27

# Inquiry into Public Private Partnerships

**Legislative Assembly**
**Public Accounts Committee**
**Parliament of New South Wales**

**Submission prepared by**
**Annette Schmiede**
**November 2005**

Introduction.

This submission is based on my 11 year involvement with hospital PPP projects in Australia and a study of these projects, undertaken in 2004, by myself and a colleague, for the World Bank. These projects were a group of seven distinct PPP's, called BOOT projects, which included the provision of clinical services as well as the provision of capital infrastructure.

My experience with these hospital PPP projects began in 1994. I have participated in a number of tenders, two successful projects, one hospital in NSW the other in Qld. I have had an ongoing role with one of these hospitals as a director for 11years and Board chair for 8 years.

I have participated in all aspects of these projects from project conception, tender preparation, contract negotiation, financing, building, commissioning and operations.

History.

A few Liberal state governments embraced an ideology of economic rationalism beginning in the early 1990's. This philosophy was associated with the Thatcher government in the UK, and promoted the view that governments no longer needed to own and directly provide public services. These state governments adopted entrepreneurial strategies to stimulate improvement in public services and provide much needed infrastructure. There was an underlying belief that the private sector was more efficient, and through the creation of market pressures, this would encourage contestability and innovation, and as a result, better value would be achieved for the public.

Despite this ideology, the main driver of reform in Australia in the 90's was the poor economic situation of many state governments. Australia was emerging from a severe depression. State revenues were static, government debt was high and demand for services was growing. State governments were restricted in being able to raise loan funds. Off balance sheet transactions involving the private sector were seen as a way around these constraints.

In 1991 NSW was the first state to embrace the PPP approach to providing hospitals and health services. It was a radical approach to

propose that the contract with the private sector include not only the physical infrastructure but the clinical services as well. At this time the Federal government was selling two Veterans Hospitals.

Between 1991 and 2000 seven hospitals were developed in four states using the Build/Own/Operate PPP model. These were:

- Port Macquarie Hospital. NSW
- Hawkesbury District Health Service. NSW
- Joondalup Health Campus. WA
- Latrobe Hospital Vic.
- Mildura Hospital. Vic.
- Noosa District Hospital Qld.
- Robina Hospital. Qld.

Privatisation Objectives.

A main driver of health system reform, of which these projects were part, came out of macroeconomic policy, not health policy reform. State treasurys had a major role in promoting this approach. Initial project responsibility generally resided in the capital works branches of Health Departments. They usually coordinated the tender, building and commissioning phase. Upon completion, these projects often became the responsibility of operational branches who did not always understand the philosophy or detail of the projects. There was often bureaucratic opposition to these projects as they did not have bipartisan political support. The policy was seen as belonging to conservative governments.

The stated objectives of these hospital PPP projects could be broadly classified along the following lines:

1. Accelerate the upgrade of health funds infrastructure by gaining access to private funds.
2. Optimise efficiency and effectiveness of service delivery through introducing a measure of competition between service operators and enabling greater flexibility in operational management.
3. Improve accountability for the delivery of health services by separating the role of service operator from those of purchaser and regulator, specifying the nature and quantity of services and the criteria for assessment of quality and introducing guarantees of access and sanctions for non performance.

Results.

The Australian experience includes successes as well as failures. The first project in NSW unleashed significant opposition in political and health policy circles.
Three of the seven state projects listed above have reverted to government ownership well before the expiration of the contracts. Some of these have involved substantial financial losses for the operators.
There has been no systematic evaluation of each project against the stated objectives and actual outcomes.
There have been no comprehensive evaluations undertaken to determine if these contracts are delivering services at a comparable or lower cost than the government sector. A number of the hospital PPP projects required prices for clinical services to be discounted to government price benchmarks.

Benefits.

The major demonstrated benefit of these PPP hospital projects has consistently been health facilities delivered at a reduced initial capital cost over what governments could deliver.
Delivery time frames for these hospitals were shorter due to the streamlining of the planning, design and construction process. Space was generally used more efficiently by the private operators.
Another benefit has been the lifecycle maintenance built into the pricing of these projects. This allowed generous maintenance and replacement of facilities and equipment over the contract period, usually 20 years.

Process Issues.

Competition was fierce in finance and legal circles to advise government and operators, and earn the lucrative fees associated with these contracts. Construction firms were also eager to participate in these projects and often brought the initial skills to the table in consortiums with operators.

Financing and ownership structures were complex and complicated.

There was no standardized approach. Each state and each project often differed in approach, contract requirements and project structure.

Public servants often lacked experience and knowledge. Private operators were building skill and expertise as they bid on successive projects.

Probity requirements were onerous and did not always lead to sensible processes.

Implementation Issues

All of these hospital projects were initiated by conservative governments. There was often fierce opposition to these projects by opposition Labor parties. When there was a change of government, which happened in NSW, Vic and Qld, there was an underlying antagonism to these projects by the incoming government. This environment often made it difficult to negotiate issues that were either not anticipated in the contract or had not been given enough clarity or detail in the contract. Relationships often became adversarial.

A major issue with implementation was often the difficulties in negotiating acceptable annual operating budgets. Another area that resulted in protracted disputes was the methodology for covering price increases. Underlying these problems were the methodologies used by government to set ongoing prices. They were not always transparent, consistent or logical. Pricing methodologies used in the contracts were complex and not easily benchmarked to government services.

Preceding the transfer of these projects back to government ownership were many disputes around the unequal and open ended risk exposure operators were exposed to. This was particularly the case with accident and emergency services. There have been considerable subsidisations of some services in these projects, particularly accident and emergency services where demand was open ended.

Another area of dispute were the growth assumptions contained in tender documents. They were often not reflected in annual operating budgets.

Lessons

The Australian experience with hospital PPP's includes successes as well as failures. With only a few exceptions these experiences have not been systematically or independently evaluated to test the

achievement of the stated objectives that motivated each State Government when they embarked upon each project.
The lessons learned can be summarized as follows:

- Policy intent should be overt and bipartisan. Without government and bureaucratic commitment to the model and to ironing out the wrinkles, a hospital PPP is unlikely to be sustainable based on the experiences of the seven projects that this submission relates.
- The community must be supportive.
- The process must be clearly understood and driven by the responsible department, not only treasury.
- Clarity about the role of the private sector in the overall health sector.
- Understanding the real costs of providing government services - capital and operating.
- Risk allocation must be equitable.
- Goodwill and commonsense must be used otherwise the relationship will become adversarial.

I look forward to elaborating on these points with the committee.