

How the NSW Coalition Should Govern Health: Strategies for Microeconomic Reform

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Executive Summary

NSW public expenditure on health represents one-third of the entire NSW budget. Despite public hospitals consuming nearly 60% of the high and rapidly growing health spending, elective waiting times have lengthened in NSW compared to other states in the last decade.

In an ever-tightening fiscal environment, the focus of NSW health policy must be microeconomic reform of the rigid public service monopoly model of public hospital care. The adoption of market or private sector methods, including greater involvement of private operators in the delivery of public health service, should be encouraged to enhance productivity and improve access to quality hospital services at the least cost.

The implementation of comprehensive structural reform stalled under the NSW Labor governments from 1995 to 2011. Fledgling privatisations of public hospital services, by experimenting with privately financed projects (PFPs), were discontinued, principally at the bidding of public sector health unions.

PFPs are one of the avenues that have the potential to fundamentally change the traditional role of the NSW government from health service funder and provider of centrally coordinated hospital services to that of health service purchaser.

A 'purchaser-provider split' may deliver efficiency gains by creating a contestable market for public hospital care—at least to the extent possible under Medicare. This would oblige competing providers to adopt business axioms (such as a culture of competition, innovation and more customer-focused service delivery) that are usually foreign to public hospitals. Incentives for operational efficiency would be enhanced as responsibility for a hospital's entire budget, including financial risk for 'core' clinical services (covering nurses, doctors and allied health), would be carried (at least in part) by the provider instead of the purchaser (the state government).

Most importantly, effective managerial autonomy would include the freedom to hire clinical personnel on terms relevant to, and most suitable, for local conditions. Centralised control of human resources by NSW Health—the centrepiece of the restrictive public model—means that hospital managers currently lack administrative authority over their clinical workforce. Statewide nursing awards and prescribed ratios of nurses to patients, combined with the freedoms visiting medical officers (VMOs) and staff specialists may exercise over their work practices, deny managers the flexibility to secure efficient and effective care.

By default, the NSW Coalition appears destined to retain a 'revised' and diluted PFP model adopted by Labor in 2001. This limits future PFP outsourcing in health to projects that involve only building services and other so-called 'non-core' support services such as cleaning, catering, maintenance, etc.

Instead, the centrepiece of the Coalition's design for health policy is its necessary but insufficient reform of the governance and management structure of NSW Health. This largely cosmetic restructure has re-established an administrative system of Local Health Districts (LHDs) that is virtually identical to the Local Health Networks (LHNs) the Keneally Labor government (2009–11) agreed to establish in return for additional Commonwealth funding as part of the Rudd government's national health reforms.

The Coalition's overhaul of health administration in NSW seems unlikely to achieve its ostensible purpose of offering health providers the benefit of genuinely independent governance. It speaks the language of authentic purchaser arrangements, but it eschews models of management and administration where there is meaningful devolution of financial accountability by way of legitimate, arm's-length purchaser-provider split arrangements and a proper exercise of local autonomy in procuring and delivering public hospital services.

Under the Coalition's 'new' district model, centralised command-and-control management prevails. Hospitals remain, via LHDs, de facto branch offices of NSW Health. LHD managerial independence is compromised because financial risk continues ultimately to be held by the state. LHDs do not have the power to borrow or incur debt; nor can they accumulate reserves as a reward for efficiency—as is the practice of Foundation Hospital Trusts in England, for instance. This restricts the scope for local innovation and competition and augurs the retention of high departmental involvement in operational matters (including service planning) as well as enforced financial control to prevent LHDs from overspending their budgets.

Furthermore, control over the health workforce remains a state responsibility, with centralised departmental control persisting over rigid statewide employment conditions. Retention of restrictive clinical work practices in the public system continues to have major implications for its capacity, productivity and cost-effectiveness.

The public health sector should no longer be quarantined from the structural reforms that have improved the performance of other government instrumentalities and sectors of the economy over the last 30 years. As a first step towards meaningful purchaser-provider relationships, NSW's revised PFP model should be reviewed with a view to introducing new criteria incorporating a wider range of services—as has occurred in other states. New PFPs should be considered and evaluated for impending suitable hospital projects; they could offer innovative opportunities for contracting for full accountability and devolution of risk via LHDs onto private operators of public hospitals, including responsibility for all clinical, accommodation and related services.

Public provision of hospital services in NSW has long supported government jobs at attractive wages and conditions. Undoubtedly, there remains a role for government in health service supply—especially in service monitoring and quality control—but without compromising the efficiency or unreasonably intruding into every aspect of hospital operations as a source of workforce protection.

Introduction

Health is the single-largest area of NSW public expenditure. The auditor-general predicts that spending on health will consume the entire state budget by 2033 if current expenditure growth continues.¹ Total health expenditure represented almost one-third of the NSW budget in 2010–11, amounting to \$16.4 billion.² Despite high and rapidly growing spending, and despite hospitals consuming nearly 60% of NSW health expenditure in the last decade, waiting times for elective admissions to public hospitals have lengthened in NSW compared to other states.³

In an ever-tightening fiscal environment, and amid a multitude of competing priorities, the focus of NSW health policy should be microeconomic reform. The adoption of market or private sector methods, where appropriate, should be encouraged to enhance productivity and improve access to quality hospital services at the least cost.

Microeconomic reform in NSW 1988–2011

Since the late 1980s, NSW governments have tried microeconomic reforms in health that have concentrated broadly on three areas:

1. outsourcing to the private sector of ‘non-core’ hospital support services such as cleaning, catering, maintenance, etc
2. expanding private hospital capacity through deregulation of bed licences, including encouraging private hospitals to colocate with public hospitals, and
3. purchasing a limited amount of accommodation and treatment on behalf of public patients from the private sector, mostly by experimenting with ‘privatising’ some public hospital services via privately financed projects (PFPs).

These policies originated under the Greiner-Fahey Coalition governments (1988–95), and were designed to substitute private clinical and support services for public hospital services where possible and feasible. Private colocation and outsourcing limited to support services continued under the Labor governments (1995–2011). The first two strategies are less controversial owing to the cost-effectiveness of contracting out arrangements⁴ (although unions doggedly oppose them) and belief in the potential of colocations to ease the load on public facilities and improve efficiency through sharing infrastructure.

However, the implementation of a more comprehensive reform agenda stalled under Labor when it discontinued privatising public hospital services with PFPs.⁵ These involved a management contract whereby the state paid a private operator ‘availability’ charges to meet a project’s capital cost as well as service fees to pay for the operational costs of public hospital services. In NSW, the value of the PFP asset was added to the balance sheet once the facility was handed over to commence operation, with a corresponding finance lease liability coming onto the state balance sheet at the same time to cover future availability payments.

Where privatisation of public hospital services occurred through PFPs, it fundamentally changed the traditional role of the state government from health service provider to health service purchaser. In the interest of financial integrity and accountability, a ‘purchaser/provider split’ necessarily delegates autonomy to the private manager of a hospital, and obliges them to adopt business axioms (such as a culture of competition, innovation, and more efficient, customer-focused service delivery) usually foreign to public hospitals. Importantly, managerial autonomy and flexibility includes the freedom to hire clinical personnel on terms relevant to, and most suitable for, local conditions.

In an ever-tightening fiscal environment, the focus of NSW health policy should be microeconomic reform. The adoption of market or private sector methods, where appropriate, should be encouraged to enhance productivity.

Reform of the rigid monopoly model of public hospital care could maximise the scope for achieving efficiencies within the stringent limitations imposed on the operation of public hospitals by Commonwealth health policy—but, as discussed below, the fledgling model of complete public hospital privatisation did not last long.

Policy constraints

In all states and territories, governments of all persuasions have struggled, amid rising demand and escalating community expectations, to run ‘free’ public hospitals effectively. States and territories have always been responsible for their public health services. Since the Whitlam era, however, this authority, which principally concerns the management of public hospitals, has been exercised within a framework in which funding for public hospital services was shared with the federal government, but with major policy settings determined by the Commonwealth. Since the start of Medicare (Australia’s universal taxpayer-funded health insurance scheme) in 1984, state governments have been obliged to provide public hospital services without user charges and ensure the system functions as best as it can to meet this obligation in return for receiving federal government health funding. Inevitably, demand for public hospital services in NSW under Medicare’s zero-price environment has grown faster than supply and led to rationing of access by ever-lengthening waiting times in emergency departments and for elective surgery.

The dilemmas created by Medicare’s demanding service responsibilities and the restrictions they impose on policy authority over the operation of public hospitals have been compounded as the share of federal specific-purpose health funding have progressively dwindled over time.⁶ Blurring of Commonwealth and state responsibilities is also legion, with medical services provided outside hospitals being the principal responsibility of the Commonwealth and receiving separate, open-ended Commonwealth Medicare funding. Jurisdictional complexity means Australians are obliged to trade public hospital system waiting times for their freedom of choice in non-inpatient care.^{7†}

Reform gap

The intractable nature of the health ‘crisis’ in NSW is aggravated by a failure to tackle the structural defects inherent in the traditional public service monopoly model that are within the power of the NSW government to address. The largest and most critical area of a hospital’s operating costs is clinical services, covering nurses, doctors and allied health. Mainly because of the influence of public sector unions and other self-interested health provider groups, this crucial part of public hospitals has been quarantined from the structural reforms that have improved the performance of other government instrumentalities and sectors of the economy over the last 30 years.

Under the public sector model, the financial risk for clinical services is carried by the purchaser (the NSW government) rather than by the provider. In reality, the lack of formal outsourcing or contestability means NSW Health, via LHDs, functions as both the funder and provider of centrally coordinated hospital services. This environment denies the benefit of the competitive discipline of a true market. Government custom is assured, as it seeks to discharge its Sisyphean obligation under Medicare of free care to public patients. Incentives for operational efficiency are dulled as public hospitals are unlikely to become properly accountable for their performance. Local hospitals also lack managerial autonomy. Such rigidities can have implications for all areas of a hospital’s operations and work practices.

† Although since some general practitioner charges may exceed the Schedule Fee, the latter will involve a copayment. This in turn can deflect clientele back into overworked hospital emergency departments.

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Hospital administration continues to be reminiscent of the 1980s, when NSW's public hospitals (as well as community-based primary and public health services) were administered centrally within designated regions by 'area health services.' Initially, there were 23 metropolitan and 23 country area health services. The Carr Labor government cut these to nine and eight respectively in 1997, and they were further reduced to just eight covering the entire state in 2005. Central command-and-control management prevailed in all these configurations, under which hospitals, via area health services (under the nominal control of local boards), were de facto branch offices of NSW Health. Exposure to financial risk, which is linked to NSW Health's role as both funder and provider of services, has exacerbated because, unlike states like Victoria and South Australia, NSW has hitherto substantially relied on an input funding model—using resource allocation funding (RAF) based on population criteria—rather than productivity and output criteria related to casemix activity. This will begin to change from July 2012 when activity funding based on efficient price is introduced where 'practical' for acute hospital admissions. Disincentives of input funding had previously reinforced the managerial disincentives that have dogged the NSW hospital system.

Centralised control of human resources remains a major factor contributing to underlying anomalies. Hospital managers lack authority over their clinical workforces and are denied the flexibility to secure efficient and effective care. Nursing is the largest single area of recurrent hospital cost, and nurses' awards uniformly fix scales of remuneration across the entire state as well as conditions of employment that protect nursing jobs, such as prescribed ratios of nurses to patients. This constrains the efficient allocation of labour as there is limited scope for productivity gain, flexible deployment of labour, or bidding for and retaining health workers where shortages are always prevalent, such as in southwest Sydney or rural and remote localities. Rigid demarcation persists, inhibiting opportunities for multi-skilling and multi-tasking. It would be inconceivable, for instance, for an enrolled nurse to drive an ambulance or to use at least some hospitals as ambulance stations.

There is limited scope for introducing effective accountability from specialist medical practitioners over the resources they deploy or the decisions they make. In NSW, part of the consideration visiting medical officers (VMOs) and staff specialists receive under their respective contractual arrangements and award conditions for treating public patients is the right to admit their private patients into NSW public hospitals on the same surgical lists as their public work. This is a measure of specialist bargaining power that has evolved under conditions of cartelised supply, and which is remote from efficiency principles. It primarily benefits specialists in larger public hospitals and their patients who can rely on hospital infrastructures and amenities (including free professional indemnity insurance, 24-hour hospital medical officer support, intensive care units, catheter labs, etc.) that are rarely available in private hospitals. Treating private patients in congested public hospitals exacerbates public waiting times by crowding out public patients. This could prejudice NSW's access to reward payments in consideration of meeting specified Medicare goals for reducing excessive public waiting time for Category 2 and Category 3 elective surgery patients (pursuant to COAG's new National Reform Partnership Agreement).⁸

Public hospital capacity constraints have been relieved but not eliminated by the deregulation of the private hospital industry since the 1990s, culminating in the removal of the ceiling on private acute beds in 2008. This contributed to an expansion and consolidation of both standalone and colocated overnight private beds. Private overnight beds, however, are imperfect substitutes for public hospital beds and their associated infrastructure. Even though a NSW Health report in 2005 suggested that approximately 70% of private sector general activity could substitute for public sector activity,⁹ private hospital casemix is necessarily different.

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Few private hospitals operate accident and emergency units. Public hospitals hence capture more serious and critical admissions that weigh disproportionately on hospital infrastructures.

Adding capacity to the private hospital sector has therefore not always made them more attractive for specialists to work in. Nor does this appear to have diluted the freedom of specialists to control their own schedules and work practices in the public system with the associated implication for its capacity, productivity and cost-effectiveness to accommodate the public caseload.

Privatisation of health services

In the quest to better manage the activities of specialist doctors and other clinical labour, in the early 1990s, NSW Health experimented with two markedly different models of public hospital privatisation.

In December 1992, the Greiner government entered into a 20-year contract with Health Care of Australia Pty Ltd (HCOA), a subsidiary of Mayne Nickless Ltd. In return for an ‘availability’ charge (to cover the \$40 million capital cost) and a service charge (to cover operational costs of public hospital services), HCOA built and operated Port Macquarie Base Hospital to replace the ageing Hastings District Hospital. The new hospital opened in November 1994.

The introduction of a purchaser/provider split at Port Macquarie fundamentally changed the local role of NSW from traditional provider to purchaser of health services. Separating the funding source from the service provider in the delivery of hospital services offered a new model for future private public sector health participation. In its original for-profit version, the model offered a fundamentally new strategy that had the capacity to introduce more flexible health labour work practices and superior managerial accountability for a hospital’s entire operating budget, including clinical services. Most importantly, the financial risk for clinical services was carried by the private provider rather than the purchaser as under the traditional public model. PFPs thus had the potential to deliver to NSW efficiency gains flowing from greater financial accountability of competing providers and offer health providers themselves the benefit of independent governance.

Immediately after Labor came to power in March 1995, NSW health unions and others¹⁰ embarked on a campaign to make the Port Macquarie PFP contract unworkable and discredit the model because of its for-profit association.¹¹ The unions played to the sympathies of the NSW Labor government by assiduously campaigning for replacing private sector awards with more generous public sector wages and conditions. They opposed the outsourcing of cleaning and other services, and plans for nurses to work with TAFE-trained nurse assistants.¹² Representations were also made to the Australian Competition and Consumer Commission (ACCC) (to no avail) about the danger of Port Macquarie ‘becoming a Mayne Nickless company town.’¹³ (Mayne also operated a private hospital there). However, the Upper House inquiry demanded by the unions delivered the hospital a clean bill of health.¹⁴

Nevertheless, the conflict ultimately bore fruit. In February 2005, NSW Health repurchased Port Macquarie Hospital at a buyout cost of \$87 million¹⁵ using a ‘probity review’ precipitated by the novation of Mayne’s contract to a third party as justification for breaking the operator’s ‘non-cancellable’ lease. Labor accordingly succeeded in reasserting, at health union bidding, the public monopoly model—reversing an experiment that combined genuine management devolution with accountability and reform in provider governance.

Hawkesbury Hospital, another PFP, opened in August 1996. This project is a not-for-profit model under agreement between NSW Health and Catholic Healthcare Services. Managed as a public sector clone, under public sector conditions, it is nevertheless unlikely to deliver recognisable productivity improvements.

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Revised PFPs

Although the Port Macquarie model was criticised by the NSW auditor-general and others on the grounds of being too generous to its private operator,¹⁶ the government indiscriminately threw out the good with the bad. Following the demise of the Port Macquarie model, in 2001, NSW Treasury announced revised guidelines that limited future PFP outsourcing in health to projects that involved only building services and other so-called ‘non-core’ support services such as health facilities management, cleaning, catering, etc. Investment in ‘core’ clinical services was to be reserved as the province of government in the future.¹⁷

Rather than determining services that might be contracted out using efficiency criteria, differentiating between ‘core’ and ‘non-core’ services was how Labor chose to define the scope of services suitable for a health sector PFP. This apparently was driven primarily by considerations of industrial relations to avoid alienating unions, especially nurses. In their revised and current form, NSW PFPs exclude clinical services. To the extent that in their revised and current form NSW PFPs exclude clinical services, they depart from the conventional purchaser-provider split models of health service in lacking the potential for efficiency gains offered by the original for-profit PFP version.

With NSW’s revised model, PFPs can hence secure efficiency gains only from privately outsourcing public building and construction services and contracts for the supply of support services. The latter, however, are not restricted or unique to PFPs; they may be entered into as a means of outsourcing by any NSW public hospital or health service, as indeed has long been the practice.

Diluted PFPs may still offer the government savings (though less bountiful) because the private sector can assume many of the building project risks. Between 2005 and 2008, the NSW government under Labor let four new PFP contracts in health under which the private sector is designing, building, financing and maintaining hospital redevelopments with support services at the Royal North Shore Hospital, the Orange Base Hospital, the Newcastle Mater Hospital, and the Long Bay Prison and Forensic Hospital.

Under Coalition management

By default, the NSW Coalition, led by Premier Barry O’Farrell, appears to have retained Labor’s limited hospital building services’ PFP model. Instead of revisiting microeconomic reform, the centrepiece of the Coalition government’s health policy reform is replacing ‘the huge and out-of-touch Area Services’¹⁸ with smaller health districts. Each district is now governed by its own government-appointed community board with suitable business, legal, health and other expertise. Nevertheless, the overhaul of health administration under the Coalition seems unlikely to achieve its ostensible purpose. It eschews models of management and administration where there is meaningful devolution of financial accountability and a proper exercise of local autonomy in procuring and delivering public hospital services.

Local Health Districts

Ironically, the Coalition’s health district policy was anticipated in then Prime Minister Rudd’s national health reform agenda, announced in April 2010. This was conflated with an attempt to repair defective hospital management at the state level.¹⁹ In return for the additional COAG funding for better access to elective surgery, emergency and subacute care (referred to above), states and territories (excluding Western Australia) agreed to establish Local Hospital Networks (LHNs) intended to integrate with primary care through Medicare Locals.

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In NSW, legislation assented to in November 2010 (on the eve of the 2011 election) provided for 15 LHNs to replace the state's eight Area Health Services. This re-established a structure virtually identical to the one Labor abolished in 2005. Since the federal agreement had assured NSW Health's primacy as 'statewide system manager,'²⁰ Labor's eleventh-hour policy could never have achieved genuine (and much-touted) devolution of hospital management—in any case, it would have been meaningless without effective local financial accountability and efficiency incentives.

After the March 2011 state election, the O'Farrell government in May 2011 nominally discarded Labor's last-minute LHN changes for a cosmetic restructure that it could call its own.²¹ This re-badged Local Health Networks as Local Health Districts and substituted 'boards' for Labor's 'governing councils.' Even the boundaries that the 15 LHDs assumed were the same as Labor's defunct LHNs.

The Coalition affected to differentiate its LHD model from Labor's LHNs with a commitment to the principle of local health service control. The amending legislation intends LHD boards to 'function as the core accountable bodies and undertake the core accountabilities of boards of statutory corporations, with significant public responsibilities and accountabilities.'²² Revised governance arrangements seek to combine local control with appropriate oversight (for example, by giving them control over the function of Clinical Support Clusters that Labor had proposed recentralising).

Boards are enjoined to exercise their authority over health services by developing strategic health service plans and are bound by financial and service measures defined in annual service and performance agreements between the state and districts. Responsibility for operational management under this tightly audited, micro-managed and rules-based system²³ is supposed to more effectively devolve to district CEOs and their administrative teams appointed by and answerable to boards.

The Coalition has identified 'smaller' LHDs as an antidote to Labor's 'huge' bureaucracies. The revised administrative structure is said to be similar to the system created in Victoria by the Kennett government in the 1990s, which has worked 'reasonably well.'²⁴

Making it work?

Whether the 'area' system will function differently this time under the Coalition depends on how genuinely independent, and thus truly financially accountable, LHDs become.

The impression is that the Coalition's election promise to give communities a local voice in running hospitals sought to capitalise on longstanding discontent with NSW Health, particularly in country regions. In reality, funding caps are essential for rationing activity in 'free' public hospital systems under Medicare, and they inevitably interfere with the operational authority of local managers. The financial accountability of public health agencies, regardless of their management functions, is often diffuse due to financial risk ultimately being held by the state. This was a principal reason for the centralisation of health administration in NSW in the 1980s, which strengthened the health department's financial control over spending to prevent hospitals (previously controlled by their own boards) from profligacy.²⁵

The O'Farrell government promises a role for its Ministry of Health, which, via annual service agreements, intends to operate as an 'informed purchaser and planner of health services.'²⁶ There is a risk that this is code for NSW Health remaining the 'central planner' and funder of inputs to the system, given that LHD services agreements 'specify what services will be purchased or funded.'²⁷ This augurs continuing departmental involvement in operational matters, based on 'strategic' considerations, including (essential) budgetary limits and the political imperatives of the government

pertaining to contentious and critical issues such as planning anomalies. The duplication of city and country hospital facilities imposes large fixed costs on the state budget. As a result, recurrent health funding is spread so thinly across the system that it compromises the hospital system's overall capacity and sustainability, with some units often remaining under-utilised due to chronic shortages of recurrent funding for frontline services.²⁸

A review by Mary Foley (Director General of NSW Health) released in August 2011 intimated that the revised management structure will give LHDs greater planning authority 'for determining how it will deliver health services within the framework of the Service Agreement.' It also stated:

A critical responsibility of Districts and Networks, and one strongly supported by LHD chairs and clinicians, will be the delineation of roles of hospitals and other health facilities in their Clinical Service Plans within Statewide planning frameworks.²⁹

The implication is that service agreements are not to be unduly prescriptive, and LHDs may have discretion to commence service restructures. Hence, the governance review speaks of performance agreements that 'will only be specific to the most important performance parameters ... to avoid micro-management of service operations.'³⁰ It also remarks on 'a different relationship with LHDs based on clear funding and performance specifications and statewide policy and planning frameworks which support the LHDs to deliver safe and effective clinical services.'³¹ The review supports LHDs developing service plans that incorporate purchasing services from private hospitals and other non-government providers—which are now permitted for the first time under the COAG National Reform Partnership Agreement. This may convey the flavour of LHDs operating as active budget-holders rather than passive funders and supervisors of centrally mandated services.

Scope for efficiency and competition

Yet many questions remain unresolved. There is no indication of devolution and financial accountability by way of genuine arm's-length purchaser-provider split arrangements. Real management authority would depend on whether LHDs are permitted to commercially manage their assets. What would happen if (as precedent suggests) LHDs were to overrun their budgets and unable to meet KPIs while tethered to existing service configurations? Would they simply function as 'stakeholders' and lobby government for more funding?

It would be inconceivable for the state to allow an LHD to operate with a risk of becoming insolvent. LHDs do not have the power to fund their activities through debt finance (nor to seek independent guarantors for debt) to invest in new and improved services—as do, for example, the National Health Service (NHS) Foundation Hospital Trusts in England, which remain independent of Whitehall and whose solvency is not underwritten by Treasury. Their financial risk rating instead is assessed by Monitor, the independent regulator of trusts. In NSW, LHDs could exercise real management authority only if they were truly financially accountable with a sound credit rating and were expected to rationalise under-utilised facilities and efficiently deploy the workforce to meet budget and service targets. Neither are there rewards for efficiency. LHDs cannot accumulate their own reserves, hence restricting their scope for local innovation.

LHDs may no doubt continue to outsource ad hoc support services according to local management practice. Under the revised LHD management structure, these arrangements for non-clinical services (apart from *eHealth*) are now coordinated through HealthShare NSW, a new ministry agency. In early 2012, a trial for outsourcing non-emergency ambulance services from a private operator commenced along

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lines similar to arrangements widely adopted for patient transport in Victoria.³² While outsourcing of support and related services is conceptually similar to public hospital privatisation, but on a smaller scale—outsourcing of all hospital services via PFPs remains wholly within the realm of NSW Treasury and tethered to the revised PFP model that is restricted to ‘non-core’ services. State funding of LHDs that is not shared activity based (after 1 July 2012) will essentially remain input funding that fails to encourage LHDs to gain effective control of their output.

Although LHDs in NSW are now being encouraged for the first time to outsource to private hospitals to relieve elective surgery bottlenecks, NSW Health, unlike in other states, has never actively engaged the private sector as a customer for spot or specific volume service contracts. Some private hospitals built recently possess significant excess capacity and could be engaged. One example is the Macquarie University Private Hospital, a full service hospital.

If LHD purchases from private hospitals in proximity were effectively managed and contracted, they could spur efficiencies in public hospitals. For instance, in England, NHS trusts supplement their own public (specialist) consultant care with purchases of procedures from proximate Independent Sector Treatment Centres (ISTCs). Some ISTCs concentrate simply on particular types of procedures such as cataract extractions and hip replacements. By streamlining care, ISTCs can undercut prices that NHS Trusts normally charges their fundholders.

There are limited public system purchases of private clinical care in NSW—such as from a private urology practice in the Illawarra and the Eastern Heart Clinic in Randwick—but these arrangements and their variants are exceptional and born of necessity. They may be likened to ‘group’ versions of a typical VMO contract (based on input criteria that shift risk to the purchaser). Clinical outsourcing is unlikely to lead to efficient outcomes when a private supplier is a cartel or has significant non-competitive market power. Without incentive mechanisms in contestable environments that give LHDs greater discretion over their ‘core’ service inputs, purchase risks are transferred to the LHD rather than shared with the provider. Queensland (via its Surgery Connect program) and New Zealand have some experience with outsourcing private sector surgery, but evidence as to its equity, efficiency and sustainability is lacking or doubtful.³³

Other Australian jurisdictions have adopted approaches to efficiency in hospital reform bolder than NSW.

Developments in other Australian jurisdictions

Other Australian jurisdictions have adopted approaches to efficiency in hospital reform bolder than NSW. Developments in Queensland, Victoria and Western Australia include privately managed public hospitals that may treat private patients; many of these public hospitals operate in conjunction with private colocations. Noosa Hospital in Queensland is a privately owned for-profit hospital that provides public services to the people of Noosa and surrounding areas. Mildura Base Hospital in Victoria is a privately owned public hospital that operates on the same campus as a not-for-profit private hospital. Western Australia is developing a series of ‘health campuses’ at Joondalup and Mandurah (Peel Hospital) that embody a comprehensive range of privately operated public hospital and community health services colocated with for-profit private facilities. Other ‘health campuses’ of this design will follow at Albany (due for completion in 2013), the new Children’s Hospital in Nedlands (due for completion in 2015), and the new Midland Health Campus (due for completion in 2015).

Western Australia’s Fiona Stanley Hospital in Murdoch (due to open in 2014) is a legacy of an erstwhile Labor government. It will be a publicly owned hospital for public patients but colocated with St John of God—a major existing 363-bed private not-for-profit hospital, with which FSH will have synergies from sharing of health facilities and services.

Unlike current procurement strategies for large teaching hospitals in NSW that involve arrangements with a single entity, under the FSH strategy, the state has assumed not only project funding responsibility but effectively broken up the residual PFP into its constituent elements and assumed the risk of coordinating various different activities with different entities. While this may have theoretically reduced the risk premium in some contract prices, realising this benefit will rely on the state managing the retained risk effectively. The project has already been subject to considerable budget overruns.³⁴ At the operational level, WA Health will have responsibility for treatment and clinical care but has contracted a private facilities manager to deliver support services such as catering, cleaning, maintenance, waste-management, and coordination tasks.

The FSH model is an unusual method of delivering a PFP, with complicated and untested management and governance frameworks in which the state appears to have assumed risks far greater than usual in similar hospital projects, particularly the risk of coordinating Facilities and Managing contractors.

Two successful examples of public hospital privatisation are Greenslopes in Queensland (in 1995) and Hollywood in Western Australia (in 1994). These hospitals were sold as going concerns by the Commonwealth to a private for-profit owner—in each case, as part of a divestment program by the Department of Veterans Affairs (DVA). They are now the two largest private hospitals in Australia and carry a predominantly private caseload but continue to treat DVA clients under contractual arrangements. The divestment appears to have proved cost effective for the DVA, and there is evidence of greater satisfaction of veterans with the treatment they obtain from privatised hospitals than from other former DVA hospitals that were taken over by state jurisdictions.³⁵

The Australian Department of Defence, through its Joint Health Command, is managing a Request for Tender (RFT) for proposals for the privatisation of ‘all or part of the services’ that comprise its Garrison Health Service—the provider of all defence health services.³⁶ The contract is expected to be let by mid-2012. The scope of services to be procured under the RFT includes all on- and off-base health services, a health hotline, and all laboratory services. From the wording of the RFT, it seems likely that the new provider will assume responsibility for Garrison Health’s payroll and will be expected to apply private sector management philosophies in securing efficiency gains.

Realising efficiency and competition in NSW

All innovative public projects in health that involve private sector cooperation behave sound departmental financial expertise and the wisdom to select proven and reliable private sector players. Poorly drafted agreements with inadequate provisioning and unrealistic service projections can create fertile opportunities for costly litigation and service disruption.

The inappropriate choice of a private partner in a worst-case scenario may oblige a government to take over a bankrupt business—similar to when in 2002, the Queensland government had to assume control over a 200-bed not-for-profit public hospital privately operated on the Gold Coast by the Sisters of Charity.³⁷ Modbury Hospital in South Australia, Latrobe in Victoria, and Mersey in Tasmania are other examples of PFPs that failed to survive in unstable private hands and had to be returned at considerable cost to public sector management.

Sound planning and contracting skills are essential to facilitate microeconomic reform, especially in implementing PFPs that include ‘core’ clinical services for new hospital projects. Obvious candidates in NSW include the new hospital mooted in French’s Forest to replace the dilapidated facilities at Mona Vale and Manly and the prospective redevelopment at Hornsby Ku-ring-gai. To safeguard against the

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risks of being locked into long-term monopoly PFP contractual arrangements, such projects should ideally compete with rival colocated private hospitals, as in the case of Mildura Base. This would give the state the option of independently entering into competitive spot and specific volume service contracts for elective surgery—analogous to the role performed by ISTCs adjacent to NHS Trust Hospitals, with which fundholders may sub-contract to supplement trust-based consultant care with competitively outsourced services.

The foundation for germinating or mimicking such market processes within a state system will be a more responsive and flexible workforce. For political reasons, private colocations may not be attracted to compete unfairly with, or to expose themselves to discrimination in favour of, nearby publicly operated facilities supported by the state underwriting costly and inefficient work practices.

Given the opaqueness of NSW health policy, the extent of authority that LHDs may possess is unclear. It may be difficult for LHDs to exercise control over productivity, given the lack control over their workforce and its remuneration. Under the Coalition's 'new' district model, control over the health workforce remains a state responsibility. Unlike NSW's educational portfolio, which in March 2012 (to the disenchantment of the NSW Teachers Federation) foreshadowed a system of teacher remuneration based on standards and performance quality, in NSW Health, centralised departmental control over rigid statewide award employment conditions—the centrepiece of the restrictive public service monopoly model—seems destined to persist.

One of the most frequent general explanations for the regularity of local public system budget overruns has been the absence of financial incentives that could encourage individual LHDs to make their clinicians more accountable and adopt rational decisions about the disposition of their time and the deployment of resources they use, including capital equipment. NSW's input-based contracts with its oligopolistic VMOs and staff specialists are examples of where microeconomic reform in NSW has long been dogged.

The scope for LHDs to encourage their hospitals to change their contractual relationships with specialists in NSW need not necessarily compromise their remuneration or alienate them in other ways—as regrettably appears to have occurred as a result of management failings in the Port Macquarie experiment in the late 1990s. Indeed, in exchange for more flexible work practices in new hospital projects, proceduralists could even augment their earnings under innovative private output-based contracts, perhaps with fully outsourced nursing and support services extending their access to public theatres in customary public downtime.

Yet it is questionable whether LHD boards, not of all of whose members have a sound grasp of health service issues, will have an appetite for bold planning decisions or risks of innovative contracting and outsourcing. Neither may administrative officers possess an abundance of public sector management and contracting skills. In the past, it has often been difficult to resist 'capture' by local clinicians and other vested interests. In any case, ministerial approval is still necessary, as ultimate political responsibility for public health services resides with the state government. For sure, the independence and authority of LHD boards appears no less equivocal and vulnerable to ministerial intervention than their Area Health Service antecedents—as evidenced by the controversial ministerial dismissal of a prominent LHD chairman in February 2012.³⁸

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Conclusion

NSW Health has much to gain from the efficiency dividend associated with competent local governance associated with a more flexible, competitive, better-managed and innovative state hospital system that encourages and rewards performance. It could contribute to welfare by helping arrest the upward health expenditure drift; it could release financial savings that might be allocated to expanding service capacity and enhanced access or quality; and it could replenish health infrastructure or improve population health.

When the O'Farrell government came to power, it principally conceived of failings in health as failure to 'reform the management structure of the public health system.'³⁹ Its necessary but insufficient reforms are now preoccupied with 'governance' and associated processes (already in contention); it also introduced a model substantially inherited from its predecessor, embodying reforms that rely upon a series of locally driven, rules-based criteria.

The documentation outlining reform also speaks about NSW Health being an 'informed purchaser ... of health services' and of its moving with LHDs to a different purchaser/provider-style relationship.⁴⁰ This is the language of an authentic arm's-length fundholding model where service risks devolve onto providers—or at least are shared with providers to the extent that failure to deliver a service obligation comes with financial consequences that accrue down the line in the chain of service provision within a provider entity.

However, language alone should not beguile us into thinking that NSW Health has introduced fundamental changes to the relationship between LHDs and central office, or that NSW Health as purchaser no longer has a stake in service delivery as a provider. NSW Health remains the ultimate arbiter of the terms on which services are provided by virtue of the authority it exercises over health planning, project authorisation, and the employment of the clinical workforce.

The extent of genuinely competitive outsourcing is limited to ad hoc 'non-core' support services through LHDs and building services initiatives to do with new hospital projects controlled through NSW Treasury. Health service management is not fundamentally about cleaning services or maintenance or building and construction (important as these inputs are)—it is principally a health workforce issue and will ultimately depend on the capacity of LHDs to gain autonomy and assume proper accountability by acquiring better control over their clinical workforce. Lack of clinical financial accountability can have implications for all other areas of a hospital's activity, operations, and work practices.

NSW can never aspire to purchaser-provider split mechanisms like the ones in England or New Zealand. As it is essentially a management jurisdiction, NSW's interventions must confine to supply side mechanisms that encourage supply side contestability. As a first step towards meaningful purchaser-provider relationships, NSW's 'revised PFP model' should be reviewed with a view to introducing a new set of criteria for public hospital PFPs. Following precedents in other states, consideration should be given to incorporating a wider range of services in PFPs, including all clinical services. Under the 2001 Treasury guidelines, NSW PFPs are largely building services projects. New PFPs should be implemented as systemic role models that offer innovative opportunities for contracting for full accountability and devolution of risk via LHDs onto private managers, including responsibility for all clinical, accommodation and related services. If such initiatives were to percolate through LHDs, it would inevitably introduce a new dynamic into the relationship

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between LHDs and central office. As LHDs gain more experience as genuine purchasers and public hospital managers exercise their autonomy more competitively and creatively, opportunities for public sector labour market change would evolve as managers became obliged to imitate parallel innovations of neighbouring PFPs.

In the current climate, the apparatus of government in hospital services in NSW remains an article of faith as a dimension of social infrastructure support. This has supported government jobs at attractive wages and conditions. Undoubtedly, there remains a role for government in health service supply—but without unreasonably intruding into every aspect of hospital operations as a source of workforce protection.

Endnotes

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