performance is substantially more complex.

Public hospitals have been shown to perform better than their private counterparts in a range of different areas, including in the performance of medical and diagnostics procedures and in fitting prostheses.<sup>22</sup> Public hospitals are also overwhelmingly responsible for providing accident and emergency care, with 95 emergency departments in New South Wales being operated publically and only three being operated privately.<sup>23</sup>

Additionally, public hospitals care for Australians from lower socioeconomic groups and with more complex medical conditions on a more frequent basis than the private sector.<sup>24</sup> Furthermore, while private hospitals tend to be clustered in major metropolitan areas, public hospitals provide health services to those populations living in rural and remote areas of Australia.<sup>25</sup> Private hospitals are rarely found outside of the major metropolitan areas due to high start-up costs and the necessity for high patient numbers in order to operate at a financially viable level for owners and/or shareholders.<sup>26</sup>

This evidence should be unsurprising considering the longstanding principle that all persons eligible for Medicare are entitled to receive free health and emergency services in public hospitals.<sup>27</sup> State Governments assume the responsibility for public health primarily because of this universal healthcare principle of equitable access.<sup>28</sup>



From a financial perspective, the relative strengths of both public and private hospitals essentially bring both players into near-parity when it comes to the cost per casemix-adjusted separation.\* Productivity Commission research into the performance of public and private hospitals found that, notwithstanding the differences between public and private hospitals, both types of hospitals have similar average costs.

Notably, in New South Wales, overall costs in general public hospitals per casemix-adjusted separation were lower than in private hospitals.<sup>29</sup> The Productivity Commission found also found this to be true for hospitals in Victoria. Costs per separation in NSW private hospitals were on average \$4330 per case, whilst public hospitals were able to produce average costs of \$4189 per case. In Victoria, those costs were \$4133 for private hospitals and only \$3960 for public hospitals.<sup>30</sup> These figures represent a 3.25 percent saving for the NSW government and a 4.2 percent

saving for the Victorian government when hospitals are operated under public administration.

These findings need to be acknowledged by governments that have indicated a preference for privatisation on the basis of potential improvements in financial efficiency. Table 5 shows the breakdown of public and private services and overall costs by region. The data concludes that although some privately offered services were more efficient than those offered by public hospitals; overall public hospital costs in both NSW and Victoria were lower than was the case with private hospitals, while overall efficiency levels were very similar when averaged out across Australia. Whilst this was not the case for other regions in Australia, the fact that Victorian and NSW private operators are already between 3 percent and 4 percent more expensive than their public counterparts must be acknowledged before automatically assuming that privatisation will automatically deliver most cost efficient services.

\* Cost per casemix-adjusted separation is defined as the average cost of treating different diagnoses after controlling for the complexity of treatments.



**TABLE 5:**

COST PER CASEMIX-ADJUSTED SEPARATION BY JURISDICTION AND SECTOR, 2007-08

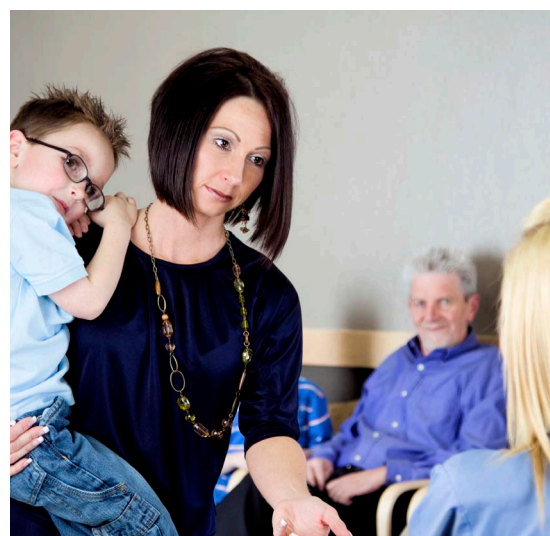
DOLLARS						
COST COMPONENT	NSW		VIC		AUSTRALIA	
	Private	Public	Private	Public	Private	Public
General hospital	2551	1944	2106	2004	2552	1953
Pharmacy	164	42	251	87	187	68
Emergency	205	16	251	50	208	34
Medical & diagnostics	733	1497	900	1226	798	1346
Prostheses	137	620	108	527	131	542
Capital	439	210	359	240	426	230
Total	4189	4330	3960	4133	4302	4172

While these state-to-state cost differences may be marginally influenced by different measuring and reporting methodologies, such findings nevertheless indicate that public hospitals can provide a number of medical services at lower cost than private hospitals, both in terms of the overall costs and the cost to patients.

For example, while Australian public hospitals have on average higher costs for general hospital cases compared to private hospitals, they offer significantly lower costs per casemix in relation to medical and diagnostics and prosthetics procedures. This is due to the propensity of public hospitals to actively manage and bear the burden of additional costs, and is in contrast to private hospitals, where doctors are more likely to charge patients higher fees in order to provide additional services.<sup>31</sup>

Setting aside considerations of value-for-money, the emphasis by public hospitals on equity of access, care based on needs rather than profitability,

and their presence in many regional and remote communities makes public hospitals vastly superior to private hospitals in one other crucial way – the ability to provide access to quality health services for Australia's most vulnerable.



# Privatisation – a blind belief in market efficiency?

The emergence of privatisation in Australia initially began as a means to reduce public debt, which had rapidly increased during the macroeconomic reform era of the 1970s and 1980s.<sup>32</sup> The phenomenon was borne out of the new public management reform agenda introduced in the mid-1980s, which sought to reduce government spending, improve service quality and efficiency, and increase government accountability.<sup>33</sup>

However, the policy goal of debt reduction and better governance is often paralleled by a belief that private sector market competition will result in more cost-effective service delivery that is better attuned to customers' needs.<sup>34</sup> Privatisation preferences were reinforced by the 1996 National Competition Policy, which resulted in a swathe of structural adjustments and programs designed to decrease regulation and administration, and transfer ownership and financing of public infrastructure and service provision projects to the private sphere.<sup>35</sup>

Some advocates of increased privatisation, particularly within the health sector, argue that the private sector provides greater autonomy for hospital management, which in turn gives them more flexibility in determining workplace practices for health professionals as well as greater control over hospital operating budgets.<sup>36</sup> The overarching belief in privatisation stems from the idea that the profit motive ensures private managers are more effective than their public counterparts;<sup>37</sup> despite large bodies of research showing this is not necessarily the case. A number of researchers have criticised the increasing use of Public-Private Partnerships (PPPs) to ostensibly reduce government expenditure, arguing that these projects have not offered substantive long-term benefits and have instead resulted in compatibility

issues between government objectives and market principles.<sup>38</sup>

Additionally, observers have highlighted the propensity of private partners to abandon projects that encounters financial difficulties, leaving the public partner – which is unable to outright abandon the contract – responsible for any remaining partnership costs.<sup>39</sup> This represents a broader issue with the pricing of risk in PPPs, in which potential private partners are often unwilling to engage with the government unless it is willing to take on a larger degree of risk, heightening taxpayer exposure.

This is of particular importance for hospital privatisation projects. The NSW Treasury classifies hospitals as a form of social infrastructure. Social infrastructure projects are projects in which the state government retains demand risk while the private party is paid a service payment by the Government.<sup>40</sup> Social infrastructure projects such as hospitals and utilities are considered critical to the nation's wellbeing and are therefore publicly protected and not entirely exposed to the harshest excesses of normal market forces. The companies operating in these sectors operate with a higher degree of moral hazard than in normal competitive sectors, confident that the costs or burdens of their actions will be assumed by the State.<sup>41</sup> Given









that Australian governments necessarily need to absorb the majority of demand risk in social infrastructure partnerships, ultimate responsibility for the delivery of hospital projects effectively resides with the government, even if service delivery is achieved via a PPP. As will be shown further in this report, this can have dire ramifications for taxpayers and governments if a project turns sour.

### **Public and private? The use of Public-Private Partnerships to privatise Australia's public hospital services**

Australian State and Territory governments are responsible for the provision of health and emergency services in the public hospital system.<sup>42</sup> However, there are broad differences in how public health services are delivered within states and territories, with the private sector playing an ever larger role in government's provision of these vital services.

In general, hospital privatisation does not equate to the wholesale transfer of a public hospital to private hands. Rather, a state government is more likely to facilitate the delivery of public hospital services by contracting or authorising a private company to build or operate a hospital. Although operated by the private sector, the hospital will remain public as the government will require the operator to continue to service public patients.

Although a significant proportion of privately owned 'public' hospitals are run by not-for-profit organisations such as Catholic groups, many of these privately-owned hospitals are contracted by the government to provide public health services. Such arrangements are commonly labelled 'Public-Private Partnerships' (PPPs), which in essence are financial and organisational relationships between the public and private sectors that are regulated by concession contracts.<sup>43</sup>

**TABLE 6:** FORMS OF PPPS<sup>44</sup>

<b>DBFO</b>	Design, Build, Finance and Operate
<b>DBOM</b>	Design, Build, Finance and Maintain
<b>DBOT</b>	Design, Build, Operate and Transfer
<b>DOD</b>	Design, Operate and Deliver
<b>BOO</b>	Build, Own and Operate
<b>BOL</b>	Build, Operate and Lease
<b>BOOST</b>	Build, Own, Operate, Subsidise and Transfer
<b>BOOT</b>	Build, Own, Operate and Transfer
<b>BOT</b>	Build, Operate and Transfer
<b>BRT</b>	Build, Rent and Transfer
<b>FBOOT</b>	Finance, Build, Own, Operate and Transfer
<b>PFP</b>	Privately financed project
<b>Semi-public companies</b>	Government and private enterprise jointly owned facility
<b>ROT</b>	Rehabilitate, Operate and Transfer

PPPs have been popular with State Governments since the early 1990s, with a range of social infrastructure projects completed or commenced during this period under such arrangements.

**TABLE 7:** EXAMPLES OF PPP-TYPE HOSPITAL PROJECTS IN AUSTRALIA<sup>45</sup>

<b>YEAR</b>	<b>PROJECT NAME</b>	<b>STATE</b>
<b>1996</b>	Port Macquarie Base Hospital	NSW
<b>1996</b>	Hawkesbury Hospital	NSW
<b>1998</b>	Robina Hospital	Qld
<b>1998</b>	Latrobe/Mildura Hospital	Vic
<b>1998</b>	Joondalup Hospital	WA
<b>2003</b>	Royal Newcastle Maternity Hospital	NSW
<b>2003</b>	Royal Womens' Hospital redevelopment project	Vic
<b>2005</b>	Royal Children's Hospital	Vic
<b>2006</b>	Royal North Shore Hospital redevelopment stage 2	NSW
<b>2011</b>	Royal Adelaide Hospital	SA
<b>2014 (at tendering stage)</b>	Northern Beaches Hospital	NSW



The growth in popularity of using PPPs to build essential infrastructure was a critical factor in the 2008 COAG decision to endorse the National Public Private Partnership Policy and Guidelines, which contends that PPPs can “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.”<sup>46</sup>

### **The resurgence of privatisation by Australian governments**

Australian governments have been intermittently seduced by the promises of privatisation for a few decades now. The promise that a successful PPP can deliver significant cost savings to government and taxpayers is too-enticing an opportunity to pass over for many policymakers.

However, the budget bottom line is not always the only factor in a government support of privatisation – the unerring belief in the ability of the market to deliver services in a more efficient manner often plays a substantial part in the decision-making of many State Governments.

In the 1990s, Victorian Premier Jeff Kennett was highly enthusiastic about injecting private sector competition into many parts of its public sector, arguing that “competition, or the threat of it, can create powerful incentives for management to improve internal efficiency and to become responsive to customers”.<sup>47</sup> More recently, Queensland Premier Campbell Newman has announced a “quiet revolution” towards privatising certain state services,<sup>48</sup> whilst NSW Premier Mike Baird has stated that privatising the State’s assets is “the only way to fund NSW’s infrastructure needs”.<sup>49</sup>

Following a lull in recent years, privatisation has once again become an issue of intense debate among Australian policymakers. The new Coalition Government has actively advocated for the privatisation of not only Federal assets, but also those under the jurisdiction of the States and Territories. The Federal Government’s own Commission of Audit – chaired by the then president of the Business Council of Australia Tony Shepherd – provided expected support for privatisation, while the 2014-15 Federal Budget outlined a renewed push to pursue privatisation as part of a broader strategy aimed at ‘reducing the size of government’.





The federal government's policy intention unambiguously includes the privatisation of health services to reduce government expenditure and to minimise the public sector's involvement in the provision of health services to the Australian community.

In the Budget, the federal government announced the sale of Medibank Private and the continued sale of assets 'where no compelling reason for government ownership exists'.<sup>50</sup> In addition, as an enticement for State Governments to privatise their own assets, the Federal Government has also earmarked \$5 billion for the creation of its 'Asset Recycling Initiative'. The Initiative is a five year program that gives State Governments a Federal grant worth 15 percent of the price of public assets sold, provided the revenue is allocated to new infrastructure investment.<sup>51</sup>

Such enthusiasm for privatisation is shared by New South Wales Premier Mike Baird, particularly with regard to the state's public hospitals. Although a number of new state hospitals are being financed publicly through a combination of state and federal funds – for example, the Blacktown Mt Druitt Hospital expansion – Premier Baird has clearly outlined a long term vision for the privatisation of NSW's existing public hospitals as a means of

improving dilapidated health facilities and to deliver 'enhanced services and facilities' for NSW hospital users.<sup>52</sup> Specifically, the Premier is supportive of Western Australia's privatisation model, under which public hospitals are privately built and managed, and non-clinical staff are employed by the private sector.<sup>53</sup>

However, this area of public policy remains hugely contested. Former NSW Opposition Health Spokesman Andrew McDonald argues that 'some private healthcare operators put returning profits to shareholders before patient care'.<sup>54</sup> Similarly, health based trade unions remain concerned about any future privatisation of state hospitals.<sup>55</sup> In particular, they have highlighted the detrimental effects for patient care that would arise from cuts to staffing numbers following privatisation. They have justifiably argued that hospitals which were previously operating under a not-for-profit model would then be forced to find budget savings in order to boost profitability for the private investors. NSW HSU Secretary Gerard Hayes said in reference to hospital privatisation: *"The private sector does not take this work on out of the goodness of its heart. It does so to make a dollar. To turn a profit, he said they would either "slash jobs and wages or offer inferior services."*<sup>56</sup>

# Hospital privatisation case studies

## – some successes but an overwhelming litany of errors, incompetence and unexpected costs

**Privatisation of public hospitals has occurred in a variety of different forms over recent decades. Some hospitals had a range of hitherto-internal services that were then outsourced to private contractors, whilst other private operators were contracted to build, own and/or operate public hospitals for a set number of years or decades, after which a hospital would either be returned to government ownership or a new private contract created.**

As the evidence will show, there have been some hospital privatisations that have been successful: costs have been reduced, efficiency has increased, and contractual benchmarks set by State Governments have continued to be fulfilled by the private operators.

However, the success of any PPP project depends on an integration of the goals of strategic, tactical and operational levels of authority.<sup>57</sup> When a partnership arrangement is inappropriately or poorly designed, service provision costs can increase and unforeseen risks can and do emerge.<sup>58</sup> These negative outcomes are exacerbated by the state's

retention of demand risk, a necessary outcome given the NSW Treasury's classification of hospitals as a form of social infrastructure. As was outlined earlier, although a public hospital may be privately operated, the essential services offered by these facilities remain the ultimate responsibility of a government.<sup>59</sup> Should there be a failure of private operators to effectively operate a hospital, it will be the government – and by association, taxpayers – that will foot the bill to fix any failures that have occurred. In essence, although a private entity would be entitled to capture any profits arising from the operation of a hospital, the risks are still largely borne by the government and its taxpayers.

## Bucking the trend: Successful privatisation of public hospital services

Although there are many examples of privatisation projects that have failed dismally, there are some examples of PPPs that have met government expectations in service delivery and other key performance indicators.

Victoria's Casey Hospital is one such project, having been conceived as a design-build-finance-maintain and transfer (DBFMT) contract whereby the private contractor designed and built the hospital, financed its construction, and provided a facility management service to maintain the hospital for the 25 year contract period.<sup>60</sup> Although the hospital's core services remained public-operated, services that were privatised – including building, cleaning, grounds maintenance, security and help-desk functions – have continued to meet required benchmarks.<sup>61</sup>

Western Australia's Joondalup Hospital is another example of a successful PPP. The partnership dates back eighteen years and has recently undergone a major redevelopment to update and expand the health campus' infrastructure.<sup>62</sup> The redevelopment was jointly funded by the Western Australia State Government; the Federal government; the operators of the hospital, Ramsay Health Care; and local universities who contributed funds towards the new clinical school. It was completed both ahead of schedule and under budget.<sup>63</sup>

Joondalup's partnership contract includes the private delivery of clinical services, meaning that healthcare staff are employed through the private operator, Ramsay Health.<sup>64</sup> Although an early Auditor-General report could not establish that the project was superior to a public sector alternative,<sup>65</sup> the hospital now appears to be operating at a high level of capacity.<sup>66</sup>

The good performance of these hospitals is supported by data from the National Health Performance Authority. 68 percent of Casey Hospital's emergency department patients

departed within four hours of arrival in 2012 – placing it in the top 10 percent of the hospital's peer group nationally – while 2013 saw this figure increase further to 73 percent.<sup>67</sup> Both Casey and Joondalup hospitals also have shorter than average median waiting times for cancer surgery: Casey Hospital's median waiting time for breast cancer surgery in 2011-12 was 9 days compared to a national peer performance of 12 days,<sup>68</sup> while Joondalup's median waiting time for bowel cancer surgery in 2011-12 was 11 days compared to a national average of 15 days.<sup>69</sup>

## The consequences of failed privatisation efforts

Despite the success of some hospital privatisations, a number of significant ramifications arise when privatisation efforts go awry. Perhaps the most visible consequence is the cost of failed projects being transferred back to State Governments – ironic given that the core purported benefit of privatisation is the public savings that are meant to be secured through the outsourcing of services. Notably, failed privatisations can and do produce the opposite outcome, significantly affecting not just taxpayers and the government, but also those who use hospital services and the morale of hospital staff.

## Negative budgetary impacts

A number of early hospital privatisation efforts by State Governments were performed on the assumption that substantial public savings could be found.

The private construction and management of New South Wales' Port Macquarie Base Hospital (PMBH) during the early 1990s is a notorious example: despite the NSW Parliament's Public Accounts Committee finding no significant improvement in the operational costs of providing patient care, the then-NSW Government nevertheless claimed that the project would save the state approximately \$46 million over the following 20 years.<sup>70</sup>

Unfortunately, the Government failed to take into account a number of additional costs in the creation of the PMBH. These costs included, among others,

administrative and legal costs associated with the contract's creation, and government liability for sick and maternity leave through the hospital's first year of operation.<sup>71</sup>

In a damning 1996 report, the NSW Auditor-General concluded that, despite providing considerable fee-for-service payments to the private operator, the State Government had inexplicably agreed to transfer the hospital, its land, and the hospital licence to the private sector at the end of the 20 year contract.<sup>72</sup> Effectively, the State Government had paid capital costs for the hospital twice – at a cost of \$143.6 million – and then gave the entire project away.

Ultimately, the NSW Auditor-General found that the final costs associated with this privatisation had substantially exceeded the cost to government that would have occurred had the PMBH been operated by the public sector.<sup>73</sup> Furthermore, the hospital's running costs had greatly exceeded its public sector counterparts, costing between \$4.5-\$6.5 million more than a public hospital of equivalent size and of similar service offering.<sup>74</sup> The failure of government in this instance was best summarised as: 'ideology, resulting in a dominance of accounting concerns at the strategic level, and conflicting goals among the three levels of players, [which in turn] led to the ultimate failure of the Port Macquarie experiment.'<sup>75</sup>

Victoria's Latrobe Regional Hospital was also slated to be built, owned and operated for a 20 year period under a similar contract to PMBH. Management issues and operation costs were again underestimated by stakeholders, this time by private contractor Australian Hospital Care (AHC). According to observers, AHC not only underestimated staffing requirements and operational costs, it outright failed to understand how Victorian public hospitals were funded for acute health services,<sup>76</sup> leading the hospital to suffer \$6.2 million in losses in 1999 and \$2.7 million in 2000.<sup>77</sup> The eventual outcome of this failed privatisation attempt was the full transfer of Latrobe Regional Hospital back to the Victorian Government, with AHC losing its entire \$17 million investment in the hospital.<sup>78</sup> This represents a prominent example of how the ultimate burden of addressing large-scale failures associated with social infrastructure projects is inevitably borne by the government when a private

partner either cannot or does not wish to uphold its contractual obligations.

More recently in 2013, the Victorian Government took the decision to buy back the Mildura Base Hospital – the State's only remaining privately owned and run hospital – after sustained criticism that the hospital's private management had provided no transparency and had given inferior salary packages to staff, which affected the hospital's ability to attract and retain staff.<sup>79</sup>

Another example of a deficient hospital privatisation can be seen with South Australia's Modbury Hospital. In 1995 the Liberal State Government signed a 10 year agreement with Healthscope Ltd to manage the hospital as well as to construct a private hospital on nearby land. However, within two years Healthscope reported continued losses, with an investigation uncovering a number of serious shortcomings in the contract management process and original management agreement.<sup>80</sup>

A 1997 State Auditor General report concluded that the contract presented an array of difficulties associated with contracting out services. A 2000 Federal Senate report found that this had led to ongoing concerns expressed about the level, variety and quality of services provided at Modbury Hospital. Notably, serious problems continued to occur even after these reviews were undertaken, ultimately leading to the Rann Government's eventual decision to return the hospital to State Government management at a cost of \$17.5 million to taxpayers.<sup>81</sup>

## Loss of staff morale and expertise

In addition to the negative impact on state revenue that can arise from failed privatisation attempts, the many individuals responsible for high quality patient treatment and care can also be negatively affected by the transfer of ownership from public to private hands.

In a series of interviews with stakeholders during one failed Victorian hospital's bid at outsourcing – the private contractor had its contract terminated after only 18 months – it was reported that staff morale had dropped, with insecurity, fear and lack of trust rife amongst staff directly affected by the outsourcing.<sup>82</sup> This low morale then spread to parts of the hospital



not affected by the privatisation (for example, radiology and pathology), who saw themselves as the next in line to be subjected to the outsourcing process. One director described the change in staff morale before and after the outsourcing occurred:

[A union organiser] explained that [hospital staff] previously had pride in their high standard of service, seeing themselves as “carers”, whereas with the contracted service they changed their view of themselves to simply “employees” of a contract cleaning firm. Their morale was reduced, cleaning standards were diminished and finally, workers “threw in the towel and did not care”.<sup>83</sup>

Simultaneously, the downsizing of staffing levels and the outsourcing of departments eventually resulted in a notable reduction in the ability of staff to provide high quality service. In one example, food services staff numbers were reduced from 15 to 4, while food was produced off-site in an attempt to avoid weekend penalty rates. Another complaint from ward nurses was that the roles of ward support staff were ill-defined, creating a continual divide between what nurses and management expected from these employees.<sup>84</sup>

The final outcome of this failed attempt to outsource services was the eventual ‘backsourcing’, or return to in-house management, of the hospital’s Food Services and PSA Services in 2004. The remainder of services — cleaning, security, waste management and linen management services — were backsourced in 2009.<sup>85</sup>

Downsizing as a result of outsourcing is not a phenomenon confined to past privatisations: in April this year over 100 Queensland Health staff in non-clinical roles at The Royal Children’s Hospital were informed that they would not be employed at the new Lady Cilento Children’s Hospital. While supporters of the outsourcing claimed that the change would result in \$4 million in annual savings, sources at the Hospital noted that morale had plummeted following the announcement, especially as the job losses appear to be confined to low-paid roles such as patient food services and laundry.<sup>86</sup>

Whilst proposals for outsourcing and downsizing need to be assessed on a case-by-case, the risks

of such action is clear – confusion, uncertainty and fear amongst staff members who provide crucial support to hospital patients on a daily basis. As demonstrated in the Victorian example, ostensible cost savings can also often illusory, which in turn can force an expensive and wasteful retreat from privatisation and outsourcing that needn’t have occurred in the first place.

## **Decline in patient care quality and access to services**

Evidence strongly suggests that financial losses combined with a reduction in staff morale and reduced staffing capacity is highly correlated with a reduction in the quality of patient care in those hospitals where privatisation has failed. According to one Victorian hospital manager interviewed by researchers:

Service standards were not met. The complaints from patients and other stakeholders were rife about the cleanliness of the hospital, poor service quality, poor food quality, poor response time for portering of patients and so on.<sup>87</sup>

This Victorian hospital was not the only recipient of criticism for poor patient treatment. A NSW Department of Health cross-service and cross-year analysis of a critical healthcare performance indicators has labelled the PMBH as the worst performing hospital in the state, with waiting times for elective patients more than double the NSW average.<sup>88</sup> Such poor outcomes appear to be either a direct or indirect result of the privatisation of PMBH.

However, patients are highly unlikely to realise that a drop in service quality is due to a change in management practices, especially in hospitals where there is a mix of public and private-operated departments. This was highlighted in the Victorian case study above, where a director noted that the fact that only some of the hospital’s services were outsourced made it difficult for patients to determine who was to blame for the decline in their care – the public or private staff. Ultimately, the result was that patients blamed the hospital rather than the private contractor for the lower quality of care that they received.<sup>89</sup>

# Hospital privatisation – the need for a broader approach in decision making

## Lessons to learn from past mistakes

Previous experience suggests that hospital privatisation and outsourcing is wrought with risk. Although there have been a small number of successful public-private hospital partnerships, the evidence is limited as to how much a government might benefit from further privatisations in the healthcare sector. The use of financial and efficiency arguments seem to be misleading: the privatised hospitals in the health sector that are deemed successful are operating at key performance benchmarks, but not necessarily exceeding them.

The case studies contained within this report have highlighted the consequences that can arise when governments privatise based on an ideological assumption that competition and privatisation will automatically improve a hospital's services and budget. In these case studies, an automatic, unquestioned assumption of efficiency gains arising from privatisation led to State Governments entering into contracts without due consideration of their true value or the ability of private contractors to properly run the hospitals and their services.

This is not to say that all forms of hospital privatisation are disaster-prone, but rather proper assessments of viability should be undertaken when the question of privatisation does arise. Ultimately, policymakers should always be aware that, although the private sector may finance social infrastructure, the government is still expected to

absorb demand risk while providing indirect support through the implicit understanding that hospitals will be financially bailed out should a project fail to produce the expected financial returns expected by private investors.<sup>90</sup> The moral hazard created by these factors heightens the risk that any failure to perform proper financial assessments of hospital PPPs could result in government paying a premium for the mistakes of private operators.

The case studies provide another crucial lesson for policy makers: whilst outsourcing may be an effective change management strategy, it is not a panacea for financial, quality and work practice issues.<sup>91</sup> Sharp declines in staff morale and capacity, particularly in the health sector, has been shown to have a measurable detrimental impact on service delivery. The confusion, uncertainty and fear created by outsourcing can also erode the passion and care with which hospital workers perform their duties. Given the lack of any evidence to suggest that outsourcing has actually led to improved results for hospital clients and staff, the measurably detrimental effects that outsourcing has on service delivery and staff morale, as well as several recent high profile examples of hospitals “back sourcing” or reversing earlier decisions to “outsource” staff, it is highly evident that outsourcing should be avoided or mitigated wherever possible. The purported benefits, unlike the risks, have failed to materialise.



Some observers have questioned whether privatisation, including downsizing, is necessarily the most effective way of improving organisational outcomes. It is reasonable to argue that, even when cost savings and efficiency increases do occur, other change processes such as improved technology, greater workplace flexibility and departmental structural change can all result in similar overall improvements.<sup>92</sup> Considering the detrimental impact privatisation has been shown to have on the ability of hospital workers to perform their duties, policymakers should properly consider alternative streamlining methods to improve outcomes.

From a purely political perspective, the general inability of the public to distinguish between private contractors and government agencies should act as a warning to governments eager to indiscriminately engage in hospital privatisation and outsourcing. Whilst there may be valid reasons for privatising certain hospital services, appropriate management systems are essential for not only the smooth operation of healthcare services in hospitals, but also for the benefit of the government

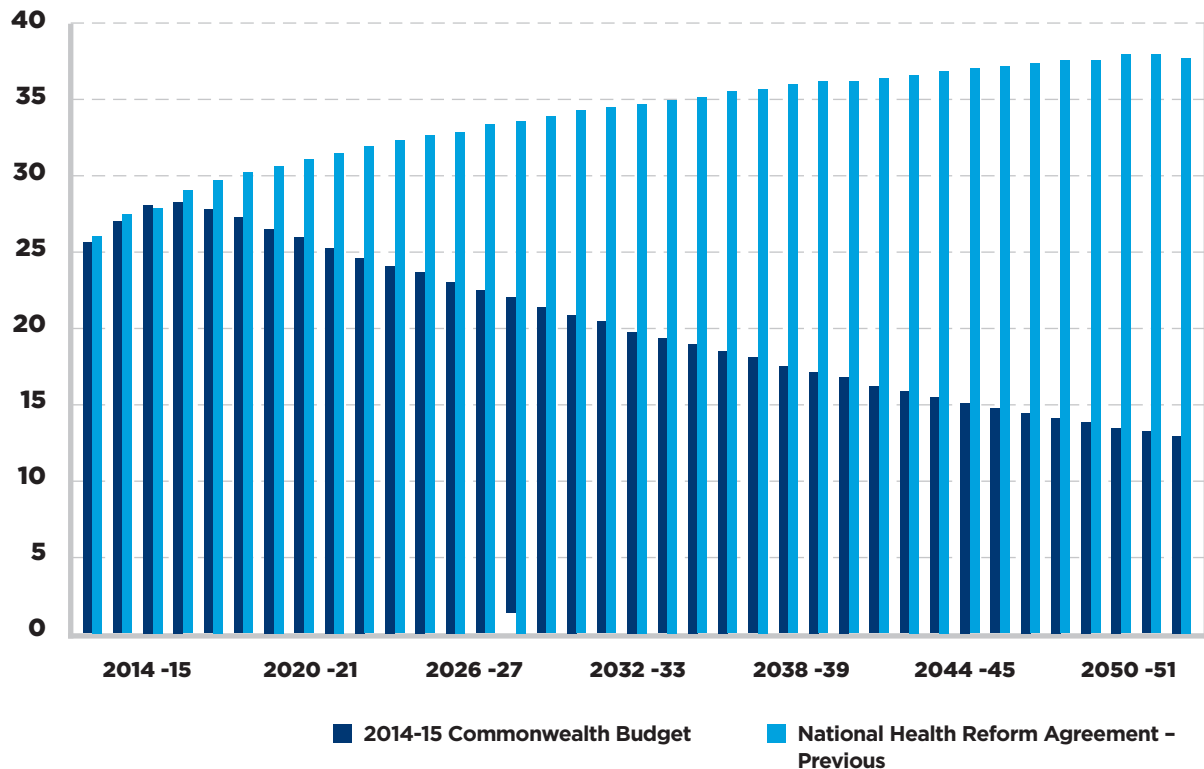
and the private contractor. If these considerations are ignored, the government will be the party that absorbs the blame – user dissatisfaction, unfavourable audit reports and the risk of voter backlash are possible negative outcomes that government could face if a project's goals are not met.<sup>93</sup>

### **The erosion of public health through increased privatisation**

When considering the merits of widespread health privatisation more broadly, it is critical that policy makers first consider whether further privatisation risks eroding the concept of universal healthcare.

Studies indicate that, although Medicare continues to allow most Australians access to doctors and hospitals, individuals on higher incomes are more likely to consult specialists, be admitted as private patients and have private health insurance, with lower income Australians not receiving the same assortment of services as their wealthier counterparts.<sup>94</sup>

**TABLE 8:** CHANGES IN COMMONWEALTH HEALTH FUNDING



In a number of areas, such as nursing, privatisation has created complex and contradictory outcomes. This has affected many hospitals' staff, and in particular has impacted workers whose primary role within a hospital is to ensure high quality patient care:

In this private system, nursing is primarily regarded as an expense to the hospital, while paradoxically marketed to potential patients as the company's most valuable asset. ... This contradictory location means that nurses are constructed as simultaneously central to the financial viability of the hospital yet unacknowledged, and hence forced into a precarious and constantly shifting role.<sup>95</sup>

Other studies, in line with international research, have found that longer waiting times for public patients in Australia are associated with higher proportions of hospital care being provided in the private sector.<sup>96</sup> As such, policymakers should

not assume that increasing support for the private sector will take pressure off the public sector and reduce waiting times for public patients.

It is difficult to determine the ultimate impact of hospital privatisation on Australia's universal healthcare system. The performance of hospitals and the cost of providing hospital services is often influenced by factors that are beyond the control of State Governments, including the recent Federal Government's announcement that it will introduce a \$7 co-payment for visits to General Practitioners whilst also implementing a steep reduction in the level of commonwealth health funding for States and Territories. NSW Health has calculated that the co-payment will result in an additional 500,000 emergency department visits per year, almost all of which will be serviced by public hospitals. NSW Treasury calculates that the scrapping of the National Health Reform Agreement will mean that the commonwealth government's contribution to NSW health expenditure will halve from 26 percent to 13 percent by 2050.



In response to these challenges, the ideological temptation for policy makers to pursue savings through privatisation will be strong. Given these pressure, it is crucial that policy makers first consider the evidence presented by past case studies. It should not be automatically assumed that privatisation and outsourcing will deliver greater savings to the public budget. Past evidence suggests a significant risk that, rather than improved efficiency and savings to the public purse, rushing headlong into privatisation will harm patients, hospital staff, and crucially, state revenue. Policy makers need to consider these risks when considering the best possible approach to management of the state health budget.

### **The need for better processes: Defining 'successful' privatisations**

In order for privatisation to be a worthwhile endeavour for governments, two glaring variations to the current model must take place. Firstly, the definition of a 'successful' hospital public-private partnership must be made clear. One of the oft-quoted objectives for the privatisation of public hospital is the assumption that a privatised hospital will operate on a more efficient basis. However, as Productivity Commission research has found, at least in NSW and Victoria, public hospitals are notably more efficient than their private counterparts at the overall casemix-adjusted level. Across Australia, there is only a slight difference in overall costs.<sup>97</sup>

For a government to take on more risk by inviting a private partner into the provision of health services, the financial benefits should be more apparent. The provision for regular reporting (~every 5 years) on key performance indicators, including both financial efficiency data and service delivery, as well as a minimum requirement for efficiency deliverables, should be written into every partnership contract.

### **Mitigate government risk**

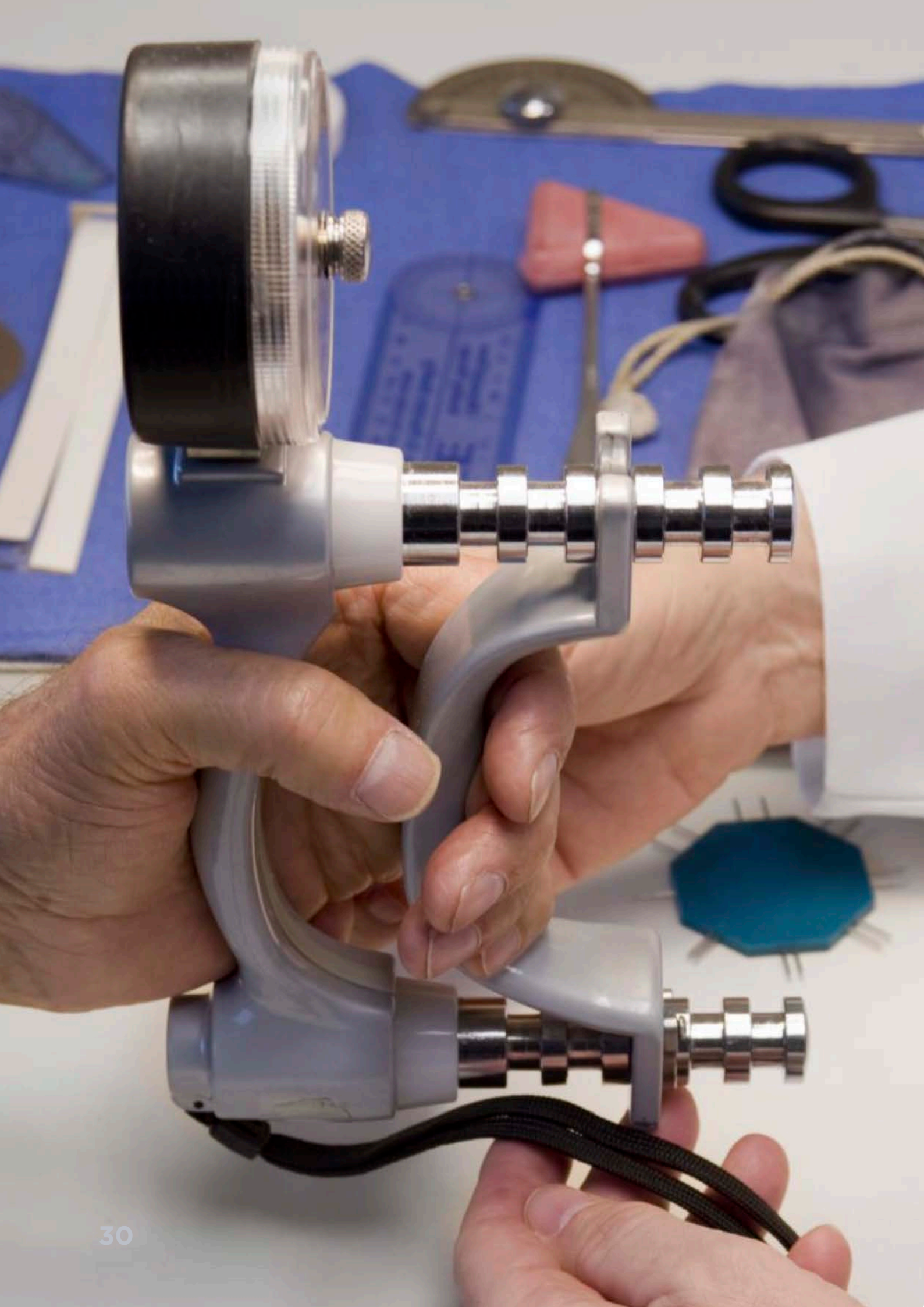
A crucial issue that needs to be addressed by policy makers is the moral hazard that is created by the absorption of demand risk by state governments when tendering a contract to operate social infrastructure. It can be argued that PPPs create a greater moral hazard by allowing private partners to take on more risk, with the knowledge that the government will bail out the hospital in the event of financial failure. This report has highlighted multiple instances in which this has already occurred, the most infamous of which occurred at the Port Macquarie Base Hospital.

More research into options for the mitigation of government risk must be undertaken, as well as further research into the general pricing and allocation of risk in hospital PPPs. The inescapable point is that, in the eyes of the public, all hospitals are ultimately still the responsibility of the government to ensure: any failure, whether public or private, will ultimately need to be addressed through state government intervention.

Moral hazard increases the propensity of private organisations to take risk, which in turn increases the likelihood of financial failure. As such, fiscal prudence and political pragmatism would dictate that an innovative new approach is required in order to ensure that PPPs are not resulting in an unfair allocation of risk for the government and its taxpayers.

### **Service-specific privatisation**

As has been revealed, many healthcare services provided by hospitals are done so more efficiently when operated by public hospitals, while others are sometimes more efficient when operated by the private sector. Greater research into the underlying factors as to why this occurs and how this information could be used to provide the most efficient and highest quality healthcare must be undertaken. Haphazard privatisation efforts have the potential to result in disastrous budget blowouts and healthcare services that are substandard.



# Conclusion

**Public healthcare comprises a significant part of state and territory expenditure. Public expenditure on healthcare will continue to grow as our population ages and expands, and as new technologies improve our national standard of health.**

Whilst private hospitals have some notable strengths, public hospitals in NSW and Victoria have been found to operate at a more cost efficient level, while nationally both public and private hospitals have overall similar financial costs on a casemix basis. Crucially, public hospitals continue to play the predominant role in providing emergency department services, services in regional areas, and services to less affluent Australians. A strong public health system is critical to ensuring universality of healthcare so that all Australians, whether rich or poor, city or country-dwellers, healthy or sick, can access free and high quality medical services.

The assumption that privatisation and outsourcing will deliver better services at a lower cost can be an enticing drawcard for policy makers seeking to reduce expenditure in healthcare. However, the evidence examined in this report finds that the expectation of budgetary savings is rarely met. Notably, decisions to privatise and outsource are often reversed at a later date once it becomes clear to policy makers that the strategy has resulted in a net negative impact on state balance sheets.

As shown by the case studies of the Port Macquarie Base Hospital and a number of Victorian hospital PPPs, poor planning and a stout belief in market efficiency have resulted not only in considerable financial detriment to State Governments, but significant negative impacts on hospital staff, patients, and general service delivery.

The examples of privatisation discussed and evaluated within this report have tended to be singular small project examples, either at smaller hospitals (Port Macquarie being the biggest as well as the most notable failure) or with selected services within hospitals. Larger privatisation

projects carry larger risks, particularly if the government has little prior experience operating larger scale health PPPs. A warning bell should be rung for any government which sees large scale private operation of the health system as a relatively simple policy goal. If the substantial problems identified in the above case studies are a demonstration of what can occur when the private operation is relatively small, then the risks and potential costs associated with failures at larger sites needs to be seriously considered by policy makers before pursuing widespread privatisation and outsourcing.

Lessons can be learned from previous attempts at privatisation, and it is imperative that they are. To ensure that privatisation is only undertaken in instances in which there will be a clear community benefit, extensive financial analysis and impact assessments must be undertaken prior to any contract being signed, with potential private sector operators thoroughly scrutinised to minimise the risk that they will fail to adhere to their contractual obligations. The question of moral hazard needs to be addressed, particularly given the classification of hospitals as core social infrastructure assets. There are numerous examples of private hospital operators being bailed out in the event of financial underperformance, and the expectation on state governments to effectively absorb demand risk is contributing to an environment which incentivises greater risk by private operators. To prevent further instances of governments being forced to pay an unexpected premium for the failures of private operators, the allocation and pricing of risk must be appropriately determined in any future privatisation attempt. If private operators are unwilling to absorb a higher degree of risk, policy makers must seriously consider whether the risks associated with that privatisation are justifiable.





The human element of hospitals also cannot be ignored. Staff morale and treatment must be maintained to the highest standard, with efforts to mitigate the inevitable pain that frequently arises as hitherto-public managed services are transferred to the private sector. Previous case studies have shown that when this is not effectively managed, a concurrent decline in quality has then affected the thousands of patients who require effective and compassionate care during their hospital stay. From a political perspective, it is rarely the private sector which is viewed by the public to be ultimately responsible for the loss of quality service, it is the government which most frequently shoulders the blame.

Government and policymakers must also consider the broader implications that can arise from increased privatisation within the health sector. Increased privatisation – whether of public health services or an increase in private hospitals more generally – could threaten the equity of access that best characterises Australia's public health system. Alternative solutions, such as improved technology, workplace flexibility and departmental structural change, need to be considered before subscribing uncritically to the renewed privatisation agenda.

Current and future governments should proceed with extreme caution when considering a hospital





privatisation project. The successful initiatives highlighted in this report exhibited clear and concise contracts that ensured all parties were aware of their obligations before the project began. As such, these projects have resulted in what can be deemed successful examples of healthcare privatisation, though this paper notes that “successful” in these instances is technically defined as the deliverance of services at par and not necessarily “better” than would occur within the public system.

Other case studies have demonstrated that the negative consequences of either a poor contract or sub-standard contractor are significant,

and that the cost of these consequences is predominantly borne by government. Governments must question whether it is worthwhile exposing itself and taxpayers to such high-risk endeavours.

But the risk is not only damage to government budgets, patients or hospital staff. Perhaps the most significant risk of all is that to one of our nation’s greatest social achievements: the envy of the modern world, our universal healthcare system. Australians must ask, what is our universal healthcare system worth?

# Footnotes

1. *The Australian*, NSW Premier Flags Hospital Privatisation, 20/4/2014, accessed on 28 October 2014 <http://www.theaustralian.com.au/news/latest-news/nsw-premier-flags-hospital-privatisation/story-fn3dxiwe-1226890483240>
2. Needham K., *Sydney Morning Herald*, NSW Premier Shares His Private Views, 20/4/2014, accessed on 28 October 2014 at <http://www.smh.com.au/nsw/new-premier-mike-baird-shares-his-private-views-20140419-36xxy.html#ixzz3EkoFCblJ>
3. Australian Institute of Health and Welfare, *Hospitals* (n.d.) accessed on 28 October 2014 at <http://aihw.gov.au/hospitals/>
4. Excluding same day discharges. See Australian Institute of Health and Welfare, *Australian hospital statistics 2012-13*, Health Services Series No 54, 2014, accessed on 28 October 2014 at <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129547000>
5. OECD, *OECD Health Statistic 2014 – How does Australia compare?*, 2014, accessed on 28 October 2014 at <http://www.oecd.org/els/health-systems/Briefing-Note-AUSTRALIA-2014.pdf>
6. Ibid.
7. Capital City Committee Adelaide, *Economist Intelligence Unit Liveability Rankings*, <http://capcity.adelaide.sa.gov.au/cities/global-city-rankings/economist-intelligence-unit-liveability-rankings/>
8. Australian Government, Australian Treasury, *Intergenerational Report 2010*, accessed on 28 October 2014 at [http://archive.treasury.gov.au/igr/igr2010/report/pdf/IGR\\_2010.pdf](http://archive.treasury.gov.au/igr/igr2010/report/pdf/IGR_2010.pdf)
9. Australian Institute of Health and Welfare, *Hospitals* (n.d.), accessed on 28 October 2014 at <http://aihw.gov.au/hospitals/>
10. Ibid.
11. IBISWorld, 'General Hospitals in Australia' (*Industry Report Q840*, January 2014) 4.
12. Ibid.
13. Ibid.
14. Ibid.
15. Ibid.
16. Australian Government, Australian Treasury, *Intergenerational Report 2010*, accessed on 28 October 2014 at [http://archive.treasury.gov.au/igr/igr2010/report/pdf/IGR\\_2010.pdf](http://archive.treasury.gov.au/igr/igr2010/report/pdf/IGR_2010.pdf)
17. PWC, Tax Reform will relieve burden on states, 21 May 2014, <http://www.pwc.com.au/media-centre/2014/tax-reform-May14.htm>
18. NSW Government, *Budget 2014-15* (2014) accessed on 28 October at [http://www.budget.nsw.gov.au/\\_data/assets/pdf\\_file/0019/124309/Ch\\_1.pdf](http://www.budget.nsw.gov.au/_data/assets/pdf_file/0019/124309/Ch_1.pdf) ch 1-5.
19. Taylor N., *The Guardian*, Liberal and Labor Premiers vow to fight \$80bn cuts to health and education, 18 May 2014, accessed on 28 October 2014 at <http://www.theguardian.com/world/2014/may/18/liberal-and-labor-premiers-vow-to-fight-80bn-cuts-to-health-and-education>
20. Australian Parliament, Office of the Treasurer, *Media Release: Treasurers agree to boost infrastructure*, 28 March 2014, accessed on 28 October 2014 at <http://jbh.ministers.treasury.gov.au/media-release/010-2014/>
21. IBISWorld, 'General Hospitals in Australia' (*Industry Report Q840*, January 2014).
22. Productivity Commission, *Research Report: Public and Private Hospitals*, December 2009, accessed on 28 October 2014 at [http://www.pc.gov.au/\\_data/assets/pdf\\_file/0015/93030/hospitals-report.pdf](http://www.pc.gov.au/_data/assets/pdf_file/0015/93030/hospitals-report.pdf)
23. Australian Bureau of Statistics, *4390.0 Private Hospitals, Australia 2012-13* (Health 30 June 2014) table 12; AIHW, *Australian hospital statistics 2012-13: emergency department care* (Health Services Series No 52, 2013).
24. Productivity Commission, *Research Report: Public and Private Hospitals*, December 2009, accessed on 28 October 2014 at [http://www.pc.gov.au/\\_data/assets/pdf\\_file/0015/93030/hospitals-report.pdf](http://www.pc.gov.au/_data/assets/pdf_file/0015/93030/hospitals-report.pdf)
25. IBISWorld, 'General Hospitals in Australia' (*Industry Report Q840*, January 2014).
26. Productivity Commission, *Research Report: Public and Private Hospitals*, December 2009, accessed on 28 October 2014 at [http://www.pc.gov.au/\\_data/assets/pdf\\_file/0015/93030/hospitals-report.pdf](http://www.pc.gov.au/_data/assets/pdf_file/0015/93030/hospitals-report.pdf)
27. Ibid.
28. Ibid.
29. Ibid.
30. Ibid.
31. Ibid.
32. Quiggin J., 'Public-Private Partnerships: Options for Improved Risk Allocation' (2005) 38 *The Australian Economic Review* 445.
33. Siddiquee N., 'Rhetoric and Reality of Public-Private Partnerships: Learning points from the Australian experience' (2011) 19 *Asian Journal of Political Science* 129, 130.
34. Ibid.
35. Young S., Macinati M., 'Health Outsourcing/Backsourcing' (2012) 14 *Public Management Review* 771, 780.
36. Gadiel D., Sammut J., 'How the NSW Coalition should Govern Health: Strategies for Microeconomic Reform' (Policy Monograph: *Papers in Health and Ageing*, The Centre for Independent Studies, 2012) accessed on 28 October 2014 at <http://www.cis.org.au/publications/policy-monographs/article/4393-how-the-nsw-coalition-should-govern-health-strategies-for-microeconomic-reform>
37. King S., Pitchford R., 'Privatisation in Australia:

- Understanding the Incentives in Public and Private Firms' (1998) 31 *The Australian Economic Review* 314.
38. Siddiquee N., 'Rhetoric and Reality of Public-Private Partnerships: Learning points from the Australian experience' (2011) 19 *Asian Journal of Political Science* 129, 130.
  39. Quiggin J., 'Public-Private Partnerships: Options for Improved Risk Allocation' (2005) 38 *The Australian Economic Review* 445.
  40. NSW Government, *Working with government: Risk allocation and commercial principles*, May 2007, accessed on 28 October 2014 at [http://www.treasury.nsw.gov.au/data/assets/pdf\\_file/0012/3135/risk\\_allocation.pdf](http://www.treasury.nsw.gov.au/data/assets/pdf_file/0012/3135/risk_allocation.pdf)
  41. Stilwell F., Jordan K., 'In the public interest?' (2004) 72 *Arena* 9.
  42. Productivity Commission, *Research Report: Public and Private Hospitals*, December 2009, accessed on 28 October 2014 at [http://www.pc.gov.au/data/assets/pdf\\_file/0015/93030/hospitals-report.pdf](http://www.pc.gov.au/data/assets/pdf_file/0015/93030/hospitals-report.pdf)
  43. Chung D., 'Developing an Analytical Framework for Analysing and Assessing Public-Private Partnerships: A Hospital Case Study' (2009) 19 *The Economic and Labour Relations Review* 69, 70.
  44. Ibid.
  45. Jefferies M., McGeorge W.D., 'Using public-private partnerships (PPPs) to procure social infrastructure in Australia' (2009) 16 *Engineering, Construction and Architectural Management* 415; SA Health, 'Public Private Partnership and the new Royal Adelaide Hospital' (2014) <http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+reform/the+new+royal+adelaide+hospital/public+private+partnership+and+the+new+royal+adelaide+hospital>; Infrastructure Australia, 'PPP Projects in the Market as at July 2014' (2014) accessed on 28 October at [http://www.infrastructureaustralia.gov.au/public\\_private/market.aspx](http://www.infrastructureaustralia.gov.au/public_private/market.aspx)
  46. Infrastructure Australia, *National Public Private Partnership: Policy Framework* (December 2008) 3 accessed on 28 October 2014 at [http://www.infrastructureaustralia.gov.au/public\\_private/files/National\\_PPP\\_Policy\\_Framework\\_Dec\\_08.pdf](http://www.infrastructureaustralia.gov.au/public_private/files/National_PPP_Policy_Framework_Dec_08.pdf)
  47. State Government of Victoria, *Competitive Neutrality: A Statement of Victorian Government Policy* (1996) 5.
  48. Elks S., 'Premier Campbell Newman flags Queensland asset sell-off after election', *The Australian* (online) (3 December 2013) accessed on 28 October 2014 at <http://www.theaustralian.com.au/national-affairs/state-politics/premier-campbell-newman-flags-queensland-asset-selloff-after-election/story-e6fgrczx-1226774347326>
  49. Nicolls S., 'Asset sales "the only way" to fund new infrastructure: Premier Mike Baird' *Sydney Morning Herald*, 26 July 2014, <http://www.smh.com.au/nsw/asset-sales-the-only-way-to-fund-new-infrastructure-premier-mike-baird-20140725-zwo27.html>
  50. Australian Government, 'Reducing the size of government', *Budget 2014-15: Overview* May 2014, 22, accessed on 28 October 2014 at [http://www.budget.gov.au/2014-15/content/overview/html/overview\\_22.htm](http://www.budget.gov.au/2014-15/content/overview/html/overview_22.htm)
  51. Australian Government, *Budget 2014-15: Building Australia's Infrastructure* (May 2014) 7, accessed on 28 October 2014 at <http://www.budget.gov.au/2014-15/content/glossy/infrastructure/download/Infrastructure.pdf>
  52. Needham K., *Sydney Morning Herald*, New Premier Mike Baird shares his private views, 20 April 2014, accessed on 28 October at <http://www.smh.com.au/nsw/new-premier-mike-baird-shares-his-private-views-20140419-36xxy.html>; AAP, *The Australian*, NSW Premier flags hospital privatisation, 20 April 2014, accessed on 28 October 2014 at <http://www.theaustralian.com.au/news/latest-news/nsw-premier-flags-hospital-privatisation/story-fn3dxiwe-1226890483240>
  53. Needham K., *Sydney Morning Herald*, New Premier Mike Baird shares his private views, 20 April 2014, accessed on 28 October at <http://www.smh.com.au/nsw/new-premier-mike-baird-shares-his-private-views-20140419-36xxy.html>
  54. ABC News, New hospital plan privatisation by stealth, 2 May 2013, accessed on 28 October 2014 at <http://www.abc.net.au/news/2013-05-02/new-hospital-slammed-as-stealth-privatisation/4666248>
  55. NSW Nurses and Midwives' Association, Media Release: Northern Beaches nurses and community united against privatisation, 26 June 2014, accessed on 28 October 2014 at <http://www.nswnma.asn.au/wp-content/uploads/2014/06/NSWNMA-media-release-260614-Nurses-and-community-united-against-privatisation-of-Northern-Beaches.pdf>; Health Services Union, Media Release: NSW Premier flags hospital privatisation, 20 April 2014, accessed on 28 October 2014 at <https://www.hsu.asn.au/mediareleases/nsw-premier-flags-hospital-privatisation/>
  56. Gregoire P., *Altmedia*, NSW nurses say: privatisation, no way, 1 May 2014, accessed on 28 October 2014 at <http://www.altmedia.net.au/nsw-nurses-say-no-way-privatisation/92470>; AAP, *The Australian*, NSW Premier Flags Hospital Privatisation, 20 March 2014, accessed on 28 October 2014 at <http://www.theaustralian.com.au/news/latest-news/nsw-premier-flags-hospital-privatisation/story-fn3dxiwe-1226890483240>
  57. Chung D., 'Developing an Analytical Framework for Analysing and Assessing Public-Private Partnerships: A Hospital Case Study' (2009) 19 *The Economic and Labour Relations Review* 69, 70.
  58. Quiggin J., 'Public-Private Partnerships: Options for Improved Risk Allocation' (2005) 38 *The Australian Economic Review* 445.
  59. Sculli N., 'Public private partnerships: an exploratory study in health care' (2008) 16 *Asian Review of Accounting* 21, 22.
  60. Ibid.
  61. Ibid.
  62. Joondalup Health Campus, 'WA Health minister unveils major expansion at Joondalup Health Campus' *News and Events: Media Releases* (8 March 2012) <http://www.joondaluphealthcampus.com.au/News/wa-health-minister-unveils-major-expansion.aspx>
  63. Joondalup Health Campus, 'Our Redevelopment', *Our Hospital: Our Redevelopment* <http://www.joondaluphealthcampus.com.au/Our-Hospital/redevelopment.aspx>
  64. Greiner, N., 'PPPs can still be a perfect infrastructure match', *Australian Financial Review* (online) (20 February



- 2012) accessed on 28 October 2014 at [http://www.afr.com/p/opinion/ppps\\_can\\_still\\_be\\_perfect\\_infrastructure\\_cP0gkbgiesf13JlmGUSDzJ](http://www.afr.com/p/opinion/ppps_can_still_be_perfect_infrastructure_cP0gkbgiesf13JlmGUSDzJ)
65. Cook, B., 'Privatising health: the demise of MEDICARE?' (2006) 41 *Australian Journal of Social Issues* 199.
  66. Acerete B., Stafford A., Stapleton P., 'New development: New global health care PPP developments—a critique of the success story' (2012) 32 *Public Money & Management* 311, 313.
  67. National Health Performance Authority, *Time patients spent in emergency departments in 2012 and 2013* May 2014, accessed on 28 October 2014 at <http://www.nhpa.gov.au/internet/nhpa/publishing.nsf/Content/Report-Download-time-patients-spent-in-emergency-departments-in-2012-13>
  68. National Health Performance Authority, 'Malignant breast cancer surgery waiting times, 2011–12', *MyHospitals* 2014 accessed on 28 October 2014 at <http://www.myhospitals.gov.au/compare-hospitals/breast-cancer-waiting-time>
  69. National Health Performance Authority, 'Malignant breast cancer surgery waiting times, 2011–12', *MyHospitals* 2014 accessed on 28 October 2014 at <http://www.myhospitals.gov.au/compare-hospitals/breast-cancer-waiting-time>
  70. Collyer F., 'Privatisation and the public purse: The Port Macquarie Base Hospital' (1997) 10 *Just Policy* 27.
  71. Ibid
  72. NSW Auditor, *NSW Auditor General's Report for 1996*, 1996, 408.
  73. Australian Parliament, Senate Community Affairs References Committee, *Healing our hospitals: A report on public hospital funding*, 2000, 107, accessed on 28 October 2014 at [http://www.aph.gov.au/~media/wopapub/senate/committee/clac\\_ctte/completed\\_inquiries/1999\\_02/pubhosp/report/report\\_pdf.ashx](http://www.aph.gov.au/~media/wopapub/senate/committee/clac_ctte/completed_inquiries/1999_02/pubhosp/report/report_pdf.ashx)
  74. Ibid
  75. Chung D., 'Developing an Analytical Framework for Analysing and Assessing Public-Private Partnerships: A Hospital Case Study' (2009) 19 *The Economic and Labour Relations Review* 69, 70.
  76. Scullin N., 'Public private partnerships: an exploratory study in health care' (2008) 16 *Asian Review of Accounting* 21, 22.
  77. Australian Parliament, Senate Community Affairs References Committee, *Healing our hospitals: A report on public hospital funding*, 2000, 107, accessed on 28 October 2014 at [http://www.aph.gov.au/~media/wopapub/senate/committee/clac\\_ctte/completed\\_inquiries/1999\\_02/pubhosp/report/report\\_pdf.ashx](http://www.aph.gov.au/~media/wopapub/senate/committee/clac_ctte/completed_inquiries/1999_02/pubhosp/report/report_pdf.ashx)
  78. Ibid.
  79. Cook H., *The Age* 'Naphthine Government to buy back Mildura Base Hospital', 26 July 2013, accessed on 28 October 2014 at <http://www.theage.com.au/victoria/naphthine-government-to-buy-back-mildura-base-hospital-20130725-2qnc0.html>
  80. Ibid.
  81. South Australian Government, South Australian, *Treasury Budget Paper 1: Overview 2006-07*, 2007, accessed on 28 October 2014 at [http://www.treasury.sa.gov.au/\\_data/assets/pdf\\_file/0019/991/200607-bp1-budget-overview.pdf](http://www.treasury.sa.gov.au/_data/assets/pdf_file/0019/991/200607-bp1-budget-overview.pdf)
  82. Young S., 'Outsourcing in public health: a case study of contract failure and its aftermath' (2008) 22 *Journal of Health, Organization and Management* 446.
  83. Ibid.
  84. Ibid.
  85. Ibid., Suzanne Young, Manuela Macinati, Health Outsourcing/Backsourcing, 2012, 14 *Public Management Review* 771, 780.
  86. Atfield C., *Brisbane Times*, 'Staff lose jobs as Brisbane Children's Hospital switches location', 26 April 2014, accessed on 28 October 2014 at <http://www.brisbanetimes.com.au/queensland/staff-lose-jobs-as-brisbane-childrens-hospital-switches-location-20140426-37ao9.html>
  87. Young S., 'Outsourcing in public health: a case study of contract failure and its aftermath' (2008) 22 *Journal of Health, Organization and Management* 446.
  88. Collyer F., Privatisation and the public purse: The Port Macquarie Base Hospital, 1997, 10 *Just Policy* 27.
  89. Young S., 'Outsourcing in public health: a case study of contract failure and its aftermath' (2008) 22 *Journal of Health, Organization and Management* 446
  90. Quiggin J., Public-Private Partnerships: Options for Improved Risk Allocation, 2005, 38 *The Australian Economic Review* 445.
  91. Young S., 'Outsourcing in public health: a case study of contract failure and its aftermath' (2008) 22 *Journal of Health, Organization and Management* 446.
  92. Australian Parliament, Senate Community Affairs References Committee, *Healing our hospitals: A report on public hospital funding*, 2000, 107, accessed on 28 October 2014 at [http://www.aph.gov.au/~media/wopapub/senate/committee/clac\\_ctte/completed\\_inquiries/1999\\_02/pubhosp/report/report\\_pdf.ashx](http://www.aph.gov.au/~media/wopapub/senate/committee/clac_ctte/completed_inquiries/1999_02/pubhosp/report/report_pdf.ashx)
  93. Scullin N., 'Public private partnerships: an exploratory study in health care' (2008) 16 *Asian Review of Accounting* 21, 22.
  94. Doorslaer E. V., Clarke P., Savage E., Hall J., 'Horizontal inequities in Australia's mixed public/private health care system' (2008) 86 *Health Policy* 97.
  95. Collyer F., White K., 'The privatisation of Medicare and the National Health Service, and the global marketisation of healthcare systems', 2011, 20 *Health Sociology Review* 238, 242.
  96. Duckett S., 'Private care and public waiting', 2005, 29 *Australian Health Review* 87.
  97. Productivity Commission, *Public and Private Hospitals*, December 2009, accessed on 28 October 2014 at [http://www.pc.gov.au/\\_data/assets/pdf\\_file/0015/93030/hospitals-report.pdf](http://www.pc.gov.au/_data/assets/pdf_file/0015/93030/hospitals-report.pdf)





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