Submission No 103

INQUIRY INTO OPERATION AND MANAGEMENT OF THE NORTHERN BEACHES HOSPITAL

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Submission to Portfolio Committee No. 2 – Health Inquiry into the Operation and Management of the Northern Beaches Hospital on behalf of Public Services International

Public Services International (PSI)[1] welcomes the opportunity to make a submission to the Committee with regard to the operation and management of Northern Beaches Hospital and thanks the committee for their consideration of the issues raised within. The author is available for further comment should the committee require.

PSI takes the opportunity to comment on the merits of public private partnership (PPP) arrangements for the provision of health care (**item g.** of the terms of reference), more broadly with regard to issues of transparency and accountability (**items a. & b.**), and on tax and finance implications related to corporate structures and how this undermines trust in government (**item h.**).

The submission will show that;

- available national and international evidence demonstrates that the privatisation of health care is a failed model,
- the failures manifest in lower standards of care delivery, poorer health care outcomes, reduced staffing levels, a failure to meet community expectations, economic losses for

[1] PSI brings together more than 20 million workers represented by 700 unions in 154 countries and territories including Australian public sector unions. We are a global trade union federation dedicated to promoting quality public services. Our role includes the coordination of advocacy on issues that affect our members and the communities in which they live. Our members, two-thirds of whom are women, work in social services, health care, municipal and community services, central and local government, and public utilities. PSI is represented through sub-regions; Oceania represents public sector unions in Australia, New Zealand and the Pacific Islands.

Disclaimer: The author of this submission is an employee of both PSI and the New South Wales Nurses' & Midwives' Association (NSWNMA). The report is submitted on behalf of PSI, of which the NSWNMA is an affiliate, however responsibility for the contents of the report rests with the author.

individuals, government and, at times, even the providers, and, diminished trust in government secondary to transparency and accountability failures,

- and that based on economic theory, the failures at Northern Beaches Hospital were entirely predictable, and that this, combined with the history of failures, demonstrates that the Northern Beaches Hospital should never have been privatised.

Recommendations arising out of this submission for the Committee's consideration appear on page 15.

The merits of privatisation for the delivery of health care:

The number health care privatisation[2] failures in Australia, and the impact of those failures, provides strong evidence that it is a failed mechanism for health care delivery. At best, it is a considerably risky proposition for governments to consider.

A 2017 report, *Taking Back Control: A community response to privatisation*[3], examined the impact that privatisation has had on Australian communities. The report outlines the breadth of failures across hospitals, disability services, and aged care. With respect to health care privatisation the report notes thirteen examples within Australia, excluding aged care and disability services (see Appendix 1). Within these examples is a mixture of for-profit and not-for-profit third-party involvement. The failures are defined by:

- The provider seeking further government funding than what was agreed to in the contract; in one case within six months (La Trobe, Modbury, Royal North Shore),
- The provider becoming unfinancial (Robina),
- Adverse outcomes and/or patient care being compromised (Port Macquarie, Fiona Stanley, Royal North Shore, Royal Perth, Juvenile Detention in Northern Territory),

[2] Privatisation is the transfer, either wholly, or in part, of the delivery and/or ownership of public services and/or infrastructure, to the non-government sector, whether to for-profit, or to not-for-profit providers/owners. The transfer of regulatory responsibility, in whole or in part, is also a form of privatisation. Therefore, Public Private Partnerships (PPPs), Social Impact Bonds (also known as Social Impact Investments in NSW), outsourcing, tendering, mutualisation, voucher systems, leasing, and commissioning should all be seen as privatisation. This reflects a WHO definition of privatisation.

[3] https://www.peoplesinquiry.org.au/report

- Decreased services and/or a failure to meet community expectations (La Trobe, Port Macquarie Base, Modbury, North West Regional Hospitals, Royal North Shore, Royal Perth, Sir Charles Gairdner, Mildura, Juvenile Detention),
- And, A reduction in staffing and numbers of qualified staff (Port Macquarie, Royal North Shore, Royal Perth, Sir Charles Gairdner).

There is a direct comparison to be made with the Northern Beaches Hospital. The circumstances at the facility were described as unsustainable and unreliable[4]. The media reports that the hospital was opened without adequate planning[5]. The Chief Executive Officer resigned shortly after opening following reports of shortages of staffing and supplies[6]. Clearly this is not what the community expects. There is some data available via the Bureau of Health Information that indicates the new hospital is not meeting the outcome standards achieved by the older public hospitals which it replaced.

That health care privatisation fails is not new information. In Australia the failures span from 1994 to 2019. In 2000, an Australian Senate Inquiry into public hospital funding explored the interface between private and public hospitals (chapter six) and made the following recommendation[7]:

> Recommendation 24: In view of the difficulties currently being experienced at several privately managed public hospitals, the Committee recommends that no further privatisation of public hospitals should occur until a thorough national investigation is conducted and that some advantage for patients can be demonstrated for this mode of delivery of services.

The Howard Government did not accept the recommendation, stating simply that healthcare delivery is a matter for the States and Territories and that the sharing of information may lead to more successful privatisation in the future. A thorough national investigation has not been carried out and the failures continue.

International evidence makes it clear that the Australian experience of hospital privatisation is not an aberration.

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[4] https://www.smh.com.au/national/nsw/unsustainable-unreliable-damning-report-for-new-sydney-hospital-20190709-p525fm.html
[5] https://www.theguardian.com/australia-news/2019/jul/09/sydney-hospital-found-to-have-opened-without-adequate-planning-or-preparation
[6] https://www.theguardian.com/australia-news/2018/nov/21/ceo-of-troubled-sydney-hospital-resigns-two-days-after-opening
[7] Commonwealth of Australia (2000). Healing our hospitals: A report on public hospital funding. Available at: https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries/1999-02/pubhosp/report/index

In the United Kingdom (UK) at least twelve heath care privatisation failures have been reported. These include Paddington Health Campus, Durham District Hospital, Hereford, Seacroft Hospital[8], Hinchinbrook and Peterborough, the Cumberland Infirmary, Walsgrave, North Durham, the Royal Edinburgh Infirmary, the Royal Liverpool and Broadgreen, Norwich and Norfolk, and the Queen Alexandra[9]. Two other privatisation proposals (Staffordshire palliative and cancer services, and *NHS Professionals* (NHS agency staff)) were abandoned by the current government[10]. These failures replicate the Australian experience with evidence of:

- Cost blow outs (though the local Trusts are having to cover the costs and are therefore making reductions in other areas, or are being supplemented by the government)
- Reduced services (ward and bed closures)
- Staffing reductions, including qualified staff being replaced by unqualified staff
- Patient outcomes being compromised

In 2006 The World Health Organisation released a bulletin that explore public private partnerships for hospitals[11]. In addition to six of the UK examples cited above it identified Australia's La Trobe Hospital, the Alzira Hospital in Spain, and Bishop Auckland Hospital in New Zealand. The report's conclusion makes it clear that the risks of hospital privatisation were known (emphasis added):

> The theoretical justification for private financing of public facilities, although debated, has come to be widely accepted. However the practical results seem not to have lived up to what was expected from privately funded ventures. The new facilities have, in general, been more expensive than they would have been if procured using traditional methods and where the public sector does achieve a good deal from a privately funded development, it may have to pay more later to prevent the project from collapsing.
>
> One positive finding is that, compared with the traditional system, new facilities are more likely to be built on time and within budget; but these gains seem often to be at the expense of quality. The need to minimize the risk to the parties means that it is very difficult to "futureproof" facilities in a rapidly changing world. Finally, while the processes involved in procuring standard general hospitals are now well established, the complexity involved is increasing, especially with very large projects.
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> Major capital procurement is very difficult in any sector. Examples from the defence sector offer many cautionary tales and there are striking parallels between the difficulties being

[8] McKee, M., Edwards, N. & Atun, R.(2006). Public-private partnerships for hospitals. *Bulletin of the World Health Organisation*. 84(11). pp. 892-893.
[9] https://bankwatch.org/public-private-partnerships/case-studies/uk-hospital-ppps
[10] https://www.kingsfund.org.uk/publications/articles/big-election-questions-nhs-privatised?gclid=CjwKCAjw67XpBRBqEiwA5RCocaLTPsWylOUI0_b4oXYb3oNzSYv-esHCMA8MsdElpwnIWfUdDSSJJBoCaoEQAvD_BwE
[11] McKee, M., Edwards, N. & Atun, R.(2006). Public-private partnerships for hospitals. *Bulletin of the World Health Organisation*. 84(11). pp. 892-893.

> faced by those procuring a major teaching hospital and the current procurement of two planned British aircraft carriers. However, public–private partnerships to procure hospital services do seem especially difficult.
>
> Unfortunately, the debate on the merits of different approaches has been characterized by ideology rather than evidence, with a reluctance to undertake evaluations. In the United Kingdom one of the leading critics of the PFI has been subject to vociferous personal attacks by some politicians.
>
> It is impossible to say whether the model underlying public–private partnerships is flawed or whether the difficulties with such endeavours are the result of mistakes in its execution. One plausible interpretation is that the additional complexity of public–private partnerships makes all but the most straightforward projects just too difficult. Uncertainty surrounding the role and value of public–private partnerships in health care needs urgent resolution.

A 2015 report by Eurodad[12] highlights a case study of a privatised hospital in Lesotho. The hospital is now costing the government three times what the old hospital did (consuming half of the country's health budget); the government now believes that it will be cheaper to build a new hospital for excess patients rather than pay the private provider to treat them.

A subsequent report[13] by Eurodad highlighted the privatised Nya Karolinska Solna Hospital in Sweden. The report states that:

> In 2010, Swedish authorities gave single bidder the Swedish Hospital Partners (SHP) a PPP contract to build and manage the Nya Karolinska Solna (NKS) Hospital. It was intended to be "one of the world's most advanced hospitals", but is now known as the "most expensive hospital in the world". NKS is still not fully operational due to technical failures. Furthermore, the cost of the project has rocketed — a fact that was only fully exposed in 2015 by journalists at the Svenska Dagbladet newspaper. Meanwhile the private consortium has made a significant profit.

This national and international evidence of 27 failures, some minor, some severe, demonstrates that, whether a developing or developed nation, whether governments 'go it alone' or are supported by international institutions, health care privatisation fails communities.

There is a growing international discourse against privatisation in general, at times from unexpected sources.

[12] Romero, M, J. (2015). What lies beneath? A critical assessment of PPPs and their impact on sustainable development.
[13] Romero, M, J. & Ravenscroft, J. (Eds). (2018). History RePPPeated: How public private partnerships are failing.

Former chairman of the Australian Competition and Consumer Commission, Rod Simms, who identified himself as a proponent of privatisation, has since critiqued it; citing a lack of regulation and the creation of monopolies. Simms now agrees that privatisation is leading to higher prices for consumers[14]. Whilst Simms was referring to infrastructure, and in particular the privatisation of the nation's sea ports, the parallels to health are not difficult to make. Patients accessing cancer services at the Chris O'Brien Lifehouse, which saw the privatisation of cancer services previously offered by the adjacent public hospital, are paying higher out-of-pocket expenses compared to the services previously offered at the public hospital. It provides these services with a monopoly within the district. Privatised public hospitals have an automatic monopoly for the provision of public health care within each health care district. The New South Wales Nurses and Midwives' Association (NSWNMA) claims that the Chris O'Brien Lifehouse is underperforming compared to its public counter parts[15].

Whilst the International Monetary Fund (IMF) continues to push privatisation in practice, some of its own reports indicate the harm privatisation causes to economies. *The Independent* news outlet reported on the IMF's assessment of the UK economy[16] (emphasis added):

> The IMF's report takes particular aim at the privatisation of public assets, the benefits of which it says are often merely an "illusion".
>
> The UK has undergone one of the most drastic privatisations of any economy since the early 1980s.
>
> Under the Conservative government since 2015, policy has gone a stage further, incentivising departments and local authorities to sell off assets to fund day-to-day spending under the premise that such an approach is necessary to cut the deficit.
>
> But the IMF economists said the tendency of governments to focus on debt "misses large swaths of government activity and can fall victim to illusory fiscal practices".
>
> When public assets are taken into account, selling a public utility, for example, may do nothing to improve the public finances, the IMF said.
>
> "For instance, privatisations increase revenue and lower deficits but also reduce the government's asset holdings," the report stated.
>
> "Similarly, cutting back maintenance expenditure reduces the deficit and lowers debt, but also reduces the value of infrastructure assets, which could cost more in the long term."

[14] https://www.smh.com.au/business/privatisation-has-damaged-the-economy-says-accc-chief-20160726-gqe2c2.html
[15] http://www.nswnma.asn.au/wp-content/uploads/2016/09/Privatisation-booklet0517-LR.pdf
[16] https://www.independent.co.uk/news/business/news/britain-public-finances-worse-than-gambia-uganda-kenya-imf-report-a8577671.html

The IMF released an advisory "How To Note"[17] which states:

> While in the short term, PPPs may appear cheaper than traditional public investment, over time they can turn out to be more expensive and undermine fiscal sustainability".

The United Nation's Human Rights Council's 2018 annual report by Special Rapporteur on Extreme Poverty and Human Rights, Philip Alston, looked at the impact of privatisation[18]. The report states that:

> the world has been fundamentally reordered by widespread neoliberal economics that has privatized basic public goods — social protections, education, pensions and criminal justice among them — with often disastrous impacts on the human rights of the extremely poor".

And that:

> proponents of privatization — the World Bank, International Monetary Fund (IMF) and parts of the United Nations — claim the private sector is more efficient, innovative and cost effective. Yet, their projects are often costlier and provide inferior service at considerable profit, all while ignoring human rights standards and shelving compassion. There is a "striking disconnect" of the idealized narrative around privatization and the findings of many studies".

And that:

> The European Union and United Kingdom studies also raise other concerns that warrant brief mention here: (a) conflicts between public concerns over the quality of life and the private sector's preoccupation with profitability; (b) the difficulty of avoiding windfall returns to the private sector, while compensating for unanticipated losses through renegotiations; (c) private sector entities structured to minimize or avoid taxes on profits; (d) a lack of competition in privatized project design and selection; (e) the risk of private monopolies; (f) the misallocation of risk between parties and excessive remuneration rates to private companies; and (g) inflexible long-term contracts that can leave Governments with expensive "white elephants".

From an economic theory perspective, it may be that the health care privatisation failures were entirely predictable. A 2014 paper[19] by Senior Research Fellow at Sydney University's Department of Political Economy, Phillip Toner, examined the application of Transaction Cost Economics (TCE) theory to the privatisation of Vocational Education and Training (VET) in Australia and found that it "does not meet the minimum conditions for efficient contracting out". The paper explores the asymmetry between a VET student (client) and the private provider. However, aspects of the

[17] https://www.imf.org/en/Publications/Fiscal-Affairs-Department-How-To-Notes/Issues/2018/10/17/How-to-Control-the-Fiscal-Costs-of-Public-Private-Partnerships-46294
[18] https://undocs.org/A/73/396 & https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=23740&LangID=E
[19] Toner, P. (2014). Contracting out publicly funded vocational education: A transaction cost critique. *The Economic and Labour Relations Review*. 25(2) 222-239.

approach could be used to assess if the conditions are right for the efficient contracting out of health care.

Toner cites work by Williamson who analysed risk in market transactions. Key points are that:

1. There is an information asymmetry: Private health care companies typically provide comparatively low volume, low risk services aimed at elective or lower-cost procedures. Their knowledge in providing high volume complex emergency services may be limited. The government may not know the details of the private providers service delivery methodology and outcomes; most private hospitals provide no, or limited, outcomes data for public analysis. This information asymmetry may have been demonstrated in the cases cited in Appendix 1 (La Trobe, Modbury), where providers have sought additional funding, and the financial collapse of the provider (Robina); the providers had inadequate knowledge of running a public hospital. The early days of the Northern Beaches Hospital, where inadequate equipment and poor process design, indicates a fundamental lack of knowledge and therefor preparedness. In the case of La Trobe, Modbury and Robina, this suggests that the third parties underestimated the cost of providing the service within their tender offers.

2. The importance of the contracted activity: The article states that[20];

> "The more important an activity to the survival, profitability or quality of an organisation's output, the higher the risk in contracting an activity out. It is not just direct costs and rewards that enter into agents' decision-making regarding 'important' market transactions; TCE argues that externalities also need to enter into an agent's calculation. The risk of acquiring an 'important' good or service in the external market is increased when such transactions are undertaken only once or very infrequently. This limits the principal's scope for learning from market transactions and for improving outcomes from such exchanges."

From the non-government provider's perspective gaining government contracts in a diminishing private health insurance context[21] may be used as a way to ensure revenue to sustain their business model. In fact, this was admitted by Healthscope in regard to the Northern Beaches Hospital in a Sydney Morning Herald article[22].

> "We expect the Northern Beaches Hospital to ramp up to $300 million in annual revenue within three years, which will be around 10 per cent of group revenue," Mr

[20] ibid
[21] https://grattan.edu.au/report/the-history-of-private-health-insurance/
[22] https://www.smh.com.au/business/companies/healthscope-suitor-weighs-up-northern-beaches-woes-20181119-p50gxm.html

> James said. "It's therefore going to be a key part of revenue growth over the next couple of years as it ramps up."

From the government's perspective they face the choice of awarding the tender to a known provider (who is already providing a privatised government health care service) therefore creating a potential for a monopoly, or they use competition to drive the price down, risking awarding an un-known provider the job of providing health care to its citizens. The importance of an efficient and effective health care service is well understood in human and economic terms.

3. Complexity of the service: The complexity of health care service provision would make it difficult to specify detailed contract performance measures. Toner states that such contracts are described as incomplete. Incomplete contracts, Toner argues, increase the risk of opportunism to ensure profit. The examples of failures provided within this submission indicate that this has occurred through decreased services, reduction in staffing, and/or the qualifications of the staff. Further examples could be the quality and/or quantity of the materials purchased, adherence to policy and procedure guidelines, etc.

4. Risks emerge depending on the barriers to entry: Lower barriers to entry increase the risks. In the example of public health care delivery there are low, or no, barriers to the number of patients accessing care, they simply need to turn up to the Emergency Department. The complexity, and therefore cost, of care requirements rest between the treating health care professional and the patient (albeit with some restrictions being applied through policy and procedure guidelines).

5. Shifting of risk between the contractor and the contractee: Toner states:

> TCE reveals that attempting to shift risk between contracting parties arising from these multiple sources itself generates costs and risks. A principal can seek to insulate itself from such risks by the use of short-term contracts. This allows the principal to avoid long-term exposure to opportunistic agents and litigation and other transaction costs in terminating a contract. But short-term contracts will likely raise the hurdle rate of return sought by the agent investing in high-cost assets, especially in the case of assets designed to meet specialised needs of a principal. Risks to both principal and agent in this situation of 'bilateral dependence' can be addressed by the use of longer-term supply contracts, but these may reduce competitive pressure and the incentive for an agent to lower costs and innovate.

Longer term contracts also 'lock-in' the government to a service provider that may not be meeting either government or community expectations as in the case of La Trobe, Modbury, and Mildura. Toner's analysis also indicates that the government may lose knowledge of the service provision, or expertise, and this will disadvantage it in future contract negotiations/renewals.

A core principle of privatisation is that it promotes competition and innovation within the market place. Public hospital health care is not a market place, and therefore assumptions of competition driving down cost cannot apply. For the public choice is limited by there being one provider in their region unless they can afford private access. The general public have very limited capacity to decide between providers (clinicians), and bargaining power is minimal, especially in times of urgency. That some doctors are refusing to participate in publishing their costs[23] demonstrates the complexity for consumers and the barriers to correcting the asymmetry of information that could drive competition.

Whilst academic rigour should be applied to properly assess the correlation of Toner's analysis in relation to health care privatisation, a cursory assessment suggests that health care privatisation fails the minimum conditions for efficient contracting out. Irrespective of confirming an academically sound economic analysis of why the failures occur it is clear, considering national and international experiences, that the risks are so high as to preclude privatisation being an option.

Transparency and Accountability:

A 2014 report by the McKell Institute did identify two successful PPPs based on available performance indicators; Casey Hospital (Victoria) and Joondalup (Western Australia)[24]. However, a subsequent 2017 report[25] by the same institute, commenting on accountability, highlights that there are significant gaps in performance data and mixed results which means that it is "not

[23] https://www.smh.com.au/politics/federal/doctors-reject-meaningless-fee-transparency-website-20190716-p527p8.html
[24] The McKell Institute. (2014). *Risky Business: The pitfalls and missteps of hospital privatisation.*
[25] The McKell Institute. (2017). Privatised Hospitals: An accountability black hole

possible to make an informed decision on the performance of privatised hospitals". The report concludes that:

> We can see that taxpayers are not given the chance to know how privatised hospitals are performing - whether they are receiving value for money and quality care. The meagre amount of data doesn't allow for any definitive conclusions; this fact alone tells us it is misleading to claim that the private sector delivers a superior or lower cost service. These claims simply are not based in evidence because there isn't any. The absence of data exposes these claims as ideologically driven political rhetoric. Taxpayers and patients deserve better than that.[26]

Performance indicators for government run public hospitals are publicly available. Their performances vary and reveal areas for improvement. However, McKell demonstrate that private providers are not bound to comply with data provision. They make the point that a lack of data transparency can mean that the government and/or the public can not know if the services being provided are meeting key performance indicator benchmarks or community expectations. McKell also point out that this means there is a lack of evidence that the services are improved. A sound assessment of 'value for money' cannot therefore be made and, given commercial-in-confidence restrictions, cannot be made available for public scrutiny.

With regard to Joondalup, a 2000 Australian Senate Inquiry into public hospital funding[27] cited the then WA Auditor General who had stated there was

> "not reliable information to establish that the contract provides net tangible benefits to the State relative to the public sector alternative from either services or facilities"

That is to say, there is no evidence the State could not have achieved the same outcomes. The NSWNMA also question the outcomes for Joondalup and another privatised service, the Chris O'Brien Lifehouse[28]. This is a valid argument as the promoters of privatisation claim improved services at lower cost to government. Commercial-in-confidence precludes the community from knowing if this is fact, or how costs are decreased, and there is evidence of key performance indicators and community expectations not being met at these sites.

This links back to Toner's analysis of contract efficiency: Citizens accessing the privatised health care service cannot be aware of the contract outcome measures (due to commercial-in-confidence

[26] ibid
[27] Commonwealth of Australia (2000). Healing our hospitals: A report on public hospital funding. Available at: https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries/1999-02/pubhosp/report/index
[28] http://www.nswnma.asn.au/wp-content/uploads/2016/09/Privatisation-booklet0517-LR.pdf

and a lack of health care funding expertise) and, given limited exposure, may not have comparators that will allow them to recognise diminished services, or sufficient experiences that can inform their expectations.

This submission therefore supports the recommendations made within the 2017 McKell report[29]:

> Recommendation 1: Bring privatised hospitals into the Performance and Accountability Framework
>
> Whilst the National Health Reform Agreement states that privatised hospitals are to be treated as public hospitals, this provision has not carried over to the Performance and Accountability Framework that sits under the Agreement. The next hospital funding agreement signed by COAG needs to explicitly clarify how privatised hospitals are to be treated in terms of reporting and accountability.
>
> Recommendation 2: Publish privatised hospital performance data on *My Hospitals*
>
> Privatised hospitals must be required to report on their performance in the same manner as their public hospital peers through My Hospitals. This includes the same clinical, access and financial performance data that all public hospitals are required to report on. The community is entitled to expect the same accountability measures for these hospitals and to be able to make informed decisions about their performance.

Transparency gaps were identified at La Trobe where the then Victorian Government refused an order by its own Civil and Administrative Appeals Tribunal to release information. Transparency was also a feature of the Northern Beaches Hospital[30] and the recent proposal to privatise five public hospitals in New South Wales; the community and unions representing the workers were not being told who the potential providers were, what services would be provided, what staffing, or what employment conditions would be required within the contract. All on the premise of commercial-in-confidence. Healthscope was clearly not transparent with the community in its intent to sell to Brookfield. Given health care is a human right, it is morally wrong that the rights of corporations over-ride the human and democratic rights of the community.

The lack of transparency can create a cycle of accountability denial. When the public, or a civil society organisation, or an individual, have a complaint about the provision of service the government can blame the provider. The provider can claim they are meeting contract obligations, whilst never having to release those contracts details, or they can blame government funding and/or policies. Whilst the public can change government, they cannot change corporations or the Chief Executive Officers.

[29] The McKell Institute. (2017). Privatised Hospitals: An accountability black hole
[30] https://www.nswnma.asn.au/northern-beaches-privatisation-still-shrouded-in-secrecy/

This lack of transparency and accountability can be linked to the diminished trust in government and disengagement with democracy. In a statement to the *Peoples' Inquiry into Privatisation*[31] sociologist Eva Cox argued that people can no-longer see what government represents, that it is increasingly invisible within our communities, where once it was more present; the home phone, the local bank, roads and public transport. Cox argued that there is no-longer a sense that public services are something we own, and that this is contributing to a breakdown of community and democratic participation. If a community cannot hold a government service accountable, how can they build trust in the politicians elected to provide oversight of those services?

Any for-profit corporation's primary obligation is to their shareholders to whom they are accountable. The legislated fiduciary obligation to ensure that they are acting in a way that returns a profit is a clear clash of values compared to the provision of a well-funded universal health care system which lies at the heart of public health.

Corporate structures raise further questions with regard to transparency and accountability. Two of the reported failures noted earlier in this submission (North West Regional, Mildura) feature the corporation that won the tender, presumably having passed some sort of 'character' assessment, then selling to another entity. Healthscope has already sold the profits from its hospital holdings to Brookfield, a company reported to use aggressive tax minimisation practices[32]. In effect, the Australian tax payers' common wealth will now be channelled into accounts held in the Cayman Islands for private wealth, rather than being recirculated into the community. The community is paying for it twice with the well-publicised gaps in treatment and services at the site[33].

Whilst referring to aged care, three reports indicate that aggressive tax minimisation is a part of the business model for non-government providers of health care[34, 35, 36]. Analysis should be carried out to ascertain the tax practices of non-government providers prior to a tender being

[31] https://www.peoplesinquiry.org.au/report
[32] https://www.michaelwest.com.au/from-the-northern-beaches-of-sydney-to-the-northern-beaches-of-george-town-cayman-islands/
[33] https://www.nswnma.asn.au/privatised-northern-beaches-hospital-a-dangerous-shambles/
[34] http://cictar.org/for-profit-aged-care-report/
[35] http://cictar.org/australias-largest-for-profit-nursing-home-chains/
[36] http://cictar.org/all-in-the-family-tax-and-financial-practices-of-australias-largest-family-owned-aged-care-companies/

awarded to run a public hospital, or a service within a government hospital. This submission supports, in an amended form, the recommendation made within the reports on the tax practices of aged care providers: That any non-government entity, or combination of connected entities, who receive Federal or State funding, or hold a contract to provide a public service must be required to file full and complete annual financial statements with ASIC (or with the Australian Charities and Not-for-profits Commission), with no recourse to reduced disclosure filings, special purpose filings or other exemptions. This submission further supports a recommendation arising from the *Taking Back Control* report[37]; that any company found to be utilising aggressive tax minimisation process, or who has been found to have acted corruptly, or to have broken tax laws, should be precluded from obtaining contracts to run services related to public health care.

Tax payers have a right to hold governments and government departments accountable in ensuring revenue is spent efficiently and effectively whilst meeting the needs of the many, not the financial interests of non-government providers.

Corporate structures related to the use of sub-contracting adds layers of complexity and diminishes transparency when providers need to be held accountable. This has been demonstrated clearly in the recent example of the Earle Haven aged care facility in Queensland. The provider 'walked off' the premises, taking equipment and money, leaving the residents and staff stranded[38].

It should be noted that not-for-profit organisations are not a safe option for health care privatisation. The failures noted earlier include not-for-profit/charitable organisations. In submissions to the *People's Inquiry into Privatisation* it was clear that not-for-profit providers are forced to act like the for-profits, in terms of cutting staff and/or wages, in order to meet budget or to be competitive in tendering, and that smaller organisations are unable to compete (leading to monopolisation within the not-for-profit sector)[39].

The Committee should consider ways in which transparency and accountability process can be improved in existing and future contracts where non-government entities are providing health care services. As a means of further increasing transparency and accountability the Committee's

[37] https://www.peoplesinquiry.org.au/report
[38] https://www.abc.net.au/news/2019-07-16/earle-haven-aged-care-meeting-on-gold-coast/11312246
[39] https://www.peoplesinquiry.org.au/report

attention is drawn to the Principles and Recommendations contained within the *Taking Back Control* report from the *Peoples Inquiry into Privatisation*[40] . Some of these recommendations are reproduced within this submission.

Closing Comments:

There are a number of commonalities across all of the hospital privatisation failures noted within this submission. These include:

- Poor evidence of benefit to the state
- Poor evidence of benefit to the public (health care outcomes)
- Evidence of poor outcomes for patients
- Limited control over quality of care provided
- Cost overruns
- Poor contract management
- Poor understanding of contract costs (by both government and the provider)
- Increased risk to patients and to the government when failures occur
- Increased cost to tax payers who are left to rescue the service
- Loss of jobs and a resultant loss of experience both of which, apart from being devastating for the individual worker, flow on to impacting on patient care

Most of the information noted in this submission ought to have been known to government at the time that the decision to privatise the Northern Beaches Hospital was made. Given the available evidence, and the evidence arising from the Northern Beaches Hospital itself, it is clear that there must be a moratorium on any further privatisation of any health care service.

The moratorium should remain in place until there is sufficient publicly available peer reviewed evidence within the fields of economics, sociology, health and other areas for its successful return. The moratorium should remain in place until such time that legislative measures are in place which assure transparency, accountability, and that allow sufficient regulatory enforcement capacity to ensure agreed minimum standards are maintained.

This submission has not commented on the failures within aged care, disability and community health settings, however sufficient examples exist to be able to draw the same conclusion within those areas. Nor has the submission commented on the clear evidence that shows publicly funded and publicly run health care provision is the most effective and efficient method of

[40] https://www.peoplesinquiry.org.au/report

delivering universal health care. As stated by UN Human Rights Council's Special Rapporteur on Extreme Poverty and Human Rights:

> There is no substitute for the public sector to coordinate policies and programmes to ensure respect for human rights. Yet privatization directly undermines the viability of the public sector and redirects government funds to subsidies and tax breaks for corporate actors.

Recommendations:

Given this submission, Public Services International makes the following recommendations for the Committee's consideration and strongly encourages their implementation. We also draw on recommendations made by other parties as referenced within the submission and have amended where considered relevant for the purposes of this submission:

1. **We call for a complete moratorium on privatisation**. The moratorium should remain in place until there is sufficient publicly available peer reviewed evidence for its successful return, and until such time that legislative measures are in place that proper policy frameworks are implemented to assure transparency, accountability, and that allow regulatory enforcement capacity to ensure agreed minimum standards are maintained (see subsequent recommendations).

2. There is an urgent need to restore confidence in the provision of specific failed privatisations. **The government should take back control of the Northern Beaches Hospital.**

3. Prior to any new privatisation, governments must:
    - provide details of all the proposed benefits, sources of savings and evaluation of costs
    - assess the benefit to the public, including a comparison of service provision and access to prove why delivery of services cannot be maintained by the government
    - define minimum qualifications, that are not less than the State Award, for new employees prior to privatising
    - prohibit any company that has evaded taxes or broken the law from taking over public services.

4. Where there is a privatised service, governments must take back the regulatory space and set the rules. An independent regulatory body should oversee privatised assets and services to ensure accountability.

5. Governments must continue to employ sufficient, qualified ministry/department/'back-of-house' staff to evaluate the quality and competence of service providers, and to provide a

continued role in strategic advice. Departments of government should not be tendering policy decisions out to consulting or accountancy firms.

6. There must be **NO** commercial-in-confidence provisions when taking public money.

7. If a service is to be privatised, governments must set a fixed tender price that ensures cost is removed from the decision process and tenderers are competing on the basis of quality only. This prevents it being a race to the bottom.

8. Where privatisation occurs, the new provider must, as a minimum, maintain the same employment conditions and standards as the government service it replaced in regard to:
    - wages and conditions of employment
    - health and safety
    - equal opportunity employment
    - codes of ethics and other codes of practice.

8. Governments should take back control of failed privatisations rather than give contracts to new private providers (i.e. Royal North Shore's 'soft services').

9. All privatised services that receive government funding to provide a public service should report annually to ensure services and infrastructure that use public money are open, transparent and delivered to the highest quality. Such reports must contain:
    - a log of all complaints
    - a comprehensive and detailed, up-to-date cost of services, detailing government funds received and where the money has been spent
    - measurable key performance indicators (KPIs) equivalent to, and to the same standard/format as public hospitals
    - feedback from service users on quality
    - changes to workloads and employment conditions over the short and long term
    - evidence that public sector equivalent minimum staffing numbers and standards, including pay and conditions for staff, are met and that accredited qualifications are recognised.

10. Governments must legislate to ensure funding for services, in the case of not-for-profit organisations, is not linked to the ability of the provider to comment on government policy or dependent on its capacity to grow the organisation.

11. Any non-government agency who has a contract with government must provide Any entity, or combination of connected entities, that receive over $10 million in annual federal or State funding must be required to file full and complete annual financial statements with ASIC (or with the Australian Charities and Not-for-profits Commission), with no recourse to reduced disclosure filings, special purpose filings or other exemptions.

12. Bring privatised hospitals into the Performance and Accountability Framework. The next hospital funding agreement signed by COAG needs to explicitly clarify how privatised hospitals are to be treated in terms of reporting and accountability (McKell).

13. Publish privatised hospital performance data on *My Hospitals.* Privatised hospitals must be required to report on their performance in the same manner as their public hospital peers through My Hospitals. This includes the same clinical, access and financial performance data that all public hospitals are required to report on (McKell).

Appendix 1 (list of failed privatisations in Australia related to health care provision).

Hospital: **Port Macquarie Base Hospital** (New South Wales)
Period: 1994 - 2004
Key points:

- By 1998 elective surgery time was double the State average
- By 2003 there were 333 people having to wait more than a year for elective surgery compared to seven at Coffs Harbour and five at Taree hospitals. An inference to draw here is that more profitable private patients were possibly prioritised over public patients.
- In a submission to the inquiry that led to the report it was stated that staffing numbers in key areas were lower than comparable facilities, and that there is a lasting legacy of this in the renationalised service[41].
- Cost to NSW Government to renationalise the hospital was $35million (Over $49million at 2018 rates given inflation[42])

[41] https://www.peoplesinquiry.org.au/submissions

Kenneth Procter commented 2016-08-25 08:13:57 +1000

Having been through the decade long (1994-2004) experiment of private management of Port Macquarie's public hospital, I submit the following evaluation of that experience as a nurse working in public hospital services in Port Macquarie since 1990.

For staff who transferred from Hastings District Hospital, the guarantees from politicians and health bureaucrats on continuation of public award entitlements ended up being interpreted by the private management to their best advantage. Whilst wage rates were protected, other Public Award conditions were not as secure as we were led to believe. For example, we missed out on the roll out of Department of Health funding for ten hour night shifts as we were considered a 'private' hospital. The flat management structure of the privatised hospital meant that Nurse and Midwifery Unit Managers had additional tasks added to their workloads. In 2004, when the hospital came under public management, we were well behind in the numbers of nurses and midwives in consultant and education positions. Under private management, fewer allied health staff than would be normally expected in a publicly managed Base Hospital, meant that nurses and midwives had additional tasks in trying to cover for these staffing shortfalls.

Recruitment and promotion in the public service has a level of transparency that is absent in the private sector. Private management favoured appointment of staff with the right corporate mind set. Even on the day to day staffing of wards, when you have nurses and midwives employed under both Public and Private Awards, pressures to reduce wage costs inevitably influenced who was offered additional or overtime shifts.

Private management sought to reduce the number of staff employed under the Public Award. Tactics that were employed at Port Macquarie included using requests for variation in hours of employment to shift staff onto new contracts under the Private Award. Diminished direct connections with the public sector, meant that the paths for career development in the public sector were less accessible.

We had to fight against the widespread introduction of unregulated Assistants In Nursing (AINs). An attempt was made to employ large numbers of AINs under the guise of this being an innovative model of care.

Twelve years on Port Macquarie Base Hospital still suffers in comparison with peer hospitals due to the legacy of the decade of privatisation. This is particularly felt in the inadequate numbers of allied health staff and the level of services provided by the contracted pharmacy, radiology and pathology providers.

[42] https://www.rba.gov.au/calculator/annualDecimal.html

Hospital: **La Trobe Valley Hospital**[43] (Victoria)
Period: 1996 - 1999
Key points:

- Two local hospitals were merged into one privatised site. Within six months of operation the private provider approached government for more funding
- Following renationalisation, the company reported a loss of $6.2million ($10.2million 2018[44])
- The privatisation was said to be hampering the expansion of services available to the local community which occurred once the State Government took back control
- A lack of transparency is noted given the then Kennett Government refused to release the contract, citing commercial-in-confidence, despite the Victorian Civil and Administrative Appeals Tribunal ordering them to do so.

Hospital: **Modbury Hospital** (South Australia)
Period: 1995 – 2007 (despite a 20-year option)
Key points:

- Within two years the SA Government agreed to an increase in the contract price following the company's lobbying on the back of financial losses
- The private provider handed back the service in 2007 at a cost of $17.5million (today's cost)[45]
- According to a McKell report there were ongoing concerns about the level, variety and quality of services provided, leading to the handover[46]

Hospital: **Robina Hospital** (Queensland)
Period: 2000 - 2002
Key points:

- Service was renationalised as the not-for-profit organisation struggled financially

Hospital: **Fiona Stanley Hospital** (Western Australia) Non-essential Services
Period: 2014 - 1025
Key points:

- Serco was awarded a $4.3billion contract to run "non-essential" services including sterilisation.
- The WA Government ended the contract in 2015 following failures in the sterilisation of surgical equipment, including human tissue being left in sterilised equipment

Hospital: **North West Regional Hospital (Mersey + Burnie) Hospitals** (Tasmania)
Period: 1995 - 2004
Key points:

- Mayne Nickless (Mayne Health) won the tender, but sold the business in 2003 to Healthscope

[43] Note that this example is of two smaller hospitals being merged into one service, similar to the Manly/Mona Vale merger into the Northern Beaches Hospital scenario
[44] https://www.rba.gov.au/calculator/annualDecimal.html
[45] The McKell Institute. (2014). *Risky Business: The pitfalls and missteps of hospital privatisation.*
[46] ibid

- A downscaling of services at the site led to community anger which the then Howard Government capitalised on during the Federal election in a then marginal seat
- The Federal Government subsequently returned the facility to Tasmanian State Government control

Hospital: **Royal North Shore Hospital** ("Soft" Services including cleaning, porters, security, & catering) (New South Wales)
Period: 2008 - 2017
Key points:

- The private provider of the car park put a cap on the number of staff parking spots leading to a waiting list of over 500 staff to access parking rights
- A number of concerns were raised with regard to the quality of the services and staffing levels which were reduced in 2012 by 20%
- The subsequent lack of porters saw nurses and medical staff having to fill the gaps, delays in cleaning of beds at one stage reached six hours contributing to bed block in the emergency department
- The company reportedly sought more funding to maintain staffing levels, however this was refused by government
- Rather than renegotiate the contract the government returned services to the government owned operator

Hospital: **Royal Perth Hospital** (Cleaning Services) (Western Australia)
Key points:

- Reduction in staffing led to an outbreak of vancomycin-resistant enterococcus faecium (VRE) resulting in 172 patients contracting hospital acquired infections at a cost of $2.7million[47]

[47] Hansard WA Parliament; Mr R.H. Cook (2010). Available at: http://www.parliament.wa.gov.au/Hansard%5Chansard.nsf/0/9f4ecd3a6fbce11c482577120022c5d4/%24FILE/A38%20S1%2020100421%20p1965b-1968a.pdf

Hansard Excerpt:
In 1995 the Court government privatised the provision of orderlies at Sir Charles Gairdner Hospital. Immediately prior to the privatisation, 110 orderlies were employed at the hospital. The private services provider reduced that number to 56. A study of that privatisation program was reported in an article in the journal "Industrial and Corporate Change". That article suggested that higher than anticipated transaction costs and production costs were experienced by the hospital and that there were negative impacts on service quality and on other parties such as nurses. The article went on to say that, in contrast, when the service was returned to in-house delivery, transaction costs and production costs were lower than could have been achieved by contracting out the service. Hospital management and staff also considered the in-house service to be of higher quality than the orderly service it replaced.

Other hospitals have had similar negative experiences of the privatisation of services. At Royal Perth Hospital, when cleaning was privatised, there were significant difficulties in controlling infection in the hospital. I apologise for my pronunciation of the name of the following bacteria, but a single-strain outbreak of vancomycin-resistant enterococcus faecium, or VRE, occurred at Royal Perth Hospital between 23 July and 28 December 2001. A total of 172 patients were infected. A Commonwealth Scientific and Industrial Research Organisation report into the infection outbreak concluded that the factors that contributed to the spread of VRE in RPH included insufficient surveillance prior to the outbreak and not screening patients on transfer out of the intensive care unit to other wards; inadequate cleaning of wards—environmental contamination was demonstrated in many of the wards in which transmission to patients was detected; inadequate cleaning of commodes between patient use; shortage of nurses; and patient management practices, such as multiple transfers of patients within and between wards. The VRE outbreak at RPH was terminated after one month. The cost of the enhanced infection control practices that were required as a result of the outsourcing of cleaners was $2.7 million.

Hospital: **Sir Charles Gairdner Hospital** (wardspersons) (Western Australia)
Key points:

- The private provider decreased staffing by 50%[48]
- Costs decreased and quality increased once the service was brought back in-house

Hospital: **Perth Children's Hospital** (PPP for construction) (Western Australia)
Key points:

- Opening was delayed and costs blew out as controversy hit the construction process, including flooding and the illegal use of asbestos products, linked to poor public oversight

Hospital: **Mildura Hospital**
Period: 1998 – decision pending 2019
Key points:

- The initial consortium[49] who won the contract sold the business to Ramsay Healthcare in 2000
- Following a concerted community campaign, the Andrews Government sought community consultation about the future operation of the hospital. 90% of people responding to the consultation process, which included staff, stated that they would prefer the site was publicly-run[50]. The contract is set to expire in 2020

Hospital: **Midland Public Hospital** (Western Australia)
Key Points:

- Public services were reduced when the non-government St John of God Health Care provider took control. This included access to reproductive health services. This led to further privatisation when the government sourced these services from a third-party provider.
- A lack of transparency has been noted as key contractual performance measures have been kept from public view due to commercial-in-confidence.

Hospital: **Juvenile Detention** (Northern Territory)
Key Points:

- Exposure of a lack of services led to the government taking back control of healthcare provision at the facility. Examples included weekly access only to a psychiatrist, half the number of nurses thought of as a minimum resulting in guards distributing medications, no policies or protocols. Once to State resumed control policies and procedures were put in place, Aboriginal health practitioners were employed for primary health care.

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[48] ibid
[49] This included a company, Sun Healthcare Group who were named in the Victorian Parliament for having been accused of "submitting false and misleading information to obtain Medicaid payments totalling $15million over 2 years including more than $1million in travel and entertainment expenses".
https://www.parliament.vic.gov.au/images/stories/volume-hansard/smaller/Hansard%2053%20LC%20V441%20Oct-Nov1998/VicHansard_19981110_19981111.pdf
[50] https://www.premier.vic.gov.au/mildura-has-its-say-on-hospitals-future/

Other examples:

Aged Care & Disability Services:

- See the relevant chapters in *Taking Back Control: A Community Response to Privatisation*[51]
- See recent abandonment of nursing home residents in Queensland[52,53]
- See evidence being submitted to the Royal Commission into Aged Care

ENDS

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[51] https://www.peoplesinquiry.org.au/report
[52] https://www.abc.net.au/news/2019-07-11/gold-coast-earle-haven-retirement-village-shuts-homeless/11301050
[53] https://www.abc.net.au/news/2019-07-16/earle-haven-aged-care-meeting-on-gold-coast/11312246