

Developing an Analytical Framework for Analysing and Assessing Public-Private Partnerships: A Hospital Case Study

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Abstract

Public-Private Partnerships have been a popular public procurement policy in a number of countries including Australia, the UK, and New Zealand since the early 1990s. This article examines the experience of the Port Macquarie Base Hospital (PMBH), the first public hospital delivered under the Public-Private-Partnership (PPP) model in the State of New South Wales, Australia. Using a framework adapted from Macário, this study focuses on the political climate in which this PPP mechanism was implemented, identifying the underlying motives driving the use of a PPP to deliver public health services and clarifying the essential conflicts undermining the PPP process. The article covers the entire life cycle of the PPP hospital, from the initial contracting process to its eventual sale. A political desire to reduce public debt, allied with an ideology assuming private sector superiority, made this approach particularly attractive, but failed to deliver the desired outcome. The success of PPPs would appear to depend strongly on goal alignment in a multi-level political system. Auditing processes during the implementation process need to take account of the presence or absence of such alignment.

Introduction: Understanding Public-Private Partnerships

Public-Private Partnerships (PPPs)¹ are public procurement policies which involve the private sector providing services that are traditionally the responsibility of the government (Broadbent and Laughlin 2004: 4). Infrastructure and fiscal pressures continue to make such arrangements attractive to governments, so it is timely to take stock of their performance. This article revisits an early experience of PPPs in Australia. It examines the real drivers of the first PPP experiment in the health sector in the state of New South Wales—the Port Macquarie Base Hospital (PMBH). It suggests that PPPs had two origins: a macroeconomic policy agenda, driven by a desire to control public debt, and an underlying ideological belief that efficiency would be enhanced by harness-

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ing market competition through private sector bidding. This macroeconomic policy agenda was the main driver for the first generation of PPPs (Quiggin 2005), and remains a strong force motivating the current evaluation process adopted by public agencies. In practice, however, such efficiency gains are far from being automatic—the success of any PPP project depends on an integration of the goals of strategic, tactical and operational levels of authority. Evidence in this study is based on findings from government reports, information gleaned from news releases, and analysis from academic and professional literature. This study shows that ideology, resulting in a dominance of accounting concerns at the strategic level, and conflicting goals among the three levels of players, led to the ultimate failure of the Port Macquarie experiment.

The term ‘Public-Private Partnership’ is an umbrella term that encompasses a range of financial and organisational relationships between the public and private sectors (Edwards et al. 2004: 17). These relationships are regulated by a concession contract which enables a commercial organisation to finance, build and operate an asset for an agreed period. The concession contract can take many different forms. The typical forms used in Australia are detailed in Table 1.

Table 1: Forms of PPPs

Abbreviation	Detail
DBFO	Design, Build, Finance and Operate
DBOM	Design, Build, Operate and Maintain
DBOT	Design, Build, Operate and Transfer
DOD	Design, Operate and Deliver
BOO	Build, Own and Operate
BOL	Build, Operate and Lease
BOOST	Build, Own, Operate, Subsidise and Transfer
BOOT	Build, Own, Operate and Transfer
BOT	Build, Operate and Transfer
BRT	Build, Rent and Transfer
BTO	Build, Transfer and Operate
FBOOT	Finance, Build, Own, Operate and Transfer
PFP	Privately Financed Project
Semi-public companies	Government and private enterprise[s] jointly own facility
ROT	Rehabilitate, Operate and Transfer

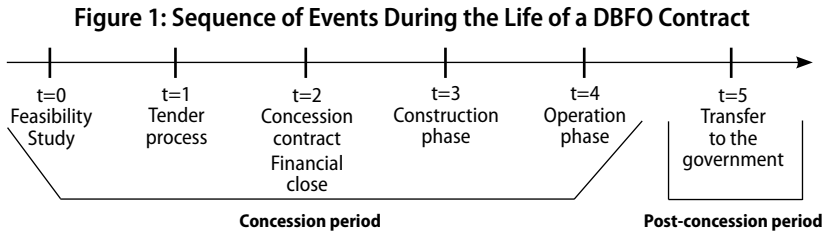
Source: Duffield 2001: 28, Table 2-7

The most popular form of concession contract is the DBFO² where the private sector is contracted to supply a bundled product. This product comprises two distinct elements. The first element is the creation of an asset: namely, the construction of physical infrastructure. Common examples are hospitals, prisons, roads and schools. The second element is the ongoing management of the asset once it is built (WWG 2006: 8). The role that the private sector plays in the second element varies depending on whether we are dealing with social infrastructure projects or economic infrastructure projects. Since the case study is about a hospital which falls under the social infrastructure category, discussion of the private sector’s role in the second element is focused on social infra-

structure projects only. Social infrastructure projects, such as hospitals, schools and prisons, where government retains demand risk (NSW Treasury 2007: 1) are normally funded from State revenue (English and Guthrie 2003: 503). The private sector's operational role requires it to meet a specified threshold level of service that is suitable for achieving stated objectives (Grimsey and Lewis 2005: 346). The delivery of front-line services, such as clinical or educational services to the public, is not part of the DBFO contract (cf. Broadbent and Laughlin 2004; English and Baxter 2007).

In return for supplying finance to build the infrastructure, the public sector partner purchases asset-based services from the private provider through a stream of regular lease payments (Broadbent and Laughlin 2005: 75). The lease payments are structured into two tiers. The first tier involves pre-defined levels of direct government subsidisation to the private partner for the availability of the facility (English 2005). The second tier pays for partial provision of facility-based service (NSW AGO 1996; Shaoul 2005: 446) and is based on specified performance criteria (English 2005). There are separate contractual conditions stipulating the required performance standards commensurate with agreed service charges or penalties that apply with abatement (NSW Treasury 2007: 60). Payments are due only when the service meets required standards (Debande 2002: 359). The payment mechanism is designed to provide private proponents with a number of incentives to work efficiently so as to deliver value for money (VFM). It encourages the private proponent to minimise costs when building the required asset and to use efficient technology, because the recoupment of costs and future profit rely on a flow of suitable quality services from the asset (Debande 2002: 360). Further, the revenue receipts flow to the private operator only when the construction of the asset has been completed and service is fully operational. Thus, it also provides incentives for the private consortium to finish the construction element on time. As will be discussed in the case study below, such incentive mechanisms can become ineffective if contractual terms remain poorly defined.

Since DBFOs are infrastructure-based products, they require from the private partner(s) a substantial amount of financial capital at the start-up stage.³ Thus the willingness of a profit-seeking private sector provider to accept the project is conditional on a long-term commitment on the part of the public purchaser. The length of DBFO contracts is on average 60 years (Broadbent and Laughlin 2005) in order to cover the expected life of the property.⁴ The asset's life covers both concession and post-concession periods.⁵ Figure 1 describes the sequence of events across these two periods. The concession period locks the public sector into a financial contractual relationship with the private party who remains the owner of the property during the term. At the conclusion of the concession period, the ownership of the property normally reverts to the public sector at no additional cost,⁶ and the contract is subject to renewal at the discretion of the public agency (English and Baxter 2007; Robinson et al. 2007).



(Source: Adapted from Debande 2002: 366, Figure 2)

Initially, PPPs emerged as a procurement technique driven by a macroeconomic policy agenda which emphasised cutting government capital spending as well as microeconomic concerns focused on improving the quality of service. Subsequently these concerns evolved into a microeconomic procurement policy. This 'macro/micro' interface is hinged by the accounting treatment of PPPs and the notions of VFM through optimal risk sharing (Broadbent and Laughlin 1999: 102).

The remaining sections of the article apply this analysis. The following section uses a framework derived from Macário (2001) to explain the proliferation of PPPs as a macroeconomic technical tool, while examining the ideology underlying the pursuit of PPPs by the New South Wales government. Given this groundwork, PMBH in section three provides a case study that investigates the application of this macroeconomic tool at the microeconomic level. The contract for PMBH was concluded in 2005 when the government purchased it back for \$35 million. Its early termination (the date originally specified was 2012) makes it possible for an *ex post* evaluation that studies the life-cycle events of the PPP experiment as depicted in Figure 1. Further, the PMBH is one of the very few PPP cases that has good quality and quantity of evidence available in the public domain. This evidence has enabled the author to examine in detail, using the Macário (2001) framework, how the three levels of government interacted during the pre-contract and contract periods of the PPP experiment. The findings are drawn together in the final section.

The Macário Analytical Framework for Assessing Public-Private Partnerships

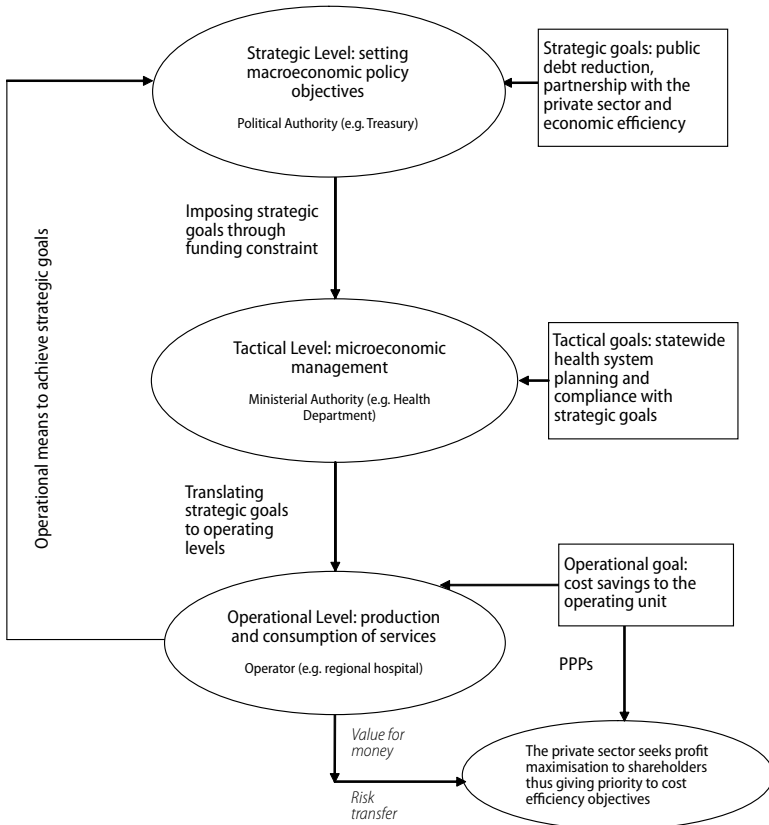
Macário (2001) identified three levels of authority in the course of studying the integrated urban transport system in Europe. At the strategic level, the political authority defines a set of overriding objectives to be followed by other authorities at lower ranks. These objectives claim to satisfy the needs of citizens. At the second political level lies the tactical authority. At this level, respective regulators design systems for public service delivery, defining policies and articulating the strategic goals into operational specifications. The last is the operational or ground face level where production and consumption of services occur. Decisions made at this level should be in line with strategic goals and tactical planning. The final outcome is the achievement of strategic objectives within the defined tactical system. In making decisions, authorities at differ-

ent levels should take a holistic view, considering the flow-on impact that they have on other levels. This ensures that service deliveries are fully integrated into the whole-of-government circle. Macário warned that the absence of well developed strategic objectives and integrated tactical planning would lead to operators

seeking the maximisation of their own profit, and without offering a network that effectively provides economies of scale and scope for the users, in particular, and for the local society in general (Macário 2001: 6).

This three-level framework offers us an analytical approach with which to understand the Australian political environment within which PPPs were initiated. Figure 2 (below) schematically lays out the Macário framework into a systematic approach for analysing the political setting of PPPs in Australia.

Figure 2: Analytical Framework for Analysing and Assessing Public-Private Partnerships



Australia has three levels of government: federal, state and local. Each state has its own parliament and executive government and is financially responsible for service delivery in areas such as health, schools, prisons, police and security as well as transport (English 2003). PPPs have been implemented extensively in almost all areas (except police and security) at the state government level, whereas experience at the federal level remains limited. The political framework developed in this article applies to the political environment at the state level only.

The strategic authority sets the macroeconomic policy for the state economy. The overriding strategic goals are commonly economic efficiency in consumption (allocation of resources in accordance with customer needs and preferences), and production (for each efficient allocation in consumption, the minimum cost of production is sought) (Macário 2001: 7). The Treasury is responsible for overseeing policy implementation and approving projects that will fulfil these defined goals. In the area of capital works, the objective has been the supply of necessary infrastructure to deliver essential public services within the state budget constraint. At the planning stage of the PMBH, the Treasury was acutely concerned with rising levels of public debt. Thus, its focus on public borrowing was extended to the accounting treatment of procured assets in the financial statements of the public sector. This reflected the control of public borrowing as institutionalised by the Loan Council at the federal level⁷ (Walker and Walker 2000). Such political concerns encouraged off-balance sheet borrowings and the proliferation of PPPs.

In government circles, PPPs were widely advocated as a new means of providing necessary social services and infrastructure without the burden of rising government debt (Broadbent and Laughlin 1999: 96; English and Guthrie 2003: 494; Newberry and Pallot 2003: 467, 481; Rutherford 2003: 373; Quiggin 2005: 446). PPPs establish a long term contractual agreement in which the public sector purchases a stream of services instead of an asset from a private provider. Since PPPs avoid any new asset from appearing on the public sector's balance sheet (Heald and Dowdall 1999: 243; English and Guthrie 2003: 494; Quiggin 2005: 445), their costs can be excluded from contributing to the 'global limits' of the public sector's borrowing (NSWPAC 1994: 41; Walker 2002: 5–7). However, to deliver the related services, the profit-seeking private provider requires financial commitments (in some cases financial guarantees) from the responsible public sector purchaser (Mills 1991). Thus in substance, government purchases of services through PPP arrangements are public debts. Ostensibly, the initial engagement in PPP commitments was driven by the political aim of removing *visible* public debt by burying capital costs within a stream of general expenditure over a long period.

More explicitly emphasised in the broader debate at the strategic level was the greater degree of efficiency derived from the PPP structure, as it allows for the provision of infrastructure and government services while mimicking a competitive situation. In particular, PPPs were seen as a satisfactory response to the crucial issue of risk assignment, whereby those most able to control risks are those who contractually should bear them. It can be argued that the private

sector enjoys higher efficiency as a result of its flexible decision-making, but flexibility is an impetus to increased efficiency in service delivery only when the private provider's operational objectives blend into the public service delivery framework. This is unlikely to be realised, however, if the public sector does not have a set of defined goals and systematic long-term planning.

The tactical level in the Macário framework translates macroeconomic policies into microeconomic management. Respective ministers are put in charge of planning an integrated system for public service deliveries. In the area of health, the Department of Health (DoH) is responsible for the planning of a state-wide public health system that facilitates the achievement of economic efficiency. The DoH needs to demonstrate that capital works are aligned with the Treasury's funding strategy.

In contrast to other levels, the operational level produces and delivers public services to constituents. The local health authority identifies the areas in need of capital works, sources the possible funding channels and submits the projects to the tactical authority, who in turn seeks approval from the strategic level. In projects that include the private provision of services, a private sector operator replaces the public operator. A functional framework should provide incentives that induce the operator to produce outcomes contributing toward strategic goals. Stanley and Hensher (2004) noted that at an operational level, the success of PPPs to a large extent relies on the existence of a soundly developed framework both at the strategic and tactical levels. At these levels, a well-defined whole-of-government approach is likely to reduce the scope for any opportunistic behaviour by a given public agency at the expense of other government units, or even of the broader community. A further challenge brought about by the involvement of private provision is the problem of 'compounded agency' whereby the tactical authority is an agent for local consumers whilst the private operator acts as an agent for the authority. Hence, indirectly the private operator becomes a delegated agent for consumers (Trailer et al. 2004: 308). Ostensibly, there exists a conflict of interest in this dual relationship which creates a need for integrating the goals of maximising consumer surplus with that of maximising the value of the private firm (Trailer et al. 2004: 308).

It has been observed that the lack of long-term systematic thinking at the tactical level (Stanley and Hensher 2004) and the accounting and ideology motives at the strategic level (Spackman 2002) have resulted in the pursuit of absolute private provision at the operational level. The above problems, identified in the literature, were manifested in the case of PMBH.

The Port Macquarie Base Hospital

This section applies the Macário three-level framework in assessing the case of PMBH.

Initially, the regional health authority (the operational level) established the business case for building the PMBH to meet rising demand for public hospital services in the Port Macquarie region. During the concept stage of the hospital project, the authorities representing the State Government and Treasury (the strategic level) envisioned that building the PMBH as a private-public venture

would provide a working model for expanding the private provision of public health services (Daley 2000). The strategic authorities also maintained the view that the private sector could bring greater competition as well as cost-efficient services into the health provision (Chung 2003).

In translating this strategic ambition to the operational level, the Department of Health (tactical level) alleged that public finance was unavailable and claimed that the capital budget for the health program for the next three years was fully committed. The DoH's position at that time was that the only channel by which to obtain adequate funding for timely construction of a hospital was through private financing. The decision to deliver PMBH through the PPP model fast-tracked the significantly delayed development of this regional hospital at the operational level. The tactical level achieved strategic consent by tailoring the hospital project to Treasury's budget objectives. In this process, the project's concept of providing quality public hospital service to the Port Macquarie region was undermined by other political intents formulated in the then political climate — the removal of visible public debt and the pursuit of private provision of public infrastructure.

The Need for a New Hospital at Operational Level

Port Macquarie was one of Australia's largest retirement centres with a rapidly expanding but aging population, characterised by its lower socio-economic characteristics (NSW PAC 1992: 21). The old Hastings District Base Hospital (HDBH) was considered unable to meet the demand for the fast growing region around Port Macquarie. The proposed Port Macquarie Base Hospital was designed to satisfy this rising demand and to provide an increased level of health service to the region (NSW AGO 1996: 395).

In 1978, the Labor Government of NSW announced that a new public hospital would be constructed to replace the old HDBH. For a decade, nothing further happened. A struggle between the shortage of funding at the tactical level and the need for an upgraded hospital at the operational level significantly delayed the hospital development. In March 1988, the regional health authority produced a Master Development Control Plan suggested that a new 219-bed⁸ hospital be built on a new site. In August 1991, NSW Health Minister Hannaford nominated the PMBH as a possible site for private infrastructure provision. The private provision was seen as a quick fix to the political power struggle between the tactical and operational authorities. At the very least, the private option offered the Port Macquarie community advantages in terms of certainty and timing. At an operational level, it provided a definite present rather than an ill-defined future. In December 1992, the DoH entered into a 20-year, non-cancellable contract with Mayne Nickless Limited, whose subsidiary, Health Care of Australia (HCOA), subsequently formed the hospital management. The hospital was contracted to treat a mix of 80 per cent public and 20 per cent private patients. The DoH, in turn, promised to purchase public health care services from the hospital, operated by the HCOA, for a span of 20 years.

Project Details

PMBH was a landmark in the provision of health services for NSW. The government's role changed from that of traditional health service provider to health service purchaser. Being the first PPP hospital experiment, PMBH differed from the archetypical DBFO discussed in Section One in many ways. For example, the project vested the perpetual ownership of the asset in the private consortium as well as providing for the delivery of core clinical services by the private operator. The project constituted a contractual agreement between DoH and a private consortium made up of:

- the owner, the Port Macquarie Base Hospital Pty Ltd (PMBH PL);
- the financiers, NATWEST Australia Bank Limited (NatWest);
- the finance packagers, Hambros Nominees Australia (Hambros);
- the builder, Fletcher Constructions;
- the private operator, Health Care of Australia (HCOA).

The hospital was built on the site of the existing public hospital (HDBH). PMBH PL leased the hospital building to HCOA. HCOA operated the hospital and provided public and private health services to the Port Macquarie region. Hambros arranged the financing, and also provided 49 per cent of the funds. NatWest contributed 51 per cent of the total funding and provided the majority of the development funds. The DoH retained its role as health services regulator, as well as adopting a new role — that of purchaser of public health services from HCOA.⁹

A DBFO structure was established for the whole project from design and financing to construction and operation. The terms of the project constituted two tiers of payments: an availability charge and a service charge. Under the terms of the contract, the obligation of DoH to pay the availability charge did not arise until the hospital had been constructed and commissioned to the satisfaction of the DoH (NSW AGO 1996: 431). Through the 'Availability Charge', all costs incurred in relation to the construction of the hospital, together with their interest costs, were repaid by the DoH to the Owner. Expenditure on ordinary repairs and maintenance to the hospital carried out by the Operator were factored into the availability charge. The total payment over the term of the contract for the availability charge was \$143.6 million (in constant dollars). At the end of the 20-year period, the ownership of the hospital would remain in the hands of PMBH PL (NSW AGO 1996: 429). In addition, the DoH was contracted to pay the Operator a service charge each year for public patients treated in the hospital. The budgeted service charge was calculated annually on a set fee per service and the number of bed days. It would continue to escalate each year irrespective of the actual number of services incurred during the year (NSW AGO 1996: 403). Although the annual service charge was set to cap at DoH's budgeted amount (NSW AGO 1996: 403, 404), it did not insulate the DoH from the risk of rising costs. This will be revealed in the later discussion on risk transfer.

In August 1993, the builder Fletcher Constructions commenced construction. The hospital was commissioned in November 1994. In October 2003, the Mayne Group proposed selling its entire Australian Hospital business including the PMBH to another private consortium. In April 2004, the NSW State Government commenced legal proceedings against the Mayne Group in relation to the novation of the PMBH contract to Affinity Health (part of the private buying consortium). On 31 January 2005, the Labor Government bought back the hospital for \$35m¹⁰ (price as of 2006).

Funding Choices at the Tactical Level

In 1990, the DoH prepared an assessment (Table 2) of the cost of building a new public hospital for Port Macquarie, compared with the option of allowing private provision. Table 2 shows that at the operational level, the private option was expected to save \$15 million in capital and \$46 million in recurrent costs over the span of 20 years. However, why the initial capital outlay was estimated as being \$15m higher under the public option than the private option was never fully disclosed. Firstly, in the absence of information to the contrary it was possible but implausible to argue that it was based on the assumption of greater efficiency on the part of the private constructor. More plausibly, the \$49m estimate for the private option merely represented capitalised availability charges and did not reflect the full cost of building and equipping the private hospital (NSW PAC 1992: 36).

The DoH produced further figures to demonstrate that, at strategic and tactical levels, the private option would be cheaper than the public option, as shown in Table 3.¹¹ Both tables were constructed to support a perception that the private sector was more cost-efficient. A closer examination reveals that the PPP deal was in fact costly. A discount rate of 13.71 per cent p.a. brings the present value of the total 20 payments to an amount approximately equivalent to the value of the hospital at the date of commission.¹² At the time the contract was signed (1992), compared to the NSW Treasury Corporation 10 year bond rate of 9.7 per cent, private financing cost the residents of NSW an additional 4.01 per cent in interest payments. In fact, there are better grounds for believing that the publicly financed option would have been the lower cost option. At 9.7 per cent, the NSW Treasury Corporation 10 year bond rate was 2.55 per cent lower than the indicator rate of 12.25 per cent provided by Westpac (one of the major private financial institutions in Australia) (Gain 1992: 1). Government bond financing would have saved State taxpayers 2.55 per cent in interest expenses. Moreover, the cost of running the hospital was the highest amongst its peers. PMBH in fact cost taxpayers \$6 million more in recurrent funding compared to the average of other public hospitals (NSW Hansard, 29 May 1996).

Table 2: PMBH Costs Assessment^{(a), (b)}: Comparison of Public and Private Options

		Public	Private	Savings
Capital Costs				
TOTAL		\$64	\$49^(c)	\$15
Recurrent Costs^(d)				
Year 1	Operating	\$30	\$28	\$2
	Finance and Capital	\$6	\$4	\$2
TOTAL		\$36	\$32	\$4
20 year contract (NPV @7%)				
	Operating	\$335	\$306	\$29
	Finance and Capital	\$93	\$65	\$28
	Residual Value	-\$11	\$0	-\$11
TOTAL		\$417	\$371	\$46

(a) Costs are in millions of dollars.

(b) All costs are in 1991 prices.

(c) No information is provided for this calculation.

(d) These are costs of maintaining and running the hospital.

Source: Collyer 1997: 30, based on NSW DoH, 1992-8

Table 3: PMBH Comparative Costs to the Department of Health and State Budgets

	New Public	New Private	Savings
Number of beds	160	160	
Costs (\$m p.a.)			
Total Operating Costs	27.8	27.9	
Less State Income (Payroll tax etc.)		-2.2 ^(a)	
Net Operating Costs to State	27.8	25.7	2.1
Availability Charge	5.5 ^(b)	3.8 ^(c)	1.7
Total Costs to Government	33.3	29.5	3.8

(a) The State Government would receive \$2.2m in taxes from the private partner.

(b) The reason why the availability charge under the 'New Public' option was higher than that under the 'New Private' option was not disclosed.

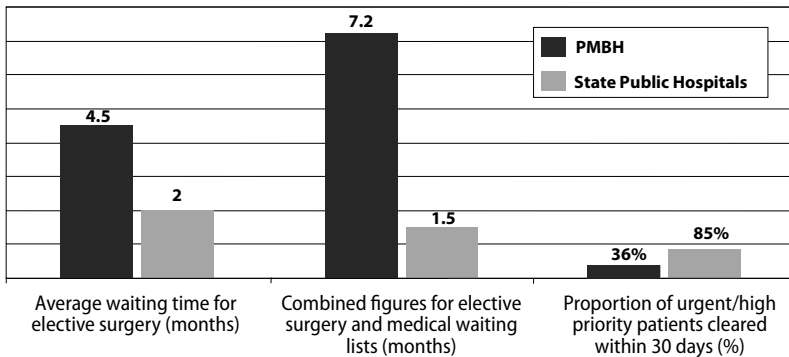
(c) The DoH would pay \$3.8m per annum 'availability charge' to the private sector for the provision of public health services provided by the private hospital.

Source: Collyer 1997: 30, based on NSW DoH, 1992-87

The computation in Tables 2 and 3 did not factor in other costs, such as bargaining costs, legal costs,¹³ equipment costs, and transaction and monitoring costs. Moreover, the increased administrative costs due to the complexity of the arrangement were also excluded from the private option¹⁴ (Chung 2003). A number of hidden costs were included in the calculation of the 'availability charge'. The availability charge was taxable in the hands of PMBH PL. The DoH contracted to compensate the private sector for all the tax expenses, but this allowance for the tax liability was in itself taxable, requiring a further allowance embedded in the availability charge. In this sense, the \$2.2m taxes (see Table 3)

from the private sector are arguably not much more than window dressing to make the deal look appealing. The calculations assumed a company tax rate of 45 per cent (NSW AGO 1996: 430). In the event the tax rate fell, the benefit to the Owner would increase.¹⁵ To make the Government's accounts look better, the DoH purchased the land from Hastings Council for \$550,000 in 1989 then sold it to PMBH PL for \$1.2m. In fact, the DoH reimbursed PMBH the price of the land through its availability charge. Effectively, the Department was borrowing \$1.2m from PMBH and repaying it plus interest.

Figure 3: Performance Indicators of PMBH as of April 1998



Source: Author's calculations based on data from Doherty, 30 May 1998.

The PPP hospital contract locked the DoH into a long-term commitment to guarantee the private consortium an annual risk-free and tax-free return of 13.71 per cent. NSW taxpayers would have at least gained substantial savings in interest payments if these had been calculated using variable rates in accordance with movements in the market.¹⁶ Moreover, after paying off the availability charge, DoH would not own the hospital at the conclusion of the agreement unless it purchased it at market value. As noted before, it cost the State Government \$35m to buy out the contract.

Ideology and Debt Reduction Motive at the Strategic Level

If the ideological belief of the strategic authorities that the private sector through a competitive bidding process could lead to a more cost-effective and better delivery of services was true, PMBH should have outperformed its peer public base hospitals. This was not shown in the PMBH experiment. A cross-service and cross-year comparison over a number of indicators set by the DoH between the PMBH and other base hospitals shows that the PMBH consistently under-performed its peers over the years. In 1998, the PMBH had waiting times for elective patients more than double the State average and was the worst performing hospital in NSW (see comparable data in Figure 3). Performance was falling further in 2003. Table 4 shows the waiting time for elective patients in major non-metropolitan hospitals located in the Mid North Coast NSW for the period ended June 2003. The PMBH had the largest number of patients who had waiting times longer than a year. Some patients

had to wait up to three years for orthopaedic surgery. Compared with the other two hospitals in the same peer group, the PMBH appeared to be the most inefficient elective surgery provider.

Table 4: Current Waiting Times Listed by Specialities for NSW Major Non-Metropolitan Hospitals Mid-North Coast Area Health Services (June 2003, elective patients)¹⁷

Speciality	Coffs Harbour		Manning Base		Port Macquarie Base	
	Waiting Time > 12 months	Average Waiting Time (months)	Waiting Time > 12 months	Average Waiting Time (months)	Waiting Time > 12 months	Average Waiting Time (months)
E.N.T.	4	7.15	0	0.00	100	1.41
General	1	1.42	0	2.06	63	5.45
Gynaecology	0	2.71	1	2.52	71	2.90
Ophthalmology	0	8.77	0	6.80	9	0.00
Orthopaedic	0	3.75	4	5.54	65	7.60
Other	0	0.16	-	-	0	0.07
Plastic	0	0.00	-	-	-	-
Urology	2	1.77	0	4.11	25	0.99
Vascular	-	-	-	-	0	0.48
TOTAL	7	3.62	5	3.79	333	3.29

Source: NSW Department of Health, June 2003

Table 5: PMBH — Impact on Health and State Budgets^(a)

Budget Impact		Public Option		Private Option	
		1 st Year	20 Years	1 st Year	20 Years
Health	Capital	\$63	\$63 ^(b)	Nil	Nil
	Recurrent	\$28	\$327 ^(c)	\$32 ^(d)	\$390 ^(c)
State	Capital	\$63	\$63 ^(b)	Nil	Nil
	Recurrent	\$36 ^(e)	\$431 ^(c)	\$32 ^(d)	\$390 ^(c)

(a) In millions of dollars, 1990 prices

(b) Expenditure occurs prior to commissioning, debt servicing costs in recurrent impact.

(c) Net present values taken over 20 years.

(d) \$28m plus \$4m p.a. availability charge, paid to PMBH PL by Health Administration Commission (trading arm of DoH), bringing the total recurrent cost of the private option to \$32m.

(e) Includes overhead rates and taxes (sales tax, rates and taxes, insurance, regional administration costs; capital recovery (debt servicing); replacement and refurbishment (over and above public hospital asset maintenance standards); working capital servicing; payroll tax to State Treasury.

Source: NSW PAC 1992: 39, Table 10

For the strategic authority—the NSW Government—the most convincing reason in favour of the private provision was that the partnership arrangement could change the form of government payments from capital costs to recurrent spending, thus avoiding the global limits imposed by the Loan Council. Table 5 shows that the private option offered advantages in terms of the capital impact to Health and State budgets, because the public option would result in debts of

\$63m to both budgets. However, in recurrent costs in terms of the impact on the health budget, the public option had a significantly lower cost,¹⁸ although the difference was largely accounted for by the fact that Treasury did not charge DoH borrowing costs (NSW PAC 1992: 42). It is clear that PMBH deal entered into by DoH merely shifted the burden away from the State Government's capital works budget and into recurrent spending over a number of periods. These capital savings were partially offset by higher recurrent costs in payments for services and an availability charge.

Value-for-Money and Risk Transfer

Value-for-money and risk transfer were the advantages PPPs promised to bring. The following analysis demonstrates that the PMBH delivered poor VFM to taxpayers and transferred a significant proportion of ownership risk to the DoH.

Value-for-money can be assessed by a combination of: net present value of future spending; ownership and whole-of-life costing; whole-of-government outcomes; and improved risk management. Based on the information provided, an assessment of PMBH can now be made based on these criteria. In regards to the first criterion, the net present value of the sum of 20 annual payments of availability charges (\$67 million)¹⁹ is 27.7 per cent higher than the initial capital outlay (\$52 million). Poor whole-of-government outcomes were manifested by the high running costs of PMBH compounded by the low quality of its performance. PMBH cost the State 30 per cent more to run than its public sector comparators, whole-of-life-cost-savings have transferred the cost burden to taxpayers. The hospital has had the longest and largest number of waiting lists in the State. The argument for 'private efficiency being superior to that of the public sector' is not supported by the experience of PMBH.

PPPs would seem to offer the opportunity of ideologically claiming that risk can be transferred along with ownership to the private sector, because ownership implies risk bearing. The principle set out in Paragraph 7 of the Australian Accounting Standards AAS17²⁰ prescribes that risks incidental to ownership of assets include unsatisfactory performance, obsolescence, idle capacity, losses in realisable value, and uninsured damage or condemnation of the property. In the case of the Port Macquarie Base Hospital, the Department of Health bore all the risks associated with ownership, and the risk transferred to the private sector was negligible (NSW AGO 1996: 416–418).

Risk allocation was not symmetrical. While the DoH bore the downward demand risks, it gained no protection against rising costs, even though the contract provided for the annual service charge payable to be capped at DoH's budgeted amount. Irrespective of demand, the DoH was liable for service charges to fund non-inpatient services. The payments of non-inpatient services were set on a fixed budget basis, hence risks of inefficiency in this type of service rested with the DoH. On the other hand, the PMBH management could demand increases in its service charges. In 1997, HCOA used the threat of litigation to successfully claim an extra \$3m from the DoH to cover the cost of providing for medical patients (Downey 1997, cited in Collyer 1997: 35). These

arrangements gave the operator an incentive to curtail the quality and quantity of services it provided, since fixed revenue was guaranteed by DoH each year. It is not surprising to discover that PMBH had the poorest performance amongst comparable peer hospitals as shown in Figure 3 and Table 4.

Conclusion

The Macário framework provides an effective approach for analysing and assessing the pursuit of a PPP policy in an institutional environment that is made up of three levels of government.

The review of the literature in the first section identified some of the problems that coincide with the issues prescribed by the framework developed in the second section—namely, the lack of long-term systematic thinking at the tactical level, and the accounting and ideology motives at the strategic level. The case study presented in the third section revealed the manifestations of these problems in the case of the PMBH. The conflicting objectives between the public and private sectors and the ill-defined strategic goals resulted in the predicted outcome, a situation where the operator sought to maximise its own profit without offering a satisfactory community health facility.

The evidence suggests that the PMBH experiment was not motivated by a wish to provide better patient care, improved access to hospital services or a desire to obtain value for money for taxpayers. It was an experiment to establish a model enabling the private sector to deliver public health services which were traditionally the responsibility of government. However, based on the evidence presented above, the misalignment of interests between the two sectors and the inexperience of the private sector in public health service delivery meant that the experiment failed at a cost to taxpayers.

The PMBH PPP also failed to obtain the specified strategic goal of economic efficiency. Such an outcome was caused by the strategic authority's ideological belief that the private sector is, *a priori*, more efficient. To this must be added the over-reaching desire of keeping debts off the public sector's balance sheet. Constrained by the funding limit, the tactical authority had no option but to push ahead with the private deal in order to have an upgraded hospital for the region. Because of this, they put aside legitimate concerns focusing on the quality of care in the long run. The operator was only concerned with cost savings at the local level, thereby undermining service quality and community welfare. It has been reported in the literature (Trailer et al. 2004) that unconstrained profit-maximising objectives held by private operators are mutually incompatible with the public welfare imperatives inherent in any conception of the role of government. The evidence from the PMBH experiment offers further support for this conclusion. In this case, the conflicting goals between the three levels of government compromised the integrity of the whole-of-government system and led to the eventual failure of the venture.

The PMBH lesson has demonstrated that the achievement of strategic goals is largely dependent on the successful alignment of interests amongst the three different levels within the political system, rather than having one

level skewing the objectives of the others. Given that the private sector has a completely different set of profit-seeking goals to government, the alignment of interest is inevitably problematic. A successful outcome for both parties who appear to have inherently different objectives can only be achieved if they are prepared to work together in the spirit of partnership. This requires an understanding of each other's business, the nature of the contract and a common vision of how best they can work together (NAO 2001). This was not the case in relation to the PMBH. To achieve alignment, there is significant scope for the Auditor-General's involvement in this complex contractual relationship. It is hoped that through its independent monitoring role, the Auditor-General can facilitate the alignment of objectives throughout the implementation process thus leading to the realisation of strategic goals. Oversight would encourage greater accountability at each level and impede the implementation of misguided objectives. This task requires ongoing attention not only to contract management issues, but also to how the relationship between the public and private sectors should be developed.

Finally, it is worth considering a further impact of the PMBH study on risk-sharing arrangements in PPPs. The experience of the PMBH supports a strong case for a claim that the government's stewardship function failed to ensure that financing was channelled through appropriate risk-sharing arrangements. PPPs are long-term contracts featuring incomplete information that must be carefully managed at all levels (Hart 2003). This inherent uncertainty has compounded the problem of risk sharing. In PPP contracts, risks are typically allocated up-front and are calculated based on a set of assumptions which are irregular and often non-repeating (Froud 2003). As in the case of the PMBH, the calculation of availability charge payments was based on fixed levels of interest rate and tax rate. Optimal risk allocation also requires contracts to offer the scope for flexibility in re-negotiation. It seems that the government has learnt some lessons from the PMBH experiment. In the case of the more recent Hawkesbury Hospital, the 20-year DBFO contract between the NSW Labor Government and Catholic Health Care Services (the private partner) contained specific terms allowing on-going negotiation of payments in accordance with market movements (Chung 2003). An investigation of the effectiveness of these recent arrangements will provide a fruitful avenue for future research.

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Notes

1. They are also termed Privately Financed Projects (PFPs) in the procurement policy of NSW — *Working With Government* 2006. The early generation of the British equivalent is named Private Finance Initiative (PFI).

2. The use of terminology varies among countries. In the UK, DBFO involves the transfer of ownership at the end of concession period (cf. Glaister et al. 2000), while the similar arrangement in Australia is termed BOOT (Debande 2002: 380).
3. Total contract value is usually \$50m or more. But the whole contract value does not entirely fall onto the private sector party. The public sector supplies physical capital like land and related capital works (WWG 2006).
4. The life of some transport infrastructures can be well over a century. The Skye Bridge in Scotland has a design life of 120 years (Bain 2005).
5. To date, no DBFO project has ever reached the post-concession period.
6. The zero reversion cost should not be seen as buying a property at no cost. Financial commitments from the public purchaser to the private owner during the concession period, as argued by Heald (2003: 359), are in fact paying for the post-concession life of the property.
7. A 1928 referendum approved constitutional amendments to empower the Commonwealth to co-ordinate borrowings by state governments. The maximum sums were established by agreements amongst the Commonwealth and State governments, and allocated by the Loan Council. The Council assigned each state government a 'global limit' via a formula based on population (Walker and Walker 2000: 191).
8. The plan was subsequently revised down to 160 beds.
9. Details of the functions of these entities can be found in Collyer (1997) and the NSW Auditor-General's Report (1996).
10. Information obtained from media releases from the Department of Health, NSW [www.health.nsw.gov.au] and the Mayne Group [www.symbionhealth.com], accessed on 24 August 2007.
11. Differences in the savings presented in Table 2 and Table 3 are largely due to tax effects. The strategic authority has the power to impose taxes on profits generated by the hospital.
12. The constant discount rate is calculated according to the 20 annual availability charges payable by DoH to the private consortium. The calculation is provided in Appendix 1. The calculation was based on the data published in the Auditor-General's 1996 report. The report revealed that the nominal value of the contract was \$143.6m, equivalent to \$52.3m in terms of present value. The report did not disclose how the present value was derived. According to the given data, Appendix 1 applies a 13.7 per cent discount rate to bring the nominal value down to the present value of \$52.3m.
13. The legal cost to DoH to privatise Port Macquarie Base Hospital was \$510,000 (NSW Hansard, 18 September 1997).
14. In total, there were 17 contracts written to give effect to the project.
15. The company tax rate has been falling since. As of the 2004–05 fiscal year (during which the hospital was bought back), the company tax rate was 30 per cent.
16. As of September 2003 (around the time the Mayne Group proposed to sell PMBH), the 10-year NSW Treasury Bond rate was 5 per cent p.a. Even the most recent rate was only 5.5 per cent (data obtained from the NSW Treasury

Corporation website, www.tcorp.nsw.gov.au, accessed in September 2003 and on 23 August 2007).

17. The DoH did not provide an explanation for the measurements of 'Average Waiting Time Months'. The measurements in this table are conservative. A NSW parliamentary inquiry in 2002 found evidence that the PMPH manipulated waiting lists. 'If patients have been on a waiting list for a long time and they're asked if they want to go to another service, another doctor, and they say "yes", they're instantly taken off the waiting list until the new surgeon accepts them. If they say "no", they're also taken off the waiting list, although they're still waiting for their operation, they're not counted in the government's official figures' (ABC News, 05 September 2002). It is not unreasonable to expect that the actual waiting times were much longer than those reported.
18. Recurrent costs per annum to the health budget, under the public option and private option, were \$28m and \$32m respectively. The private option included the \$4m annual availability charge, which would not occur if the public option was adopted.
19. This is calculated using a discount rate equivalent to the NSW Treasury 10 year bond yield, 9.7 per cent in 1992. Calculation is provided in Appendix 2.
20. The harmonisation of Australian accounting standards with the International Financial Reporting Standards in 2005 has resulted in the replacement of AAS17 by AASB117, but the principle in accounting treatments of finance/operation leases remain the same.

Appendix 1: Annual Availability Charge Payable by the Department and the Present Value of the Total Charge at the Discount Rate of 13.71%

Year Ended 30-Jun	Availability Charge \$'000	Present Value \$'000
1995	3,242	3,242
1996	5,753	5,059
1997	6,098	4,716
1998	6,464	4,396
1999	6,852	4,098
2000	7,263	3,821
2001	7,699	3,562
2002	8,161	3,320
2003	8,650	3,095
2004	9,169	2,885
2005	9,719	2,689
2006	10,302	2,507
2007	10,921	2,337
2008	11,576	2,179
2009	12,270	2,031
2010	9,218	1,342
2011	5,007	641
2012	2,720	306
2013	1,477	146
2014	803	70
2015	248	19
143,612	52,461	

Source: Author's calculations using 13.71% discount rate based on data from the Auditor-General's Report 1996, Vol. 1, Appendix 4

Appendix 2: Annual Availability Charge Payable by the Department and the Present Value of the Total Charge at the Discount Rate of 9.7%

Year Ended 30-Jun	Availability Charge \$'000	Present Value \$'000
1995	3,242	3,242
1996	5,753	5,244
1997	6,098	5,067
1998	6,464	4,896
1999	6,852	4,731
2000	7,263	4,572
2001	7,699	4,418
2002	8,161	4,269
2003	8,650	4,124
2004	9,169	3,985
2005	9,719	3,851
2006	10,302	3,721
2007	10,921	3,596
2008	11,576	3,474
2009	12,270	3,357
2010	9,218	2,299
2011	5,007	1,138
2012	2,720	564
2013	1,477	279
2014	803	138
2015	248	39
143,612	67,005	

Source: Author's calculations using 9.7% discount rate based on data from the Auditor-General's Report 1996, Vol. 1, Appendix 4

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