The looming spectres of public–private partnerships for hospitals and the resulting decline of government responsibility for comprehensive secondary healthcare in Aotearoa New Zealand

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Governments are often short of capital for the provision of costly infrastructure projects. Such infrastructure aims to provide a long-term benefit to society; however, the cost is upfront, so methods of funding that spread the cost over a longer period are attractive to governments. Public–private partnerships (PPPs) are one way of achieving this and may extend beyond the costs of construction and maintenance to the delivery of services as well. PPPs, in general, are best described as structured cooperations between public and private partners in the planning, construction or operation of infrastructure, in which they share or redistribute risks, costs, benefits, resources and responsibilities.[1] The potential for PPPs to be used increasingly in Aotearoa New Zealand for the provision of hospital-level secondary healthcare has been recently raised in our news media. From that report, it was clear that knowledge of this type of development is not well understood by the public and our medical profession[2]—hence the need for this editorial.

In the provision of hospital-level secondary healthcare, PPPs can take different forms (Table 1).[3]

These range from franchising arrangements, where a public authority contracts with a private company to manage an existing hospital to the DBFO model, where a private consortium is responsible for the designing, building, financing and operating of a hospital, based on some public authority's requirements.[3] Another recent iteration is the Private Financial Initiative, in which private money is provided for projects at commercial rates of interest, which are higher than governments are usually required to pay.[4,5] The benefit to the government is that this loan does not sit on its balance sheet, as it is allocated to the private provider.

As in many other countries, Aotearoa New Zealand uses multiple public–private service arrangements in healthcare.[2] These include: 1) private support services, such as hospital food supplies, cleaners, pathology services and pharmaceutical supplies, 2) temporary or permanent specific elective clinical procedures, such as outsourced hernia or hip surgery, contracted to private hospitals to address growing public hospital waiting lists, 3) outsourcing complete clinical services such as all midwifery in some regions, and 4) healthcare research done by large accounting firms,[6] which nonetheless also work profitably against the health of the population.[7]

Pros and cons of extending PPP models into secondary healthcare

Are PPPs part of an overall plan to stealthily reduce government responsibilities for healthcare? In Aotearoa New Zealand, GP practices are being increasingly taken over by private companies.[8,9] Is our government looking to turn its attention to PPPs to reduce its responsibilities for secondary healthcare?

The academic literature is divided over the ways to evaluate the performances of PPPs and whether they are effective in the long term.[3,10] Others have shown that empirical evidence around risk management and appropriateness in "sensitive service delivery such as medical services" is lacking.[11] Many advantages have been claimed for PPPs, including financial ones already mentioned, which spread the risk of large,

Table 1: Models of public–private partnership in hospital provision.

Model	Description
Franchising	Public authority contracts a private company to manage existing hospital
DBFO (design, build, finance, operate)	Private consortium designs facilities based on public authority's specified requirements, builds the facility, finances the capital cost and operates their facilities
BOO (build, own, operate)	Public authority purchases services for fixed period (say 30 years) after which ownership remains with private provider
BOOT (build, own, operate, transfer)	Public authority purchases services for fixed period after which ownership reverts to public authority
BOLB (buy, own, lease back)	Private contractor builds hospital; facility is leased back and managed by public authority
Alzira model	Private contractor builds and operates hospital, with contract to provide care for a defined population

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complex projects such as building and maintaining hospitals. The injection of capital from the private sector reduces government debt in the short term and claims are made that the private sector is more efficient. Private hospitals are said to provide faster throughput, greater choice of clinician and reductions in waiting times, leading to higher patient satisfaction.

Conversely, governments can always borrow money at cheaper rates. Private companies may inject capital but that usually comes with high interest rates, which taxpayers have to cover.[4] Efficiency of the private sector provision is hard to evaluate because relevant data are often shrouded under claims of commercial sensitivity. Claims are also made that the private sector provides greater efficiency in healthcare delivery but, for surgical services, for instance, the private sector rarely offers to undertake the more costly delivery of acute care or the care of more complicated cases. In addition, if clinical complications occur, private patients are regularly transferred to the public system to address problems and carry the additional cost. There are numerous examples of failed PPP projects that then must be bailed out by governments.[4,12]

To manage the maintenance of infrastructural quality and standards of clinical care that are needed for sustainable healthcare delivery, PPPs require complex and protracted contractual agreements. These reduce the ability to keep pace with the frequently changing secondary healthcare environment and decrease the ability to respond flexibly. Furthermore, PPP contracts become saleable on the open market, with potential private profit at every transfer and zero benefit to the taxpayer or patient.[13] Both real increasing costs and cutting corners to keep within budget reduce quality of healthcare delivery, impairing care and causing suffering.[14] Finally, the cost of training staff is rarely undertaken by private providers, which undermines the long term general sustainability of healthcare provision.

Health-outcome measures are crucial to deciding whether changes in the funding of healthcare are appropriate. A systematic review concluded

that there was no improvement in the quality of healthcare following privatisation and that most financial system-level changes resulted in either inconclusive or deleterious outcomes.[15] A study in Italy concluded that there was no benefit from higher private spending and that a greater proportion of spending on private services resulted in increased avoidable mortality; in contrast, each additional €100 per capita of public spending was associated with a 1.5% reduction in avoidable mortality.[16]

Private and public systems differ markedly in their purposes and functions. The goal for business is profit and dividends to shareholders. The government's goal is to provide necessary care for its citizens. Many countries, including Aotearoa New Zealand since 1939, believe that one of the responsibilities of a civilised, democratic polity is to provide free, accessible, sustainable and equitable healthcare to all its citizens,[17] although we still continue to fall well short on equity for Māori, Pasifika and those living in poverty. One key challenge lies in who is responsible for meeting the cost. Governments are charged with the responsibility of raising funds through taxes. Business raises funds by passing costs to individuals. Problems arise when individuals cannot afford the care. Insurance schemes mitigate this: the healthy pay in advance for medical care. Problems arise when individuals cannot afford the insurance.

What to learn from past experience?

In the UK, governments have been steadily reducing their responsibility for providing free, fair access to secondary healthcare.[13,18] In a long series of legislative changes, the NHS has been progressively dismantled until it is increasingly exhibiting similarities to the healthcare system in the US.[19] Closer to home, we must never forget that the draconian attempt at introducing a business model into hospital-level healthcare in Aotearoa New Zealand in the 1990s was a spectacular failure, for which the perpetrators have not been held to account.[20] Any stealthy introduction of PPPs in the funding and provision of hospital-level care into Aotearoa New Zealand would repeat, in slow motion, this failed experiment, with most of the consequences of the serious damage suffered by future generations.

Conclusions

The provision of secondary elective healthcare in a democratic country like ours can exist happily and productively with a comprehensive free and fair public hospital system working alongside a separate, user-pays private hospital system. The clear margins between the two systems get blurred when private companies try to capture trade from the public system or when governments decide to abrogate their responsibilities to provide free, fair comprehensive secondary elective services by sharing the costs, risks and benefits with the private sector. Experiences in the UK, Europe, Australia and elsewhere around the world have shown that these two developments have almost invariably led to short-term gain and long-term pain: a slow decline into a prohibitively expensive healthcare system and an unacceptable disparity of standards of care between the haves and the have-nots.

COMPETING INTERESTS
Nil.

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