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# Public Private Collaboration: A Successful Case in Australia

## WA HEALTH: JOONDALUP & MIDLAND EXPERIENCES

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Delivering a Healthy WA

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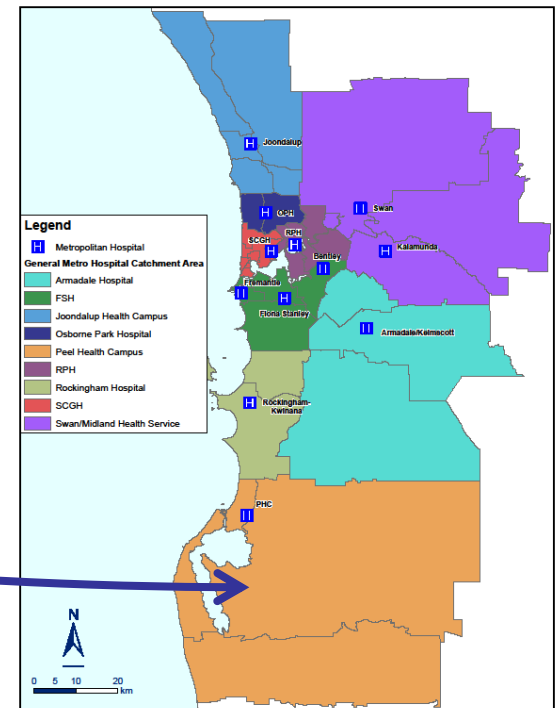
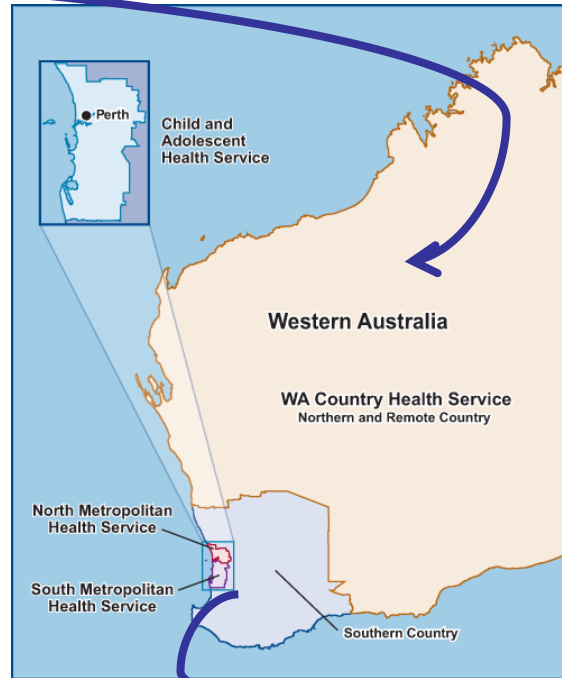
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# Overall Contents

- Why PPPs
- PPP Models in Western Australia
- Joondalup Health Campus – growing an existing partnership (DBFO)
- Midland Health Campus– developing a new partnership (DBOM)
- Potential outcomes



# Down Under



# Why PPPs

- Objectives are to motivate the private proponent to deliver VFM over the whole length of the concession.
- Efficient allocation of risk
- Offering better value for money
- In the public interest
- Period where capital payments via an availability charge or upfront public capital financing is made for the construction of the building.
- Ownership of the property will normally revert back to the public sector at no charge
- Purchase of the service provision is specifically paid for via an agreed payment method (e.g. casemix, volume defined, maximum payment amount, discounts, additional volumes possible)
- Payable only when the service meets required standards

# Design Build Finance Operate (DBFO)

- A “full service” PPP
- Similar to BOOT – “Build Own Operate Transfer”
- Private sector designs, builds, funds, maintains and operates all services (clinical and non clinical) for an agreed set period of time (e.g. 20 years)
- Public sector specifies services that are required to be delivered (scope and quality) and purchases at a contracted rate
- Public sector pays back capital cost over time and facility can be transferred to the State at the end of the contract, subject to agreed handover conditions
- Enduring example is Joondalup (initial contract – JDHSA 1)
- Queen Elizabeth II Medical Centre (QEII MC) Car Park the most recent example in Western Australia and is off balance sheet on the basis of commercial sustainability and risk transference

# Design Build Operate Maintain (DBOM)

- A “full service” PPP, without capital funding by the private sector
- Private sector designs, builds, maintains and operates all services (clinical and non clinical) for an agreed set period of time (say 20 years)
- Public sector provides the required capped capital funding
- Public sector specifies services that are required to be delivered (scope and quality) and purchases at a contracted rate
- Enduring examples are Peel Health Campus and Joondalup expansion agreement (JDHSA 2)
- New Midland Health campus is the most recent example of a DBOM



# PPPs IN WESTERN AUSTRALIA JOONDALUP HEALTH CAMPUS GROWING AN EXISTING PARTNERSHIP

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# Joondalup Background



- Originally an 80 bed public “district” hospital
- Substantially expanded and redeveloped in June 1996 to a 280 public bed hospital (plus 70 integrated private beds)
- This achieved via Design Build Fund Operate PPP (JDHSA1)
- Greater than anticipated and rapid population growth with increased demand for emergency services and beds necessitated renegotiation of JDHSA1 PPP mid initial 20 year term
- Required Increase to 471 public beds and major ED - plus 145 stand alone private beds/facility
- Achieved via revision and renegotiation of existing PPP agreement as a Design Build Operate Maintain (DBOM) PPP (JDHSA2)
- Total campus practical completion 2013





# Joondalup Site 1984





# Joondalup Site 1998 (JDHSA1)





# Joondalup Current Building (JDHSA2)



# Joondalup – The Future



# Outline JDHSA1

- In 1996, considerable expansion of existing State infrastructure and hospital services through a Design Build Finance Operate (DBFO) PPP

## Infrastructure

- State owns land and buildings and leases to private operator (JHC)
- JHC designed and built comprehensive health campus with 350 beds (280 of these guaranteed for public patients, 70 integrated private beds)
- Infrastructure for this first redevelopment - public cost A\$42.1M) was financed via JHC,
- State pays for this through a biannual Availability Charge (AC)/Capital User Charge
- AC calculated on the cost of the States infrastructure component and the agreed interest (later reduced in line with market conditions) and is paid by WA Health directly to JHC over the 20 year contract period (until 2018)
- AC continues to be payable until 11 January 2018.
- Facility was to revert to State in 2018

## Health Services

- Health services provided to the public by JHC in accordance with the overall services agreement
- Annual Notice - activity volumes, principally on a DRG casemix basis, bed days and some block purchases where appropriate

# Outline JDHSA2

- In 2005, rapid population growth and increased demand for emergency and inpatient services (and resultant infrastructure) necessitated renegotiation of JDHSA1 PPP mid 20 year term
- After considerable negotiation, in 2008/09 the State and JHC agreed to substantial expansion of infrastructure and services at Joondalup under a Design Build Operate Maintain (DBOM) PPP model

## Infrastructure

- State continues to lease land and buildings to JHC, however, separate 60 year lease provided for stand alone private facility component
- Existing integrated 70 private beds reverted to State as part of new Agreement
- JHC designed and built substantially expanded health campus now with 450 public beds and major ED plus 145 stand alone private beds
- State financed its share of the development with a total cost of A\$229.8M and is paid according to the capital cost payment schedule in the Agreement.
- 'Public' facility reverts to State now in 2028
- Private facility lease 2072
- Total campus practical completion 2013

## Health Services

- Details follow



# JHC Services <sup>(1)</sup>



## The Annual Notice - Purchasing Services

- Under the Agreement the NMAHS contract manager must give JHC a formal notice annually before the last day in February specifying:
  - the maximum payment amount (MPA) that will be paid for the next contract year (July to June)
  - the activity profile detailing the service charges volumes for each service to be provided by JHC
  - volume discounts apply to services
  - the casemix plan
  - Amendments to role delineation
  - Introduction of new services, health reforms and any changes in reporting or targets
- Note the new services changes in reporting targets etc can be introduced at any time if it applies to the benchmark hospitals.

# JHC Services <sup>(2)</sup>



## Price Determination

- Benchmark pricing
- Under the contract, the prices in the 2012/13 Notice are determined by a benchmarking exercise (specified in the Agreement) based on the 2010/11 actual costs (i.e. the most recent complete year) at comparable hospitals
- These costs are then adjusted to bring the costs to 2012/13 dollars, and adding any other known increases at the peer hospitals (such as award rate increases where there has been supplementary funding added)
- Allowances for building alterations and fixed equipment have been standardised as they can vary appreciably from year to year
  - Paid within casemix price – different from public hospitals which have a capital/minor works allocation
- Equipment depreciation and payroll tax are paid separately (e.g. payroll tax paid by JHC and then reimbursed)



# JHC Services <sup>(3)</sup>



## Other Features of Contract

- Maximum payment amount (MPA) – if the operator provides more services, then it is a “donation” to the State
- Services must be provided evenly throughout the year taking into account seasonal variations (eg, winter ED demand)
- Activity is monitored and any spikes are managed through reduction in non emergency services
- Must meet all applicable standards – penalties for significant default
- Health service reform introduced at the same time as the benchmark hospitals
- Role delineation predominately higher then the benchmark hospitals
- Require private sector hospital licence (Department of Health administered)
- Subject to annual independent audit
- Higher than public standards for quality/staffing etc
- Has required ACHS accreditation since 1996
- Operator runs a private hospital on the site and private patient services are provided at no cost to the State (no subsidy) . Conversion of Emergency patients to private is higher then State Hospitals and it is in the operators interest to encourage private patient activity as it does not eat into the MPA.

# JHC Services (4)



## Reporting

- Extensive reporting including quality and activity, patient satisfaction etc (reports are weekly monthly, quarterly, biannually).
- Any Commonwealth reporting required by the benchmark hospitals is applicable as long as it relates to outputs and not inputs
- Changes in reporting are aligned with benchmark hospitals.

## Annual Independent Audit

- Accuracy and integrity of invoicing billing process
- DRG coding
- Quality indicator reporting
- Licensing compliance including nursing levels
- Critical event reporting
- Equipment Maintenance
- May include any area of contract compliance e.g. role delineation staffing levels.
- Since 2007 JHC has now been receiving A's in the audit and it was noted that the Operator maintains a high level of compliance.

# JHC Services <sup>(5)</sup>



## **Dispute Resolution**

- Pricing - Provider can commission an independent audit of the benchmarking costing exercise
- Dispute resolution order - contract manager, mediation, referral to expert, arbitration

## **Pricing Reconciliation**

- Pricing is subject to reconciliation to actual costs at the benchmark hospitals
- Difference between the estimated and the actual 2010-11 price is then applied to the volumes and the difference is to be repaid

## **Cost of managing the contract**

- Value of the Agreement in 2011-12 \$246m
- Cost of managing the contract (including DOH costs) is \$0.221m or 0.09% of the contract value

## **Other Issues**

- Assignment

# PPPs IN WESTERN AUSTRALIA MIDLAND HEALTH CAMPUS DEVELOPING A NEW PARTNERSHIP

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# New Midland Health Campus Site



# Project Objectives

- Provision of integrated, high quality and safe clinical services
- Better access to health services
- Expanded hospital and ambulatory services to the catchment
- Ensure a sustainable workforce
- Provision of care in the right setting
- Financially viable health services and value for money
- Cost effective future expansion



# Project Scope



## Stage 1

- ↑ from 194 public beds to 307
- Transition to General Hospital from Secondary Hospital
- Role delineation 4/5 generally
- ED increase from approx 35,000 attendances to 60,000 attendances by 2016/17
- Operating Theatres - 4 to 6 theatres, 1 procedure room
- Teaching and training (undergraduate and postgraduate)
- Research
- \$360.1M for infrastructure (shared equally between Commonwealth & State Governments – led by State)

## Stage 2

- Further increase to approx 450 beds by 2021/22



# PPP Deliverables

- Deliver a public patient facility and provide all contracted services from it for a concession period of 20 years, in particular:
  - design, construct and commission a public health campus (the **D & C Phase**)
  - manage the transfer of patients from the existing campus to the new public patient facility (the **Transition Phase**)
  - provide all of the contracted services at the public patient facility as well as the maintenance of the facility (the **Operational Phase**)
  - design and if and when the State elects to proceed, construct and commission an expanded public patient health campus



# Project Establishment <sup>(1)</sup>



## Need & Commitment

- Need for existing Swan District Hospital services to expand to provide care closer to home identified in “Reid Review” (2004)
- Metropolitan Clinical Services Plan clearly articulated required service level and volume including 10 year growth path
- State Government firmly committed to the most appropriate model to be determined by market sounding and Expression of Interest (EOI) process

## Governance & Management

- Accountability for the project with Department of Health through its North Metropolitan Health Service (NMHS)
- Whilst the infrastructure part of the project was a traditional building project, responsibility for procurement was assumed by Treasury’s Strategic Projects Unit
- Once it was agreed to examine PPP options, the project moved into a balanced governance model, shared between Strategic Projects and the North Metropolitan Health Service each having its own project director working in tandem
- Once the “full service” PPP model was selected the North Metropolitan Health Service project director took the lead role supported by the “building” project director
- This was critical in winning over the clinicians and designing and delivering a health service strategy that can endure for 20 years



# Project Establishment (2)



## Communications & Stakeholder Engagement

- “Readiness” communications strategy adopted for phase up to Governments selection of preferred PPP model
- Highly proactive stakeholder model adopted once full service model announced
- Strategies developed for wide range of stakeholder groups
- Operator obligated to make full use of local clinicians in development of building plans and service models

## Industrial Strategy

- Key issue for this form of PPP
- Critical that Government position does not change once decision made to go down path of full service PPP
- State Cabinet & Commonwealth Govt sign off to strategy obtained prior to announcement
- Operators not obligated to take existing workforce, however, in reality will need most of them to meet their needs
- No payout available to local staff – they either accept job from new Operator on conditions offered or accept that State will find them a position at another hospital
- Position helped in Western Australia by existing long standing Joondalup model showing that private sector employment has some benefits

# Project Process (1)



## Initial Procurement Options Analysis

- Wide range of options considered including DBFO, DBOM, DBFM and Traditional
- Options subject to rigorous desktop analysis and ranked on a risk rated basis
- Cross Government participation in analysis (including Health and Treasury) to assist in ownership of decision
- DBOM or DBFO preferred

## Market Sounding

- Small experienced team met face to face with identified National health service operators and financiers
- A structured set of questions was used to ensure comparability of responses
- Feedback from financiers was a preference for non operator led models where their products could have the most impact
- Interviews with potential operators indicated interest from at least 3 and a preference for a full service model
- It was apparent that the field would be broader if the capital borrowing impost was reduced

# Project Process (2)



## Expressions of Interest (EOI)

- Formal expressions of interest were sought and three comprehensive submissions were received
- The EOI documentation was well developed and included outline agreements
- The submissions confirmed that a DBOM would achieve the best outcome at the RFP stage
- Two proponents were selected to proceed to the request for proposal stage, including an obligation not to withdraw and on the basis that all costs would need to be met by the bidding consortia
- 1+ months were allocated for the EOI preparation process and 5 months for the assessment and Government endorsement process
- The timetable was met

# Project Process (3)



## Request For Proposal (RFP)

- From further risk analysis and studies, Government committed to a full service project, but with all of the capital funding for the public patient component to be provided by the State (DBOM)
- Comprehensive set of documents including instructions, specifications, requirements and full draft design & construct and service agreements issued to 2 selected bidders
- 2 very well prepared submissions received & assessment undertaken by a wide range of “expert” teams working in infrastructure, financial/ commercial & operational streams with major contribution from clinicians
  - Most extensive evaluation ever undertaken in WA Health/State
  - Approx 100 people, mostly clinicians/managers evaluated proposals through several Evaluation Advisory Groups
  - Collated detailed evaluations for Evaluation Panel to consider
  - Comparison to Public Sector Comparator (\$)
- Following detailed evaluation against published criteria, a clear preferred proponent was evident and EERC endorsed commencement of negotiation
- 5 months were allocated for the RFP preparation process and 2+ months for the assessment and Government endorsement process
- The timetable was met



# Project Process (4)



## **Negotiation & Contract Close**

- Announcement of winning bidder followed by intensive period of negotiation to close out “departures” from bid
- State negotiation team continued to draw on expert teams through process
- Final key issues closed out at EERC (Cabinet) level
- Contract close achieved in very creditable 5 months, principally due to the quality of the RFP/draft agreements and proposals received

## **Service Contract Management**

- Has not commenced yet, but will be based on proven Joondalup model
- States contract manager included in RFP, assessment and negotiation phases to ensure knowledge and ownership of agreements
- Contract management role accorded a high degree of importance given it will be the States primary connection point with the private partner for a 20 year service agreement period

# Timelines

- Market sounding - February 2010
  - Workup EOI – March 2010 to September 2010 (6 months)
  - EOI submission – October 2010 to November 2010 (1+ months)
  - EOI assessment – December 2010 to April 2011 (4 months)
  - RFP submission – May 2011 to October 2011 (5 months)
  - RFP assessment – October 2011 to December 2011 (2+ months)
  - Contractual close – January 2012 to June 2012 (5 months)
  - Design & construct – August 2012 to August 2015 (3 years)
  - Operate – 2015 to 2035 (20 years)
- 
- Note total time from market sounding to contractual close approximately 27 months



# Project Documents (1)



## **Design & Construction Requirements**

- Site and planning requirements
- Design and construction requirements
- Asset management requirements
- Expansion of infrastructure
- Public sector comparator – design and construct

## **Transition Requirements**

- Interim management period
- Patient transfer period





# Project Documents (2)



## Health Service Requirements

- Overall service provision
- Scope and volume of service
- Teaching, training and research
- ICT
- Quality and performance
- Reporting
- Private health service opportunities
- Other commercial opportunities
- Public sector comparator - operational
  
- **Detailed service specifications based on output based approach and:**
  - in accordance with States clinical services framework
  - role delineation
  - volumes
  - specific requirements
  - rigorous Performance regime/KPIs
  - abatement regime



# Project Documents (3)



## Contracting Structure

- Design and construct agreement
- Interim management agreement
- Services agreement
- Leases

## Commercial Model

- Commercial principles
- Commercial model
- Design and construct payment
- **Service payment**
  - Agreement based on tendered price, different to Joondalup “benchmark” price model
  - Tendered price escalated each year by independent escalator
  - Ceiling and floor in place to provide some protection to both parties, although State's risk position retained
  - Payment mechanism and contractual structure in accordance with risk position and consistent with State's policy on PPP s

# OUTCOMES

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# Joondalup & Midland Outcomes

- More efficient and effective use of capital through co-location and sharing, plus more efficient design
- Services provided at less cost than the public sector rate, including base agreements and volume discounts
- Substantial risk transfer, particularly in term of workforce and activity levels
- Ability to shift cost and attract other funding
- More responsive
- Greater emphasis on quality and performance – unlike public hospitals, these providers abated for not meeting KPIs
- More rigour through licensing process
- Pragmatic approach to ICT

# Success Factors

- Committed Government, particularly industrial aspects
- Competitive market
- Service delivery focus, not infrastructure dominated
- Capable team – establishment and ongoing management
- Right Agreement/Contract
- Proactive contract management
- Relationship management