PATIENTS BEFORE PROFITS
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Australia has a world-class universal health system

Universal health care is a publicly funded system which provides health care and financial protection to all citizens. It is organised around providing a specified package of benefits to all members of society with the end goal of providing financial risk protection, improved access to health services and improved health outcomes. Universal health care is not a one-size-fits-all concept and does not imply coverage for all people for everything. Universal health care can be determined by three critical dimensions: who is covered, what services are covered and how much of the cost is covered.

In Australia, Medicare is the publicly funded universal health care scheme, instituted in 1984. It coexists with a private health system. Medicare is funded by taxpayers through a combination of the Medicare Levy (with exceptions for low-income earners) and general tax revenue, where those with greatest financial means can pay more. Despite repeated claims by the Coalition Government about the unsustainability of “free health care”, the fact is we pay for Medicare and we do it because it is the most efficient way to ensure everyone has access to essential health care.

Universality, the central feature of Medicare, means we all pay according to our means (through our system of progressive taxation) and every member of our community is covered by that insurance with access according to clinical need. As always, when we talk about Australia’s system of health care it is important to note there are some complex forces at play, meaning the goal of universality is not fully achieved such as for Aboriginal and Torres Strait Islander peoples and some rural and remote communities. However, we believe the principles that underpin Medicare: universality, equity and efficiency must remain central to the way we fund and distribute health resources in Australia.

NSWNMA is committed to the notion of health as a public good with shared benefits and shared responsibilities. We believe access to adequate health care should be the right of every Australian and it is a crucial element of the Australian social compact.
The history of Medicare

Medicare is over 30 years old and is the scheme that publicly funds Australia’s universal health care system.

Medicare has always generated political conflict. From 1972 to 1984, Australia became the first developed country to introduce a universal health care system (under Whitlam), then discard it (under Fraser).

In those 12 years Australia attempted, on five separate occasions, to balance public and private insurance schemes. Finally, in 1984, the Hawke Government reintroduced a universal health care system – Medicare.

The introduction of Medicare was strongly contested and opposed by the Coalition from 1983. It was only after the Coalition’s fifth successive defeat in the 1993 federal election that Howard committed the Coalition to retaining Medicare – he accepted the reality that the Australian public valued Medicare and wanted it retained.

No one is pretending there are no changes that could be made to a 30 year old system like Medicare to make it more efficient. However, dismantling universalism, increasing privatisation and shifting costs to individuals will not deliver a more sustainable system – it is a recipe for higher costs overall and rising social inequity.
How does Medicare work?

Medicare is an insurance system that enables Australians to access free or lower cost medical, optical, basic dental, some allied health services and hospital care. The Medicare Benefits Schedule (MBS) lists the services that are subsidised under Medicare. A variety of health professionals are authorised to bill Medicare for services provided to Australian citizens. When the provider accepts the MBS fee for the service, the client does not pay anything upfront. This is bulk billing. If the provider charges more than the scheduled fee, or a co-payment, the recipient of the service must claim the rebate from Medicare. Currently bulk billing rates are over 83.7%\(^1\) for GP attendances and tend to be higher in outer metropolitan areas.

The Pharmaceutical Benefits Scheme (PBS) is another key aspect of Medicare that enables Australians to access most medicines at subsidised cost. In order to be listed on the PBS, a rigorous process is undertaken to evaluate the cost effectiveness of the drug. Not every medicine meets the criteria of the PBS.

Through arrangements with the States and Territories, Medicare also funds treatment and accommodation at public hospitals for public patients. There is no out-of-pocket charge associated with treatment as a public patient in a public hospital.

57.1%\(^2\) of Australians also purchase a range of private health insurance options that cover the costs of health care as a private patient, either in the public hospital or a private hospital. The cost of private health insurance is subsidised by the public through government subsidies.

Figure 1: Health funding flows in Australia are a complicated business\(^3\)
Who loses out

Australians most in need of health care are the ones least able to afford it. The evidence shows cuts to Medicare bulk billing or rebate freezes impact disproportionately on vulnerable groups such as:

- **Individuals with low income and in particular need of care** reduce their use of health care relatively more than the remaining population.
  - Delaying or avoiding consultations
  - Avoiding diagnostic tests and prescriptions – resulting in catastrophic consequences both for outcomes and costs of care.

- **People with chronic illnesses:** Australia is facing a major chronic disease burden in the future and it will become increasingly important to find more efficient ways of managing chronic illnesses. This will require more emphasis on primary health care and better integration of health care.

Data shows that out-of-pocket expenses in Australia are high, and this is creating an unacceptable barrier to effective health care for some people. In 2016, 11.7% of Australian adults reported they had experienced cost-related access problems (did not fill or skipped prescription, did not visit doctor with a medical problem, or did not get recommended care)

**IN 2016**

11.7%

of Australian adults reported that they had experienced cost-related access problems

**WINNERS**

- Private health care providers
- Insurance companies

** LOSERS**

- Unemployed
- Anyone who visits a doctor
- Elderly
- Low income groups
- People with chronic illness
- Disabled
- Seniors without concession cards
What should be done

Investing in primary care and patient education

Hospital costs account for around 40% of health expenditure in Australia. The way to contain growth in this sector is through investment in prevention and early intervention in primary care services.

Early intervention in diseases such as cancer, diabetes and those related to the cardiovascular system is critical in avoiding the need for more complex and expensive treatments down the line. Similarly, patient education delivered in the primary health care setting will contribute to the lifestyle changes that are critical in preventing so called ‘lifestyle diseases’.

Medications

Drug costs are one of the key reasons many patients do not adhere to prescribed regimes. A study (by Choudhry, et al, 2011) examined almost 6000 US patients who had had one myocardial infarction, the impact of co-payments on their compliance with prescribed

The New England Healthcare Institute estimates that hospital admissions related to medication non-adherence in the United States are as high as 10% of hospital costs. 

Recurrent spending on health goods and services, 2013-14

- Hospitals 40%
- Other health goods and services (specialists) 22%
- Primary health care (GP services, PBS) 38%
treatments, outcomes and costs. It was clear that the group who had their co-payments waived were following the prescribed regimes; they were less likely to experience further cardiovascular events, and most importantly, none of these benefits came at a net monetary cost. Ultimately, the investment in access to medications saved costs by avoiding complications down the line. The patient also benefits from a longer productive life as part of a family and community.

**Private Insurance**

Local and global evidence shows the more private health insurance is used to fund health care, the more expensive a health system becomes, without any improvement in the quality of care. The administrative costs of private health insurers including profit margin are about three times that of Medicare. Australians pay $2.5 billion per year towards private health insurers’ administration fees and profits.

In Australia, only 85 cents in every dollar collected by private insurers is returned as benefits, the rest goes to administrative costs and corporate profits. By contrast, Medicare returns 95 cents in the dollar.

Private insurance does not contribute to efficient distribution of resources because of competition amongst insurers – they are unable to influence the prices demanded by providers. In contrast, a single national insurer like Medicare has the market power to standardise prices and utilisation.
Is Medicare sustainable?

The Organisation for Economic Cooperation and Development (OECD) is an international economic organisation. The OECD provides a forum for discussing issues and reaching agreements, some of which are legally binding.

Systems of publicly funded universal health insurance, like Medicare, have been adopted by most OECD countries, precisely because they are the most efficient means of delivering high quality health care for the whole population. The one OECD country that has chosen to rely on the private market for insurance – the United States – achieves far less equity, has poor health outcomes overall, a large section of the population has no coverage and has experienced very significant cost inflation.

Figure 2: Health expenditure as a share of GDP in 2015

Figure 2 indicates spending on health as a proportion of GDP across the OECD. Spending as a proportion of GDP is a useful measure because it reflects affordability. The OECD average is marked in yellow. Note the United States, the most heavily privatised system, is almost double the OECD average.
The one OECD country that has chosen to rely on the private market for insurance, the United States, achieves far less equity, has poor health outcomes overall, a large section of the population has no coverage, and has experienced very significant cost inflation.

Figure 3: Health Care Spending as a Percentage of GDP, 1995–2014

Notes: GDP refers to gross domestic product. Dutch and Swiss data are for current spending only, and exclude spending on capital formation of health care providers.
Figure 4 charts the trend in health care affordability over a nine year period across OECD countries. For simplicity, the same chart is reproduced in Figure 4 with just the data for Australia and the US compared. Both charts demonstrate there has been some rise in the costs of health care across all the developed economies. However, it is clear those countries that rely on universal insurance have a significantly lower rate of inflation of costs. Once again, the system most heavily exposed to market forces, the US, has experienced a much more significant rate of inflation.

It is also important to note, the mere fact that health care is growing as a proportion of our GDP is not in itself cause for concern. It is normal for sectors of the economy to rise and fall as a proportion of GDP over time. Publicly funded universal insurance plays an important role in containing inflation of costs. Australia has a mixed private-public system and citizens are free to choose care in either system or to rely on a combination. Medicare provides good quality care, albeit managed through waitlists, and exerts a moderating influence on the prices in the private sector.
The myths about Medicare and its viability

5 IMPORTANT QUESTIONS ABOUT PRIVATISATION AND MEDICARE

Why shouldn’t wealthy people buy better health care if they can afford it?

Is the growth in public spending on health making Medicare unaffordable?

We already have a mixed public-private system. What is the big deal if the balance shifts a bit further toward privatisation?

We have an ageing population. Don’t we need to privatise so we don’t bankrupt the government?

Won’t privatisation and competition lead to greater efficiency?

1 Is the growth in public spending on health making Medicare unaffordable?

The short answer is NO. This is a myth that has been perpetuated by political ideology rather than facts.

The reality is that in the coming decades, spending on health care will grow but incomes will also grow.

Increased spending can be done as individuals in a user-pays system, or it can be done as a community in the form of a system of universal insurance, such as Medicare.

The difference is, in a highly privatised user-pays system, like the United States, there will be winners and there will be losers. Excellent care is available to those who can afford it (or insure against it) but those who cannot afford it suffer terribly as a result. Never forget also that the highly privatised US health care system costs far more and delivers far less than systems based on universal insurance (see Fig 5).
Australians’ out-of-pocket expenses for health care are high and above the OECD average (Fig 6). Large numbers of Australians already report not filling prescriptions and delaying consulting health care providers due to costs. Further privatisation of the system will exacerbate these concerns.

The rest of the developed world economies have chosen to rely on universal insurance because it costs less, is more civilized, equitable and results in better health outcomes.
We have an ageing population. Don’t we need to privatise more of Medicare so we don’t bankrupt the government?

The overwhelming evidence is that our ageing population will not have a major impact on the sustainability of Medicare. In fact, the impact of ageing on this growth in costs is small or potentially insignificant. Most of the growth in costs in health can be attributed to developments in technology and changes to practice.

That is not to say the health system should disregard the implications of our ageing population. There will be a rise in the burden of chronic diseases. It will be increasingly important that people with chronic diseases avoid expensive hospitalisations through easy access to early intervention, prevention and education about self-management in the most cost-effective settings. The correct response to this challenge is to invest in primary care and to remove barriers to access. Winding back the universality of Medicare or increased private funding is precisely the opposite of what is required.

Won’t privatisation and competition lead to greater efficiency?

Health is not the same as buying cars or gadgets and cannot be treated as the same as other goods and services on the market. Market forces do not deliver efficiencies in health.

We need to look no further than the US, where the health system is most heavily exposed to market forces and the least efficient among advanced economies. The US spends the most on health care on a relative cost basis with the worst outcomes.

The scale and unpredictability of health costs means that insurance, be it public or private, is inevitably a major feature of the industry. Individuals who are insured have an incentive to maximise the return they receive from their purchase of

America has the least efficient health care system

Most efficient healthcare

1 Hong Kong
5 Japan
10 Australia
14 Switzerland
15 France
16 Canada
21 UK
27 Sweden
29 Netherlands
39 Germany
50 USA

Sources: World Bank, World Health Organization, International Monetary Fund, Hong Kong Department of Health, Taiwan Ministry of Health and Welfare
insurance. Doctors also have an incentive to over-service and overcharge when they know that their patients are covered by insurance.

Economists call this “moral hazard”. Moral hazard is associated with any insurance market but has particular implications for the health care market. However, when that insurance is universal there are far greater opportunities to manage such issues.

**4 Why shouldn’t wealthy people buy better health care if they can afford it?**

Australians who can afford to pay for health have many opportunities to pay for increased access to health care in the private sector. And, as noted earlier, Australians already have comparatively high out-of-pocket expenses (Fig 6).13

If the government was genuine about this issue, it would be committed to maintaining means testing of private health insurance rebates or scrap them altogether. The reality is the Coalition Government claims the private health insurance rebate is an “article of faith for the Coalition”.

A critical feature to note: the public and private systems in Australia are not perfect substitutes for each other. All Australians still rely on Medicare to some degree. If all Australians rely on the same health system, then we all have an interest in ensuring that system is properly funded and of high quality. Those that can afford and want private health insurance are free to pay for its extra benefits.

We must reject the argument that Medicare should be reduced to a safety-net for the poor.
This would inevitably lead to a two-tier system with substandard services for the poor. Calls to improve safety-net services would be ignored because the people who would rely on it, that is, lower social economic groups, are not commonly politically influential. An underfunded safety-net would escalate demand for private care and drive up costs. Beneficiaries would be the very wealthy and the private insurance industry. While average Australians would be ineligible for the safety-net and have to deal with inflated direct costs of care and insurance premiums.

5 We already have a mixed public-private system. What is the big deal if the balance shifts a bit further toward privatisation?

Any move towards privatising elements of health care currently covered by Medicare are a stealth strategy of incremental cuts to reform Medicare as a safety-net for the poor. Various Coalition leaders have adopted strategies of incremental cuts that will gradually erode the broader public’s confidence in, commitment to and support for Medicare and universal health.

Unless defeated, a tipping point will be reached and Medicare will be re-cast as merely a welfare program for the poor.

In a mixed public-private system, a strong, publicly funded health system plays an important role in containing the overall rate of inflation of health costs. Weakening Medicare while strengthening the private sector creates incentives that result in:

- Increased waiting times in the public sector as doctors have an economic incentive to serve private patients.
- Incentives to maintain long public waiting lists in order to increase the attractiveness of more lucrative private care. How will the private operators of the new Northern Beaches Hospital, which will provide both public and private beds, deal with the temptation to create circumstances that optimise the attractiveness of their more lucrative private beds?
- Ethical questions when entrepreneurial doctors refer patients to private care in which they have financial interests.
- Growth in input prices due to competition between the public and private sector. In the public sector this leads to either a reduction in the provision of services or the need for public spending growth to maintain previous levels of service.
- Privatisation leads to poorer working conditions for the nursing and midwifery workforce.
NSWNMA rejects the notion that Medicare is unsustainable.

The reality is that in the coming decades, spending on health care will grow but so will incomes. As we become richer we will be willing to spend more on maintaining our health.

This increased spending can be done as individuals in a user-pays system, or it can be done as a community in the form of a system of universal insurance such as Medicare. Either way, health care spending will grow and someone will be paying for it.

The difference is, in a highly privatised, user-pays system there will be winners and there will be losers. This is what happens in the United States. Excellent care is available to those who can pay for it (or insure against it) but many who fall ill cannot afford care and they and their families suffer terribly as a result. The highly privatised US health care system costs far more and delivers far less than systems based on universal insurance.

The rest of the developed world economies have chosen to rely on universal insurance because it costs less, is more civilised and equitable and results in better health outcomes. Beneficiaries pay according to their means through progressive taxation and have access to the system on the basis of need.

No one is pretending that there are no changes that could be made to a 30 year old system like Medicare to make it more efficient – there certainly are many. But the notion that dismantling universalism, privatisation of health services and shifting costs to individuals is the answer to making the system more sustainable is a recipe for higher costs overall and rising social inequity.

Serious commitments must be made to ensure that inflation of costs in health is contained in the future. It is vital that the Australian Government maintains the lever of universal insurance to maintain a downward pressure on costs. The shift towards greater user pays, greater privatisation and co-payments as a barrier to primary health care is profoundly inconsistent with the goals of efficacy and equity and must be rejected.
Public Private Partnerships – failed model

Public-Private Partnerships or PPPs are a long-term relationship between the State and a private contractor for the construction, maintenance and operation of infrastructure. The private consortium owns the infrastructure for the term of the contract and provides services. This period is usually 20 years. At the end of the contract, a hospital is transferred back at typically nil cost to the government (although the Port Macquarie Base Hospital in NSW involved a major buyout cost due to poor management).

PPPs for new hospitals are usually embraced by governments as a means of delivering infrastructure without adding to public debt. The justification purported is they provide value-for-money and deliver improved services.

A PPP is not a true public hospital, it is an arrangement that gives a profit seeking entity control over public services. This is the wrong path for Australia’s health care system.

Table 1 presents the list of Australian public-private partnerships for hospitals.

<table>
<thead>
<tr>
<th>PROJECT</th>
<th>YEAR</th>
<th>CAPITAL VALUE</th>
<th>BEDS</th>
<th>OPERATOR</th>
<th>LOCATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Port Macquarie</td>
<td>1994-2004</td>
<td>$40mil</td>
<td>160</td>
<td>HCoA</td>
<td>country NSW</td>
</tr>
<tr>
<td>Hawkesbury Hospital</td>
<td>1994-ongoing</td>
<td>$47mil</td>
<td>127</td>
<td>Catholic Healthcare</td>
<td>outer metro NSW</td>
</tr>
<tr>
<td>Joondalup</td>
<td>1996-ongoing</td>
<td>$70mil</td>
<td>335</td>
<td>HCoA/Ramsay</td>
<td>outer metro WA</td>
</tr>
<tr>
<td>Latrobe</td>
<td>1998-2001</td>
<td>$56mil</td>
<td>257</td>
<td>AHC</td>
<td>country VIC</td>
</tr>
<tr>
<td>Mildura</td>
<td>1998-2015</td>
<td>$37mil</td>
<td>92</td>
<td>Ramsay</td>
<td>country VIC</td>
</tr>
<tr>
<td>Noosa</td>
<td>1998-ongoing</td>
<td>$20mil</td>
<td>100</td>
<td>Ramsay</td>
<td>Regional QLD</td>
</tr>
<tr>
<td>Robina</td>
<td>2000-2002</td>
<td>$48mil</td>
<td>192</td>
<td>Sisters of Charity</td>
<td>Regional QLD</td>
</tr>
</tbody>
</table>

Source: Schmiede (2009)
Port Macquarie Base Hospital (PMBH) – failure in management

Australia’s first major partnership involving delivery of clinical services was the Port Macquarie Base Hospital in NSW, which commenced operations in November 1994.

Most people in NSW are aware of the sorry tale of Port Macquarie Base Hospital – famously described by the Auditor General as a contract where the government was “paying for the hospital twice and giving it away”. Costs were 20 per cent higher than those in the public sector and the majority of the risks were passed on to the government.

It is worthwhile to examine the performance of the PMBH on the criteria of quality of services and value for money. On the first point (quality of services), a number of performance indicators for the PMBH were set between the NSW Department of Health (DoH) and Mayne Nickless which included elective surgery waiting times. Peer hospitals for comparison were also set between DoH and Mayne16.

In 1998, waiting times for elective surgery at the PMBH were double the state average and it was the state’s worst performing hospital. Within NSW, the PMBH had the State’s largest number of patients with waiting times longer than a year.

Performance indicators of Port Macquarie Base Hospital (PMBH) as of April 199816

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>State Public Hospital</th>
<th>PMBH</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Average waiting time for elective surgery</strong></td>
<td>2 MONTHS</td>
<td>4.5 MONTHS</td>
</tr>
<tr>
<td><strong>Proportion of urgent/high priority patients cleared within 30 days (%)</strong></td>
<td>State Public Hospital</td>
<td>85%</td>
</tr>
<tr>
<td></td>
<td>PMBH</td>
<td>36%</td>
</tr>
</tbody>
</table>

Combined figures for elective surgery & medical waiting lists

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>State Public Hospital</th>
<th>PMBH</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Combined figures for elective surgery &amp; medical waiting lists</strong></td>
<td>1.5 months</td>
<td>7.2 months</td>
</tr>
<tr>
<td><strong>Proportion of urgent/high priority patients cleared within 30 days (%)</strong></td>
<td>State Public Hospital</td>
<td>85%</td>
</tr>
<tr>
<td></td>
<td>PMBH</td>
<td>36%</td>
</tr>
</tbody>
</table>
By 2003, at the end of its operating period, there were 333 elective patients with waiting times for surgery of longer than a year. In comparison, Coffs Harbour and Manning Base public hospitals, in the same peer group, had just 7 and 5 patients respectively with waiting times longer than a year.

**Healthscope and the new Northern Beaches PPP**

In late October 2014, the NSW Government announced Healthscope had been chosen as the preferred tenderer to design, build, operate and maintain the new Northern Beaches Hospital. The Northern Sydney Local Health District will partner with Healthscope to provide public patient services over the next 20 years. At the end of the contract period, the public portion of the hospital can be handed back to the NSW Government at no additional cost. Healthscope then has a further 20 years to provide services to private patients before the remaining part of the hospital can also be returned.

NSWNMA has a number of concerns about how the PPP arrangement will affect quality and safety, as well as the employment conditions of the nurses and midwives who will work at privatised hospitals. Clearly, the Healthscope contract must prove it can deliver services more efficiently than the public sector – otherwise, what would be the point? At the same time, Healthscope is obliged to strive for profits to deliver growing returns for their investors.

**Joondalup Health Campus – poor results in urgent care**

The NSW Government has frequently cited the Joondalup Health Campus PPP as a base model for further hospital privatisations in NSW. Latest figures from the myhospitals.gov.au website indicate only 26% of patients in the urgent category presenting to the ED received care within the recommended timeframe, compared to a national average of 63%. Joondalup also received poor results in the semi-urgent category of care.
**Joondalup urgent waiting time (requires treatment within 30 minutes)**

In 2015-16, 26% of urgent patients were treated within 30 minutes of arrival at the emergency department of this hospital, compared to its national peer group performance of 63%.

<table>
<thead>
<tr>
<th>YEAR</th>
<th>NUMBER OF PATIENTS</th>
<th>PATIENTS TREATED WITHIN 30 MINUTES</th>
<th>PEER GROUP AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015–16</td>
<td>35,514</td>
<td>26%</td>
<td>63%</td>
</tr>
<tr>
<td>2014–15</td>
<td>34,029</td>
<td>24%</td>
<td>63%</td>
</tr>
<tr>
<td>2013–14</td>
<td>30,175</td>
<td>26%</td>
<td>65%</td>
</tr>
<tr>
<td>2012–13</td>
<td>28,582</td>
<td>25%</td>
<td>63%</td>
</tr>
<tr>
<td>2011–12</td>
<td>28,539</td>
<td>30%</td>
<td>62%</td>
</tr>
</tbody>
</table>

**Joondalup semi-urgent waiting time (requires treatment within 60 minutes)**

In 2015-16, 50% of semi-urgent patients were treated within 60 minutes of arrival at the emergency department of this hospital, compared to its national peer group performance of 73%.

<table>
<thead>
<tr>
<th>YEAR</th>
<th>NUMBER OF PATIENTS</th>
<th>PATIENTS TREATED WITHIN 60 MINUTES</th>
<th>PEER GROUP AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015–16</td>
<td>43,452</td>
<td>50%</td>
<td>73%</td>
</tr>
<tr>
<td>2014–15</td>
<td>43,925</td>
<td>49%</td>
<td>72%</td>
</tr>
<tr>
<td>2013–14</td>
<td>41,911</td>
<td>51%</td>
<td>72%</td>
</tr>
<tr>
<td>2012–13</td>
<td>39,982</td>
<td>52%</td>
<td>68%</td>
</tr>
<tr>
<td>2011–12</td>
<td>42,832</td>
<td>57%</td>
<td>66%</td>
</tr>
</tbody>
</table>
Performance of other PPPs in Australia

La Trobe Hospital in Victoria and Robina Hospital in Queensland also resulted in contract failure. The Victorian Minister for Health entered into a 20-year contract with Australian Hospital Care in 1997 for the design, construction and operation of the La Trobe Regional Hospital. It commenced operations in October 1998. After 6 months of operation, Australian Health Care approached the Liberal Government of Victoria for more funding following significant operating losses. The government did not assist. In November 2001, the staff of Latrobe Regional Hospital transferred back into state employment and in 2002, the ownership of the hospital reverted back to state management.

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

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

According to the NSW Bureau of Health Information, the privately run Chris O’Brien Lifehouse is underperforming compared with public counterparts against a range of important clinical quality measures.

Over three months in 2015, the Bureau surveyed 3700 patients after they visited a cancer clinic. Lifehouse fell below the state average on symptom severity, maintaining a positive attitude and patients understanding and participating in their care.
Staffing, skill mix and quality at stake

Private operators owe a duty to shareholders, so there is financial responsibility to deliver profit on investment first and high standards of care second. No large private hospital operator has been prepared to agree to nurse to patient ratios anywhere in NSW. We know from experience in Australia and abroad that nursing and midwifery services are the single biggest cost in running a hospital and they will most certainly be a key area targeted for cutting costs. This could be achieved through reduced staffing, diminution of skill mix and a reduction of conditions for staff or a combination of these. Not only does this affect nurses and midwives but international evidence shows a very clear correlation between staffing ratios and improved patient outcomes.

**IDEAL NURSE TO PATIENT RATIOS**

1 : 4
NURSE PATIENTS
General Adult Inpatient Wards, Inpatient Mental Health, Drug and Alcohol Units

1 : 1
NURSE PATIENTS
Neonatal ICU, Critical Care, Resuscitation Beds (ED)

1 : 3
NURSE PATIENTS
Emergency Department, Paediatrics
Cutting costs

Other strategies to boost profits include purchasing of less expensive equipment and targeting of more profitable services at the expense of less profitable services. This could be achieved through offering free screening services and developing mutually rewarding relationships with specialists and other providers. Over-servicing is a well-documented outcome of profit seeking in the health care industry both here and overseas.

We are also concerned about how the operator will resist the temptation to use their influence to enhance the attractiveness of private care over the public waiting list.

Maintaining labour costs, equipment, developing the more profitable aspects of a business, maximising sources of income while minimising outlays, are all things highly successful corporations do. It is exactly these imperatives that have led the US to a health system which delivers much less but costs far more. Unlike many other markets, profit seeking does not deliver efficiency in health. Fortunately, Australia still has a viable public health system. A Public-Private Partnership (PPP) is not a true public hospital, it is an arrangement that gives a profit seeking entity control over public services. This is the wrong path for Australia.
Clearly, these measures are aimed at putting pressure on the States and Territories’ public health systems to the point of collapse — where they will be forced to cut their health budgets even deeper, axing frontline jobs, shutting hospital beds and ultimately selling off our public hospitals.

Australians will end up with a more expensive American style system of privatised health care — where if you don’t have the money you don’t get the care. This direction from the government is an unethical one.

Everyone will feel the pain, especially young people, the elderly, people living in regional and rural communities, the chronically ill, people with disabilities and disadvantaged Australians.

Annie Butler, Australian Nursing and Midwifery Federation

The stage is being set for a US-style managed care system in both the primary care and hospital settings. I am concerned that the government is also looking towards such a system...

Clearly, the AMA agrees that funding a sustainable health system is important. However, health cannot just be viewed through a financial lens...

Proper funding of our public hospital system is essential and the Commonwealth must do its share of the lifting. Funding public hospitals at CPI plus population growth from 2017 turns the Federal Government from a lifter into a leaner.

Dr Brian Owler, ex-President of the AMA

The losers in this political stoush are the Australian public — and most of us, at some stage in our lives, will rely on a public hospital, regardless of whether we have private health insurance. This is because emergency department services and highly complex medical and surgical services are largely provided via the public hospital sector.

Alison Verhoeven, Chief Executive, Australian Healthcare & Hospitals Association

Public opposition to privatisation isn’t the result of fear of the unknown or misunderstanding of the arguments. Rather, it’s the product of decades of experience. Far from producing lean, innovative and customer focused organizations, privatisation and corporatisation have given us bloated and overpaid management, higher prices, and customer service that ranges from limited to appalling.

Professor John Quiggin, Economist, University of Queensland

Despite the naive and optimistic views expressed in the enthusiastic initial public announcements of public-private partnerships, they are not magic puddings. It is not clear that private-sector management necessarily leads to greater efficiency in hospital delivery...

Governments must be extremely careful about how they negotiate public-private partnerships and cannot assume the contracts they negotiate will be free from the problems seen in past contracts.

Dr Stephen Duckett, Director, Health Program at Grattan Institute
References

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