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AMQ International

Strategic Asset Management

Risk:

Managing it Strategically, Part 2.

Strategic risk management, like strategic asset management of which it is a part, addresses those questions that determine the direction an agency takes. We looked at a number of these questions in SAM 91.

The Public Demise of a Private Hospital pp. 315-317

In this issue we look at the Latrobe Hospital contract. When it was devised, in 1999, it won plaudits around the world for its daring. No other contract before had attempted to shift so much risk onto the private sector. My concern, in a review of the contract approach at the time, was with whether the private sector could stand up under the strain. As it turned out, it could not.

Another View on Risk Transfer p. 318

As is to be expected, not everyone would agree with my assessment of the risk transfer issue, and so by way of fairness, I present an alternative view by PricewaterhouseCoopers and refer you on to their survey of the situation in the UK.

Sep 11 and the World Trade Centre p.320

The world press has focussed on those who died, but there is an equally incredible story to be told in the numbers who survived. More than 18,000 people evacuated safely from the World Trade Center complex in the one hour, 42 minutes, and five seconds between the first jet to hit the Towers and the last building collapse. In fact, while 99% of the people above the floors struck by the jets died; *99% of the people below (and sometimes on) those floors survived*. The evacuation was a success.

Professor Victoria Hardy held the audience spellbound with stories, pictures, descriptions and analysis of the design and management of the World Trade Centre that made this possible. Her presentation at the 13th FMA Conference in the Barossa Valley in June is likely to be published, at least in part, in a forthcoming issue of FM Magazine, so watch for it!. In the meantime, we include Professor Hardy's description of how the World Trade Centre managed risk – by design.

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Strategic Risk Management

The Strategic Management of Risk, the management of Strategic Risk, or both?

> "Not long ago a Melbourne hospital was rung up by the Health Department to say "You're not meeting your service targets. What are you going to do about it?
>
> This was a high-pressure burns area, so the hospital's answer was: "Well, should we employ another surgeon or an arsonist?"
>
> Dr David Campbell. Healthcover. April-May 1998, p.60

This illustrates two points:

- First, and most obviously, the problems caused by setting input rather than outcome targets!
- Secondly, and maybe not so obviously, the problem of trying to identify the problem to be addressed when there is no clear direction from the goals, objectives and values of the Asset Management Strategy.

Strategic risk

This occurs when, in pursuit of a small goal or objective, larger goals, objectives and values are put at risk. Knee jerk reactions will do this all the time and examples abound.

The opportunities for strategic risk increase as the agency increases in size. In order to manage large organisations, the tendency of such organisations is to set up separate business units. Each of these business units, by their very nature, pursue small individual goals at the expense of larger, corporate, ones. Value management teaches that the optimisation of the parts of a whole, will inevitably de-stabilise the whole. It follows that business units will add to strategic risk *unless they are pursuing a common set of goals.*

The pursuit of competition for its own sake is an example of such a de-stabilising small goal,

Managing risk strategically

This requires all risks to be viewed from the perspective of achieving the agency's goals, objectives and values. The reference to values is very important. It constrains the options that are available. For example, if one of your values is environmental sustainability, then in the disposal of waste the question is not simply one of minimum cost. If one of your values is to improve the quality of life of your community, you may choose not to contract services outside your area even if that would result in reduced costs and the opportunity to provide more services.

Message:

The Asset Management Strategy is the key to strategic risk management

Risk Transfer Case Study

Latrobe Hospital—the demise

From “FIXING HEALTH CARE - Hard lessons Down Under; A very public failure of a private hospital” by Thomas Walkom, Toronto Star National Affairs Writer, Mar 25 2000

TRARALGON, Australia - There is a buzz in the auditorium of Latrobe Regional Hospital as the doctors gather. Stuart Rowley, executive director of the privately owned institution, has grave news.

The hospital, he tells the doctors grimly, is losing money, $2 million in the past six months alone. As a result, it has decided to launch a $10 million lawsuit against the state of Victoria - for whom Latrobe's owner, Australian Hospital Care, operates the institution.

The state government simply has not been giving as much money as Australian Hospital Care thinks it is owed.

One doctor, thoughtfully munching a sandwich, interrupts to ask the central question: If you don't win the lawsuit, will the company walk away from the privatization contract?

``We can't," answers Rowley grimly.

Latrobe, completed in 1998, is the first of three [private contracts] to become operational. It is a spanking-new, state-of-the art institution which, even critics of privatization agree, does a fine job treating patients.

But it was the economics that made Latrobe attractive to government. Its owner, Hospital Care of Australia, agreed to provide services at 96 per cent of what it would cost the state for an equivalent publicly-owned institution.

Latrobe head Stuart Rowley says the health care firm was sure it could trim sufficient waste to meet this target. As it turned out, privatization was not that easy. First, the privatized hospital had to deal with the opposition of local residents. The La Trobe Valley, southeast of Melbourne, is a region in flux. Hundreds of workers had already been laid off by the state's decision to privatise the valley's main industry, electrical power generation.

When Victoria's conservative Liberal-National government announced it was going to follow this by privatizing the local hospital, residents were outraged. Officials of Latrobe Hospital (name is spelled differently from the valley) were booed when they held public meetings to explain the new system. ``There were tomatoes thrown at us," recalls Rowley.

``People received death threats. One doctor we had hired interstate (from another part of the country) was told what would happen to him if he came . . . He didn't come." ``I had my power cut off," adds nursing director Marilyn Sneddon.

While the new owners were able to eliminate 257 jobs by amalgamating three older hospitals into Latrobe, they were not able to force wage rates down.

Rowley and Sneddon say they were able to institute more flexible work practices to increase efficiency. But public hospitals were becoming more efficient, too.

The better public hospitals became, the more the government ratcheted down their grants. Every time public hospital grants went down, Latrobe - which had promised to do the same job for 4 per cent less – got squeezed even more.

Meanwhile, in Victoria's political arena, privatisation was not serving the governing Liberal-National coalition well. Victorians were becoming alarmed by the sell-off. The government's decision to privatize a major Melbourne teaching hospital was the last straw.

In a fall campaign dominated by the hospital privatisation issue, the opposition state Labour Party decisively defeated the coalition.

Then, last month, came Health Care of Australia's announcement. After enduring heavy losses at Latrobe, the company was suing the state

government for $10 million, arguing its contract was not being interpreted generously enough.

Both politically and financially, Victoria's privatisation attempt had been a stunning disaster.

The fundamental problem, says Monash University health economist Dick Scotton, is that privately-owned hospitals aren't really any better than their public counterparts.

``The efficiencies are always illusory," he says. ``Governments think they will save money. But the private operators always bid low - then they threaten to go into bankruptcy and the contracts have to be restructured."

His arguments are borne out by studies from both the United States and Britain. Even a review of the literature by Canada's right-wing Fraser Institute concludes that there is no discernable difference in efficiency between for-profit and not-for-profit hospitals.

The Facts

The Latrobe Regional Hospital contract is an excellent case study in the application of complex financial and legal contracts to support a major assignment of risk to the operator. (the actual contract ran for 316 pages- if you want the original, you can find it at http://www.vgpb.vic.gov.au/major/47/Latrobe.pdf)

" In 1996 a contract was signed between the Victorian state government and Australia Health Care Ltd (AHC) for the provision of a 257 bed public hospital. The hospital was to be owned and operated by the private company.

Separate company established
Latrobe Regional Hospital Pty Ltd was the special purpose vehicle established to build and own the hospital, provide the funding required, enter into project documents, and lease the project to the operator.

The contract In 1999, the Department of Human Services entered into a contract to purchase public health services from Latrobe Regional Hospital Pty Ltd under a 20 year "build,own and operate" contract.

Full range of services to be provided
The 256 bed hospital was designed to provide a comprehensive range of general and specialist medical services, including accident and emergency, ambulatory outpatients, aged care and rehabilitation, and psychiatric in- and out- patient services.

* In February 2000 AHC alleged that the State Government had breached the contract relating to the LaTrobe regional Hospitals and issued proceedings in the Supreme Court of Victoria seeking compensation.

* The AHC accused the State Government of refusing to honour its contractual obligation to pay appropriately for a range of services including mental health, child and adolescent community health, women's health and a suicide prevention programme.

* Whilst the AHC maintained that the court action was designed to maintain high quality health services standards it was also clear that the allegations were designed to protect the share holder interests. AHC, which operates 16 hospitals nationally, made a total loss in 2000 of $79 million. LaTrobe hospital was the single biggest contributor to this loss.

*On 31 October 2000 the LaTrobe Hospital was transferred back to the Victorian Government. AHC had reported a loss of $6.2m in 1999 for the hospital. The Victorian Minister for Health stated that the losses incurred by Australian Hospital Care meant it could no longer guarantee the hospital's standard of care'

(Comments marked with an asterisk were included In a response to the IPPR's (Institute for Public Policy Research) Commission on Public Private Partnerships June 2001 By Allyson Pollock, Jean Shaoul, David Rowland and Stewart Player, Health Policy and Health Services Research Unit at UCL)

Onerous Risk Transfer

How much did it contribute to the demise of the Latrobe contract?

We will probably never know for sure, but consider these risk transfers and their impact

Demand risk
It was able to draw on the La Trobe catchment area and it was paid a fee for services performed. However, to ensure that the hospital did not 'generate undue business for itself' – there was a maximum fee payout set (to be exceeded only in the case of localised emergencies eg fire, flood, etc.) As the hospital could not turn away customers under the contract arrangements, this presented an area of demand risk.

Crown risk.
AHCL bore crown risks! This transfer is rare—and one may suspect, unfair. If the Government changed its mind on how hospitals were reimbursed, Latrobe management had no recourse, unless they were discriminated against.

Risk of Default on Debt Servicing.
The 'strong structural protection of revenues for debt service' included a provision for no debt interest or repayment to be made to the $10m invested by AHCL for the first five years - from year 6 on repayment to AHCL is dependent on there being sufficient funds available. In essence the operator has to make savings in order to be paid a return on his capital.

Risk of Operator Failure
In the event that AHCL was replaced as operator of the hospital, under the replacement operator regime, AHCL would lose its entitlement to payments on its subordinated debt - and since no debt repayment was allowed within the first five years, this meant losing the lot for operator failure!

Risk of continued commitment by Government
No guarantee existed that the State would continue to buy services from this facility if the issuer could not find another operator at the bid price. If no conforming bids were received, after three months, the State could accept either a bid for services at a price higher than the price under the NLRHA (a non-conforming bid) or a greenfield bid for services to be delivered at a new site.

Risk of not achieving price reductions sought
Operators were required to bid a discount on the casemix unit prices. The winning tenderer bid a sliding scale discount, a greater discount in the early years tapering away to a lower discount later. This was in recognition of the fact that (a) it would have its greatest advantage when it new and (b) the casemix price was, itself, declining over time.

A key risk for the Government was that the AHCL may have agreed a pricing that is uneconomic,
therefore making it difficult for a replacement operator to be found at the bid price. This risk was mitigated somewhat, as the new operator would not be required to invest any subordinated debt, and therefore would not need to reflect a return on this debt in its pricing. While this did not guarantee that a replacement operator could be found at the bid price, it did provide a cushion within the pricing of the contract.

A Walk Away Contract
At the end of the 20 year contract, the Government could offer one five year extension or walk away and start over again on a new greenfield site with a new hospital.

I had the pleasure of having the details of this contract explained to me by its designer. At the end I asked him two questions:

(1) "How replicable is this contract? As we increase our demand on the private sector and need to seek investors from overseas, how likely is it that they will be prepared to agree to the same onerous conditions?" He agreed that it was most unlikely that we would find such investors.

(2) "Would you take on this contract?" "Not likely!" he replied with a grin. And therein lies the answer! Unless we set up 'win-win' contracts, unless we are prepared to pay for the risks transferred and worn by the contractor, the contracts will fall over. There is a lot of evidence to support this. The unrealistic hype that accompanies the contract launch could also be part of the problem.

Risk Transfer

An alternative view from PricewaterhouseCoopers

The views expressed about risk transfer in this issue of SAM and the previous one may be at odds with the general profession, particularly those elements of the profession who advise governments and agencies on privatisation. In the spirit of impartiality, I provide the following view with links to both the IPPR report (which, incidentally, argues that the private sector has accepted too much risk that it has been unable to handle) and the PwC survey.

PricewaterhouseCoopers writes “In June this year the Institute of Public Policy Research [in the UK] published 'Building Better Partnerships', the findings of their work into Public Private Partnerships (PPPs). The report highlighted the lack of hard evidence to support the pros and cons of PPPs, and the need for such data if PPPs are to make a sustainable contribution to the improvement of public services.

“Well over a hundred PPPs are now helping to deliver public services in diverse areas such as transport, defence, water, education and health. Over the summer PricewaterhouseCoopers has undertaken a survey of 27 schemes covering these areas of application, the findings of which are to be published in a report entitled ' Public Private Partnerships: A Clearer View'.

- Risk transfer to the private sector is real and can result in substantial losses to the private sector, effected through robust contracts and payment mechanisms. Both the public and the private sector by and large believe that the balance of risk transfer is fair.
- There have been some additional benefits to the public sector, including improving procurement disciplines, acquiring commercial skills and, in some cases, sharing in the benefits of re-financing.
- Virtually all of the public sector participants viewed the PPPs as a success.
- Some concerns have been raised about the inflexibility of PPP models. “

More?

You will find the “Building Better Partnerships” report as well as the “Public Private Partnership: A clearer View” Report through the **www.amqi.com** site. Go to the library where you will find them listed at the top of the page as a reference from this issue (SAM 92)

Risk and Insurance

Insurance is a means of evening out uneven cash flows.

Unlike the privatisation route discussed on page * (SAM 91) where even annual payments to the private sector take the place of lumpy, but reasonably predictable and measurable, cash flows to the public sector, insurance evens out *unpredictable* and *non-measurable* (at least in advance) cash flows.

Most people choose to insure those events that, were they to occur, could be life threatening. Thus more people are likely to take out medical health cover for themselves than for their pets (although the latter service does exist).

The richer you are, the more likely you are to be able to sustain occasional losses – and the need for insurance is correspondingly less. The same goes for agencies. Large agencies are more able to self-insure than smaller ones.

Insurance and Control over Costs

Agencies that self-insure have more control over their risk costs that those that do not.

Agencies that are part of a pooled risk scheme do not have to bear the full cost of any risk event related to them and so they may be less careful and take fewer steps to avoid risky incidents (see page *, SAM 91). However the same applies to other pool members. None have a strong incentive to manage their own risk. And thus risk costs can rise for all.

Insurance companies try to increase responsibility by rewarding risk management activities on the part of their insured – thus non-smokers may get lower rates on health insurance, pensioners lower rates on house insurance. Agencies in pool insurance schemes can do the same.

Message:

With commercial insurance becoming harder to get and more expensive, many agencies may be forced into pool schemes. If so, it will pay them to set minimum risk management practices for their members.

Risk Management

By Design

Risk, Design and the World Trade Centre

Victoria Hardy made the following points to the FMA Congress in the Barossa Valley in June this year. The World Trade Centre had learnt from the experience of the bombing of its parking garage in the North Tower in 1993 and a number of improvements were made to the exit routes to enhance the opportunity to get out of the building, if necessary.

- Reflective paint was added to all exit doors, stairs, railings, and bright arrows were painted along exit corridors to guide people in the event of poor visibility.

- A building wide-speaker system was installed to be able to talk to people in the exit locations.

- Every disabled person was given an evacuation chair to enable people to carry them down the stairs; one such chair was used to carry a man down from the 67th floor.

- In 1993, the explosion knocked out the main power source, its backup, and the firecontrol command post. The Port Authority (public owner of the complex) added a second source of power for safety equipment, such as the fire alarms, the emergency light, and intercoms. It built two duplicate fire-command posts, one in each tower.

- Emergency lighting in the stairwells and corridors was also set up on a back-up battery power source. The lights in the stairwells were also designed in modular sections; like Christmas tree lights, if one section failed, the other sections stayed on. The lights were functioning on the lower levels of the Towers, even as the top floors were collapsing.

- The building design also aided in the evacuation of these thousands of people, especially the stairwells. Designed much better than required by the building codes 30 years ago, the Towers had three evacuation stairwells, instead of the minimum of two. In addition, the center stairwell in both Towers was 56 inches wide, instead of the code-required 44 inches on the two corner stairwells. This allowed two people to move down these stairs side-by-side, and allowed for the firefighters to pass them without stopping the downward flow of occupants.

- Last, but certainly not least, the elevator system became a hero of the day. The system, redesigned and enhanced by Otis Elevator after the attack in 1993, was one of the biggest and fastest in the world. Room-sized express elevators moved thousands from the lobby on the 78th floor to the ground in 45 seconds. Each of the 12 elevators held 55 people; every two minutes 500 people were moved down and ultimately, out of the Towers

What went wrong?

- One serious flaw in the improved planning was the lack of a set of as-built drawings in each of the fire-command centers, and in a near-by off-site location. This made search and rescue operations very difficult initially.