

# LATROBE REGIONAL HOSPITAL

## Case Study

It was the former Victorian Government's policy that private enterprise be actively encouraged to invest in the State's future wherever benefits in terms of efficiency and cost effectiveness could be demonstrated. A recent change in Government from Liberal to Labour, has seen that policy change to one of private partnershiping, ie. the private sector provides the infrastructure but Government continues to deliver the services, similar to British PFI system.

The *Infrastructure Investment Policy for Victoria* ("the Policy"), released in August 1994, demonstrated the former Government's commitment to strengthening its partnership with the private sector.

### Policy Objectives

The *Policy* had the purpose of assisting Victorian Government agencies and private proponents seeking investment in State infrastructure, facilities and services.

It set out clear and concise guidelines, promoting greater certainty for business in making infrastructure investment decisions.

### *The Government was pursuing a number of objectives:*

- to procure assets, goods and services in the most efficient, cost-effective and timely manner;
- to take advantage of new technologies and innovations, private sector management skills and a wide range of financing techniques;
- to promote the growth of new and existing Victorian businesses and employment; and
- to strengthen the State's economy, producing sustainable social, cultural and other quality of life benefits.

### Issues Addressed

The *Policy* addressed a range of significant aspects of private enterprise involvement in the financing and provision of public infrastructure, including: setting out principles for assessing the merits of proposals for private sector investment; examples of appropriate forms of investment; the process to be adopted in developing infrastructure projects with the private sector; and provisions to apply to intellectual property and confidentiality.

It demonstrated an ongoing Government commitment to reducing uncertainties faced by the private sector in pursuing project opportunities, while increasing efficiency of the bidding process and minimising costs to the private sector.

The *Policy* encouraged competitive bidding and allocation of risk to those parties best positioned to assess and manage it, providing rewards for enterprise and risk taking through appropriate returns within a competitive environment whilst securing benefits for the Victorian community.

### **Approval Process**

A major concern for private sector parties, addressed by the *Policy*, is the incidence in Australia, as in other countries, of cancellation or radical change to projects on which considerable sums have been spent by bidders in research and preparation of bids.

#### **The Policy had a three stage approval process involving:**

1. Approval by Government to call for Registrations of Capability;
2. Approval by Government to issue a detailed Project Brief; and finally
3. Approval by the Responsible Minister and the Treasurer of proposed contracts **as** properly conforming with the previous project approvals, and a report to Government confirming that the requirements of the project brief have been met by a bidder and hence that the project may proceed.

Government intended that once a Project Brief had been issued the project would proceed to implementation, subject only to achievement of the functional and other requirements specified in the Project Brief, including any cost to Government.

Through the Latrobe Regional Hospital Project, the Victorian Government sought to demonstrate its commitment to improving access to high quality health care through greater private sector involvement in the provision of public health care services. This project was designed to provide the people of the Latrobe Valley with a new, state-of-the-art hospital and high quality health services at an efficient price, through private sector ownership and operation. It provides treatment and care on exactly the same basis as is currently available in publicly run hospitals. In partnership with Monash University, the operator of the new hospital is also expected to make a significant contribution to the education and training of health care professionals, with a unique emphasis on education and training for rural practice.

### *By way of background*

In July 1991, the Central Gippsland Hospital located in Traralgon, the Latrobe Valley Hospital at Moe and the St Hilary's Nursing Home at Morwell were merged into a single management structure to form the Latrobe Regional Hospital which operated through the 3 pre-existing campuses. Subsequently, in July 1995, the Latrobe Regional Hospital also assumed responsibility for the provision of psychiatric services in the region from the Hobson Park Hospital, located at Traralgon. The objective of these amalgamations was to improve the effectiveness and efficiency of health service provision within the Latrobe Valley and the greater Gippsland region.

Both the Traralgon and Moe hospital campuses had been in operation for many years and were considered to be in need of significant upgrade to meet the current health care requirements and future demands of the region.



### *Proposals to consolidate and upgrade health services in the region*

In 1992, the former Department of Health and Community Services identified that, with the impending introduction of casemix funding by the State Government in July 1993, the viability of the Hospital in its present configuration was questionable.

Consequently, in early 1993 the then Minister for Health commissioned a review of acute health services within the region to provide a recommendation as to the suitability of the current provision of core services at the Moe and Traralgon campuses and to identify the preferred and most desirable arrangements for the adequate provision of the Hospital's non-core services. This review, undertaken by a consultant affiliated with a firm of chartered accountants, concluded that the provision of specialist services from ageing facilities across several locations was unsatisfactory and that it would be preferable for the Hospital to operate from a single campus. The consultant envisaged a new "greenfields" site as the preferred option as the existing sites of Moe and Traralgon were not considered adequate for expansion.

The former Department commissioned a further consultant in November 1993 to examine and report on all matters relating to the facilities required to optimise acute health care services in the Latrobe region, and the actions necessary to ensure the ongoing viability of the Latrobe Regional Hospital under casemix funding. This review culminated in the release of the "MasterPlan Study" in March 1994 which also recommended the consolidation of the individual hospital campuses and, in particular, the redevelopment of the existing Traralgon site into a single campus. Subsequently, the Board of the Latrobe Regional Hospital commissioned an independent review of the "MasterPlan Study" in May 1994 which resulted in the release of a report in that year that confirmed the recommendation for the consolidation of the hospital at the existing Traralgon site.

### ***Consideration of private sector involvement in the provision of hospital services***

In November 1994, the then Minister for Health approved the development of a tendering process for the establishment of a new Latrobe Regional Hospital which would include co-located private health care and teaching facilities. The Minister indicated that the tenders should allow for any site to be considered and should be assessed against the option of a redevelopment by the Government at an alternative site at Traralgon.

Subsequently, in June 1995, consistent with the framework developed under the Government's Infrastructure Investment Policy, the Latrobe Regional Hospital Project Steering Committee was established to recommend to the then Minister for Health and the Treasurer, the most appropriate form of private sector involvement in the redevelopment of the Hospital and to oversee the evaluation of submissions and negotiations with the private sector proponents. The Steering Committee was comprised of representatives from the former Department of Health and Community Services, the Department of Treasury and Finance and representatives from the private sector. The Committee was supported by a Project Team which had been previously established in March 1995, comprising a Project Director, Project Manager and consultants from a variety of disciplines.

During May and June 1995, the financial adviser to the Project Team prepared a series of discussion papers which were considered by the Committee in forming its recommendation that the project should be progressed under a build, own and operate (BOO) model of private sector participation. The first of these discussion papers identified the precedents for private sector participation in health projects within Australia, with emphasis on the differing forms of participation and the perceived advantages and disadvantages flowing to the public sector from such involvement. A further discussion paper assessed the various models for private sector involvement in the provision of hospital services, ranging from full privatisation to joint venture arrangements. However, no single preferred model emerged from this discussion.

In July 1995, a benchmarking methodology was developed by the financial adviser to the project team to determine a financial benchmark as one component against which the private sector submissions would be assessed to determine whether it would be feasible to allow private sector participation in the project on the basis of a BOO arrangement. It was considered that the project would only proceed if submissions were at or below the desired benchmark level. The benchmark represented the net present value of the cost to the Government, after allowing for Commonwealth grants, to operate and maintain over the term of the proposed arrangements, an equivalent public hospital in an equivalent rural setting with the same service profile. (see Evaluation Summary).

A probity auditor was appointed by the Steering Committee in August 1995 to ensure that fairness and impartiality were observed throughout the Project until contract execution and that the assessment of evaluation criteria stated in the Project Brief was consistently applied to Submissions.

Subsequently, in September 1995 the Steering Committee recommended to the Minister and the Treasurer that a Registration of Capability should be sought from the private sector on the basis of a BOO model for the delivery of health services to public patients in the Latrobe Valley and the broader Gippsland area. The Committee concluded that the option to build, own, operate and transfer (BOOT) the facility would be inappropriate due to potential adverse taxation implications and the desire of the Government to transfer the risks associated with the ownership of the facility to the private sector.

### ***Registrations of Capability and shortlisting of private sector providers***

In October 1995, the then Minister for Health announced the Government's commitment to the development of the Latrobe Regional Hospital by seeking registrations of capability from interested parties in the private sector for the provision of improved public patient health services to the communities of the Latrobe Valley and the broader Gippsland region, with a closing date for submissions in November 1995.

The proposed basis for delivery of health services was a BOO model, with the successful consortia required to deliver a comprehensive range of health services to public patients, while not precluding private patient activity. The development was required to provide at least the same range and scope of services as the existing Latrobe Regional Hospital, with certain specified additional services also to be provided. Under the proposed arrangements, the existing hospital services provided at Moe and Traralgon and inpatient health services at Hobson Park would be consolidated into a single campus.

Following consultation and agreement with the probity auditor, 2 parties were granted a time extension to lodge their submissions, culminating in the receipt of 7 expressions of interest.

An evaluation panel comprising representatives from the former Department of Health and Community Services and the Department of Treasury and Finance, with assistance from external consultants, was established to assess the registrations of capability in accordance with the relevant evaluation criteria, as approved by the probity auditor and endorsed by the Steering Committee. The panel concluded that 4 consortia possessed the capacity to respond to the requirements of the project brief, which did not include the 2 parties previously granted a time extension to lodge their submissions. The panel's conclusion was subsequently endorsed by the Steering Committee in December 1995.

In December 1995, the then Minister for Health announced that the existing Latrobe Regional Hospital would be de-commissioned in 1998 and that hospital services in the region would be delivered by a private sector provider. Subsequently, in February 1996, the responsible Minister and the Treasurer indicated to the Project Team that the development of the hospital would be on a "greenfields" site in order to ensure that there was no disruption to existing service delivery.

### ***Issue of Project Brief and announcement of preferred private sector provider***

In March 1996, the Government approved the issue of a Project Brief to the shortlisted consortia. In accordance with this Brief, the key objective of the Project was to ensure the delivery of a cost-efficient and improved health service to public patients in the Latrobe Valley and the Gippsland region from a new "greenfields" facility located on one site, utilising the BOO model of private sector involvement. The Moe and St Hilary's Nursing Homes managed by the existing hospital were not to form part of the new development. The Department of Human Services established a separate Steering Committee to determine the future of these nursing homes prior to the commissioning of the new hospital.

In July 1996, submissions were received from the remaining 3 shortlisted consortia, with 2 of these submissions conditional upon their assumption of the management of the existing Latrobe Regional Hospital in the "transitional period", i.e. the period between the

execution of the build, own and operate contracts and commissioning of the new hospital. The third shortlisted consortium had verbally indicated its preference to also assume the management of the Hospital during the transitional period but had not included a management proposal within its bid as it was assumed that management rights were outside the scope of the project brief.

In September 1996, after detailed consideration of the submissions by the assessment panels, the Steering Committee recommended to the Minister for Health and the Treasurer that Australian Hospital Care Ltd (AHCL) be selected as the preferred consortium to enter into contractual negotiations to build, own and operate the new Latrobe Regional Hospital.

A firm of chartered accountants was appointed by the Project Team in September 1996 to undertake a due diligence review and determine the funding requirements to ensure the continued provision of quality service delivery from the hospital during the transitional period. The review was finalised in November 1996, resulting in the formulation of a business plan which was incorporated into the Transitional Management Agreement subsequently established between the parties under the development arrangements.

In October 1996, the Minister announced the selection of Australian Hospital Care Limited (AHCL) as the selected private sector provider to build, own and operate the new hospital, with a construction cost of \$56 million and to be completed by August 1998.. The company was one of the largest private hospital operators in Australia and the largest in Victoria, having experience in the development and management of a full range of health facilities, including psychiatric, rehabilitation and major acute facilities.

The probity auditor subsequently concluded that the processes followed in assessing the bids were fair and equitable and that there were no adverse findings arising from the probity investigation with respect to the preferred consortium.

In order to provide the legislative framework for the Latrobe Regional Hospital to proceed under a BOO model of service delivery, amendments were made to the *Health Services Act* 1988, effective from December 1996, including:

- clarification of the power of the Minister for Health to enter into contracts for and on behalf of the Crown for the supply of services to public hospital patients by private health providers, including provisions dealing with ownership, design, construction and operation of such hospitals;
- outlining the reporting obligations to the State of such hospitals;
- establishing the application of the *Freedom of Information Act* 1982 and the *Ombudsman Act* 1973 to the operations of such hospitals; and
- identification of circumstances in which the Minister may intervene in the management of such hospitals.

### ***Appointment of an administrator and the transitional management arrangements***

Pursuant to the *Health Services Act* 1988, an administrator was appointed in January 1997 to replace the existing Board of Management of the Latrobe Regional Hospital. Under the terms of an agreement between the administrator and the Minister for Health, the administrator was provided the power to enter into a transitional management agreement for and on behalf of the Latrobe Regional Hospital.

Under the transitional management agreement, the role of the administrator encompassed the following:

- the collection of debts owing to the Hospital prior to AHC assuming management of the hospital;
- facilitating the payment of creditors for goods or services supplied prior to AHC assuming management of the Hospital;
- safeguarding the Hospital's assets and facilitating the disposal and acquisition of assets during the term of the transitional management agreement; and
- assisting in the handover of the Hospital's management obligations under the transitional management agreement.

The administrator's appointment under the Act ceased on the commissioning of the new Latrobe Regional Hospital.

### ***Transitional management agreement***

The transitional management agreement which was entered into in January 1997 principally between the Minister for Health, the Administrator on behalf of the Latrobe Regional Hospital, and Australian Hospital Care (Latrobe) Pty Ltd required the company to manage the Hospital for the period February 1997 to the commissioning of the new Hospital which occurred in August 1998, and to provide health services to certain quality standards to public hospital patients during this period.

Under the transitional management agreement, in return for the receipt of casemix and other health care funding, and the right to use the assets of the Hospital, the company accepted an obligation to provide specified public health care services to defined standards during the period leading to the commissioning of the new Hospital and accepted any risks associated with the reduction in patient throughput. Other key obligations of the company under the agreement included:

- Responsibility for general repairs, and cleaning, maintenance and repair of plant, equipment and motor vehicles to ensure appropriate service standards are

- maintained. Furthermore, the company cannot replace any Hospital assets, unless otherwise agreed to by the State or included in the Hospital's business plan;
- Provision of an indemnity to the State against any additional costs arising from a loss of the State's tax-exempt status, resulting from the performance of any obligations under the agreement;
  - Arranging and implementing the smooth transfer of operations from the existing Hospital to the new Latrobe Regional Hospital upon its commissioning;
  - Provision of an indemnity to the State against all claims for loss, damage, injury or death arising from the management of the Hospital from the date of handover;
  - Meeting the Hospital's reporting requirements, including reporting to the Health Services Commissioner and preparing annual reports on behalf of the Hospital, in accordance with the *Financial Management Act 1994*; and
  - Provision of an undertaking not to outsource or sub-contract the performance of any of its obligations under this agreement, unless agreed otherwise by the State.

Under the agreement, the State was required to meet certain obligations, including:

- Payment of service charges to the company for the provision of public hospital services to a required volume and quality standard, and a payment for capital expenditure items up to the maximum amount allowed for under the business plan. However, the State is not obligated to make any payments to the company if services are not provided or to make payments in excess of the amounts specified in the Hospital's business plan, which have been determined in accordance with the Health Services Agreement. Nevertheless, if the State requires that additional services be provided or increased service levels be met, the service charge paid to the company will increase accordingly;
- In the event of a force majeure event involving industrial action against the project or policies of the State which has not been caused by the company, and which has a material adverse effect on the ability of the company to meet the operating costs of the Hospital, the State will be required to pay the costs associated with the industrial action, with the company responsible for mitigating these costs. However, the State's obligation to make payments for the provision of services ceases for the period that the Hospital is not providing those services;
- An obligation to fund any shortfall between the revenue earned directly by the Hospital from the provision of private inpatient services and the projected private inpatient revenue budget agreed annually by the Department;
- Meeting the costs associated with the redundancy of staff, incurred in the period up to the transfer to the new Hospital, including all salaries, wages and leave entitlements for terminated employees accrued to the date of handover;
- An undertaking not to dispose of any plant and equipment which would affect the ability of the company to provide the required level of service;

- Provision of an indemnity to the company against all claims for loss or damage arising out of the ownership, management and operation of the Hospital up to the date of handover in February 1997;
- Provision to the company of the benefit of a number of insurance policies held by the State. However, no guarantee is provided by the State that these insurances are sufficient to cover the company's liability, with the company required to establish any additional cover at its own cost;
- Responsibility for the impact of any industrial relations issues arising as a result of the decommissioning of the existing Hospital and any changes in government policy which discriminate against the company.

In the event that specified operating defaults occur and such defaults are not cured to the satisfaction of the State, or the defaults cannot be remedied, the State may demand payment from the company as compensation for any damages suffered. The State also has the right to terminate the agreement where certain specified defaults are not remedied within the prescribed cure period and a replacement operator cannot be found under the provisions of the New Latrobe Regional Hospital Agreement. Furthermore, in the event that such a default endangers the health or safety of patients, the State is able to exercise "step-in" rights by temporarily assuming total or partial operation of the Hospital. In this case, the company is required to indemnify the State for all costs incurred while exercising these rights.

### *New Hospital arrangements*

In January 1997, the New Latrobe Regional Hospital Agreement was executed between Latrobe Regional Hospital Pty Ltd (a special purpose company established by the AHCL consortium), Australian Hospital Care (Latrobe) Pty Ltd (the operator) and the Minister for Health on behalf of the State. Under the arrangements, the company will design, construct and commission the Latrobe Regional Hospital, at its own cost, and will subcontract to the operator its obligations to provide health services to public hospital patients upon commissioning of the new Hospital for a period of 20 years, with scope to extend this term for a further 5 years subject to mutual agreement between the parties. Other key obligations of the company under the arrangements included:

- The company was required to purchase the land on which the Hospital was to be constructed and to then transfer the ownership of that land to the State with a 99 year lease granted to the company. While the State has a commitment to obtain services from the Hospital for a maximum of 25 years, at the end of this term the Government does not have a commitment to purchase or continue utilisation of the facilities and the company may use the site for other purposes;
- In consideration for the receipt of service charges from the State, the company is required to operate and maintain the Hospital and provide quality services to public hospital patients for the term of the agreement, in line with prescribed performance standards. The service charges mainly comprise payments for

casemix activity and payments for specific health-related activities. These charges also include a capital component for the utilisation of the Hospital building, equipment and technology, payment of which is dependent upon service delivery in accordance with contractual obligations;

- The company was required to use its best endeavours to meet the annual hospital revenue budgets. However, if a revenue budget for acute inpatient services was not met or is exceeded, the State would provide funding for any revenue deficiency or, alternatively, the company would reimburse the State for any amount in excess of the budget, in the same manner as existing public hospitals;
- The company would be responsible for obtaining clinical licences and other authorisations and for ensuring the registration of the Hospital as a health service establishment;
- The company would ensure that it obtained and maintained accreditation under the regulations of the *Health Services Act* 1988 and by Monash University as a Teaching Hospital for medical under-graduates and other health professionals;
- The company and the operator would indemnify the State against any claims made in relation to the Hospital's ownership, operation or maintenance;
- The company would indemnify the State in respect of all costs incurred by the State as a result of construction defaults and the company and operator will indemnify the State in respect of operating defaults;
- In the event that there are changes in law or government policy which have a material adverse effect on the ability of the company or the operator to perform their obligations under this agreement, the parties agreed to consult with a view to resolving any hardships;
- The company and the operator would indemnify the State against all claims for loss or damage arising from the performance or non-performance of any obligations of the company or the operator under the terms of this agreement;
- In the event that the Hospital is damaged or destroyed as a result of a force majeure event and the relevant event was not insured against, the company will pay all costs associated with the repair or rebuilding of the Hospital. Furthermore, following such an event, where the event has caused a partial cessation of the Hospital's operations, the State's obligations to make service payments to the company cease with the exception of a component relating to ground lease rentals associated with the land owned by the State on which the facility is constructed. However, in the case of the complete cessation of the Hospital's operations, the payments from the State will cease for the length of time the specified services are not provided;
- The company would bear all the costs associated with the transfer of patients from the existing Hospital to the newly commissioned Hospital. If commissioning did not occur by the required time, the State could demand the company to pay liquidated damages at a rate of \$10 000 a day; and

- The company was required to submit to the State periodic reports in line with reporting requirements of public hospitals and an annual report on the Hospital's activities.

Under the terms of the agreement, the State had key obligations which included:

- At any time during the development period, the State may request a variation to the construction works, with any costs associated with such variations to be met by the State where such costs exceed \$50 000. However, these variation requests must not delay the Hospital's commissioning;
- The State may, at its option, either terminate the agreement, demand a compensation payment from the company or take over the Hospital where a construction default was not remedied to the satisfaction of the State;
- In the event that the Commonwealth Government withdrew from an in-principle agreement to provide funding for the provision of services for 20 nursing home beds within the Hospital, the State agreed that it would reimburse the company for the unrecovered capital cost of providing such facilities through the capital component of the services charge, or the provision of an up-front payment if after using all reasonable endeavours the company and operator had been unable to redeploy these facilities;
- The State agreed not to utilise the existing Hospital sites to provide health services to public hospital patients, on the proviso that there was no unremedied default by the company. In addition, the State agreed not to enter into any agreement to purchase services from any other health facility in the Latrobe Valley region or construct a new health facility in the region for the term of the agreement; and
- During the development period and the term of the agreement, the State agreed not to impose any laws or taxes which may discriminate between the company and the operator in relation to the Hospital and other health facilities within the State providing public patient services.

In the event of an operating default occurring, including any threat to public health and safety which has not been overcome by the company or operator to the satisfaction of the State, under the New Latrobe Regional Hospital Agreement the State at its option may exercise all or any of the following remedies:

- demand a compensation payment from the company and the operator;
- appoint a replacement operator;
- assume the management of the hospital; and
- terminate the agreement where a suitable replacement operator cannot be found at the same price.

That is, if at any time during the operating default, the company did not provide the required level of hospital services, and as a result, the State utilised other available resources to provide public patient care, the company must pay to the State a compensation amount equivalent to the cost to the State in providing these services from other hospitals. However, in the event that such a default endangers the health or safety of patients, the State is able to exercise its "step-in" rights, including the temporary assumption of total or partial operation of the Hospital. In exercising these rights, the State will be entitled to retain a sufficient amount of the service charge to meet the reasonable operating costs.

## **Overall Audit Assessment**

**(source - Victorian Government Auditor General's Report)**

“In summary, under the arrangements established by the Government for the development of the new Latrobe Regional Hospital, a private sector company will design, construct, own and operate the new Hospital. Upon the commissioning of the Hospital, the company through a sub-contracted operator will operate and maintain the new facility, and provide specified health services to public hospital patients in the Latrobe Valley over an initial period of 20 years. In return for the provision of these services, the company will be entitled to receive specified fees from the State, mainly based on casemix activity and the provision of other health-related services. These fees also include a capital component for the utilisation of the Hospital building, equipment and technology, which are designed to enable the company over the initial period to meet its debt servicing and certain other obligations.”

“An audit analysis of these complex arrangements indicated that key risks associated with the development of the new Hospital have been substantially transferred to the private sector company. These include the risks associated with the construction, commissioning, financing and operation of the Hospital. In addition, the company also bears the demand risk associated with the non-realisation of casemix activity projections over the 20 year service agreement period.”

“In default circumstances where the company does not provide the required level or specified standard of health services and the State utilises other resources to provide public patient care, the company must pay to the State compensation equivalent to the cost incurred by the State in providing such services through other facilities. In addition, if the State exercises its "step-in" rights in the case of default by the company or the operator, which may include the temporary assumption of total or partial operation of the Hospital while alternative public hospital facilities are obtained, the State will be entitled to retain a sufficient amount of the service charge to meet the reasonable operating costs. However, in the event that the State elects to become the permanent replacement operator of the Hospital, the State must assume the financing obligations of the company under the terms of the financing arrangements.”

“Under the arrangements, the State has retained certain financial obligations and risks in relation to this development, including responsibility for the impact of any industrial relations issues arising as a result of the decommissioning of the existing hospital and any changes in government policy which discriminate against the company, and a requirement to execute any documents reasonably required to enable the company to obtain sales tax exemptions for goods or services which comprise any part of the works. However, in my opinion, despite the retention of these obligations by the State and the other mitigating factors previously discussed, the company bears substantial risks associated with the construction, operation and financing of the new Latrobe Regional Hospital. “

During the Latrobe Regional Hospital construction period, the State was also constructing another hospital using traditional Government procurement methods. A comparison of the two hospital projects is as follows.

	<b>Northern Hospital</b>	<b>Latrobe Regional Hospital</b>
<b>Architect</b>	Silver Thomas Handley	Silver Thomas Handley
<b>Builder</b>	Multiplex	Multiplex
<b>Bed Number</b>	227	257
<b>Construction Time</b>	2.5 years	1.5 years
<b>Cost</b>	\$72 million	\$56 million

New Latrobe Regional Hospital commenced operations on 1 September 1998 as scheduled and on budget. After 6 months of operation, the operator, Australian Hospital Care, approached the then current Liberal Government of Victoria and asked for more recurrent funding to ease an apparent operating loss at Latrobe Regional Hospital. The Government declined to assist for the operator was not able to demonstrate satisfactorily that operating losses were occurring and Government did not want to create a precedent for other privatisation contracts. In September 1999, the State of Victoria underwent an election and a Labour Government was installed for a period of 4 years. Privatisation or public-private partnerships involving the outsourcing of core social services was against

the new Government's ideology. The operator approached the new Government for financial assistance and again was refused. The operator instituted legal action against the Government on the grounds that Latrobe Regional Hospital was being discriminated against when compared to Victorian public hospitals.

The Government and the operator agreed that the Government should step-in and manage the hospital pending resolution of the dispute. **No operator default had occurred** which was a precursor under the contract for Government to step-in. A similar situation was also occurring at the privatised Women's Prison.

In November 2001, the staff of Latrobe regional Hospital transferred back to State employment and in 2002, the financing structure was unwound and ownership of the building reverted to the State. Why did this happen? Politics played a very big part. It is interesting to note that the new Victorian Government returned one privatised hospital and one privatised prison to Government ownership and operation. The other privatised hospital (Mildura) and the other two privatised prisons remain in private ownership and operation.

### **Why did the operator lose money at Latrobe Regional Hospital?**

There were several reasons, namely;

- The operator bid to run the hospital with a staffing level of 601 equivalent fulltime staff. In practice however, it employed 660 from day one at an average salary cost of approximately AUD 45,000 per person.
- The operator assumed the hospital would be treated as a public hospital and therefore exempt from Sales Tax, a Federal Government tax and beyond the control of the State Government. The hospital was licensed as a private hospital providing public patient outcomes. These licensing conditions were enunciated in the original Project Brief. The Federal Government therefore applied Sales Tax to those equipment items which were not exempt items; in particular the car fleet of 123 vehicles which had an annual turnover rate of 150%. The average level of Sales Tax per vehicle was approximately AUD5000.
- The operator assumed that it would be able to employ its workforce under private sector awards which were marginally lower than those prevailing in the public sector. This was not achieved and the operator entered into 3 year enterprise agreements with affected unions at public sector rates.
- The operator undervalued the cost of employee Payroll Tax..

- The operator had failed to understand the way in which Victorian public hospitals were funded for acute health services despite being given every assistance during the bid stage. Funding for Victorian public hospitals' acute health services is by way of casemix. Casemix is adjusted each year and is based on diagnostic groups and the average daily inpatient cost of all Victorian public hospitals for the preceding year. It rewards efficient hospitals and encourages non-performing hospitals to improve. In addition, each Victorian public hospital was expected to make a 1.5% productivity improvement each year.

The operator bid for the project using 30 June 1996, dollars of the day. In June 1996, the average daily inpatient cost was approximately AUD 2600. By the commissioning date of Latrobe Regional Hospital, this cost had fallen to approximately AUD 2100. The operator had also bid a discount to the normal public hospital acute health service payment mechanism commencing at 95.5% in year 1 and reverting to 100% in year 10. That is to say, it rightly or wrongly believed that operating efficiencies could be more likely achieved in the early years of operation of a custom built hospital than in later years.

Unfortunately, Victorian public hospitals had become more efficient – as expected and encouraged – but the operator was committed to the discount and acceptance of the universal payment mechanism.

- The operator may have assumed that Government would be willing to revise the contract after execution if justifiable reasons existed. The 5 prior reasons were however incorrect assumptions on the operator's behalf; the operator had a healthy profit and loss statement from its private hospital operations and was able to cope with any losses from Latrobe Regional Hospital but choose not to.

Approaching a Government just prior to an election seeking financial support, particularly when the opposition was known to be firmly against privatisation, was perhaps not well planned or thought out. The Government may well have had a different attitude if re-elected for another 4 year term.

- And finally, the operator expected the contract to be administered on a non-discriminatory basis vis a vis Victorian public hospitals as required under the contract. Strong anecdotal evidence suggests that this may not have been the case and that the operator did not receive the same levels of financial grants as its peer hospitals.

It is interesting to note the financial performance of Latrobe Regional Hospital prior to privatisation ie up to 1997/98 and the financial performance of the new Hospital in its first full year of operation under State management – 2001/02.

Figures for the intervening period are not available due to private operation.

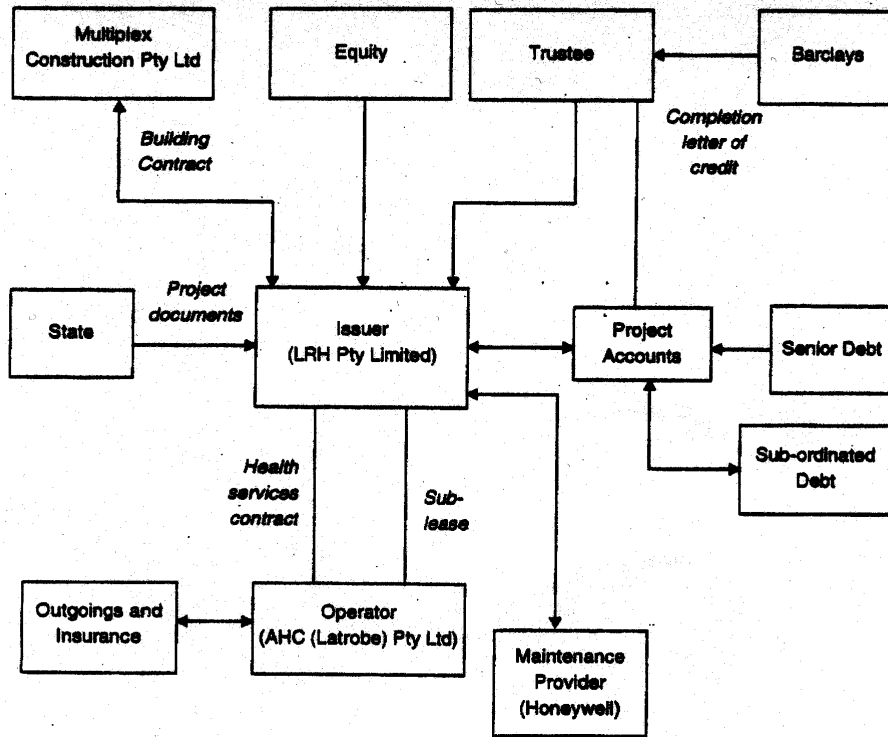
**Surplus/(Deficit)**

<b>1996/97</b>	<b>(3.432m)</b>
<b>1997/98</b>	<b>(17.553m)</b>
<b>2001/02</b>	<b>10.176m</b>

**Latrobe Regional Hospital  
Evaluation Summary**

Net Present Values at 8% discount rate	Benchmark	Bids			NPV Savings		
		AHC	HCoA	SoC	AHC	HCoA	SoC
<b>Base Service Charge costs</b>							
Acute	320,333	313,115	305,926	306,717	7,218	14,407	13,616
Aged / Rehabilitation	37,774	37,013	39,001	47,801	762	(1,227)	(10,027)
Mental Health	99,850	97,364	100,755	99,857	2,487	(904)	(7)
Public Health	464	464	464	464	-	-	-
Revenue Budget	(20,397)	(20,397)	(20,397)	(20,397)	-	-	-
C'wealth Rev & Reimb.	(8,763)	(8,763)	(8,763)	(8,763)	-	-	-
<b>Net Service Costs</b>	<b>429,261</b>	<b>418,795</b>	<b>416,985</b>	<b>425,679</b>	<b>10,466</b>	<b>12,276</b>	<b>3,582</b>
Payroll Tax	-	(15,188)	(17,736)	-	15,188	17,736	-
<b>Total BSC Costs</b>	<b>429,261</b>	<b>403,606</b>	<b>399,249</b>	<b>425,679</b>	<b>25,655</b>	<b>30,012</b>	<b>3,582</b>
<b>Allocated Facilities Charge Costs</b>							
Capital Cost	53,282	34,376	47,532	56,864	18,906	5,750	(3,582)
Payroll Tax							
<b>Total AFC Costs</b>	<b>53,282</b>	<b>34,376</b>	<b>47,532</b>	<b>56,864</b>	<b>18,906</b>	<b>5,750</b>	<b>(3,582)</b>
<b>Total Costs</b>	<b>482,543</b>	<b>437,982</b>	<b>446,781</b>	<b>482,543</b>	<b>44,561</b>	<b>35,762</b>	<b>1</b>

Chart 1 Structure Diagram



## Funding

LRH Pty. Limited issued \$40 million bonds.

Australian Hospital Care Limited contributed \$10 million by way of sub-ordinated debt.

Equity of \$2.5 million was contributed by a private investor, and Monash University contributed \$3.5m by way of pre-paid rental for 20 years.

## **So what have we learnt?**

1. You can never do too much talking to stakeholders. Messages should be simple and repeated frequently. Staff must kept informed of the project's progress through regular newsletters and open forums.
2. Agreement should be reached at an early stage with affected trade unions and therefore staff. This can be achieved through the development of a Memorandum of Understanding which details the State's obligations up to the time of decommissioning of the old facility but does not bind the State to any obligation at the new privatised facility.
3. Transitional management arrangements need to be well thought out as problems arise. Services must continue to be delivered while staff recruitment takes place. Conflicts of interest or loyalty arise as decommissioning approaches. It is probable that providing access to staff for recruitment purposes is preferable to full transitional management arrangements.
4. The Project Team must be adequately resourced both with fulltime employees and appropriate external consultants. Good consultants are hard to find. The State should appoint consultants prior to release of the Registration of Capability to ensure we secure the best advisers. Consultant costs need to be closely monitored.
5. Despite outsourcing occurring, the public still believes that the Government is responsible for service provision. The private sector always has its hand out.. Contracts need to be firm but not adversarial.
6. Freedom of Information requests are a frequent occurrence. Filing systems need to be well designed to cope with requests.
7. Experienced contract management staff are required to meet demands created by these complex contracts. Staff involved in the outsourcing should be groomed to take over contract management
8. A Project Manager, appointed by the winning consortium, is essential to ensuring that the owner and the operator under build, own and operate projects are not at loggerheads during the construction period. This is because the builder is generally contracted to the financier (the owner) rather than the operator of the new facility.
9. Make sure that a competent Probity Auditor is appointed to the Project. Develop and publicise the probity plan. The probity plan should not be overly restrictive; common sense principles should apply.

10. Contracts must be sustainable. Accepting the lowest price is not always the best decision. When privatisations first commenced, the private sector did not fully understand public hospital funding and tendered to quote low service delivery prices which were not sustainable over the contract term.
11. Proper benchmarks (Public Sector Comparators) need to be developed prior to receipt of bids as does the identification and allocation of risks to those parties best able to manage them.
12. **Beware of the political pendulum and bureaucratic bias against public private partnerships.**