The Australian Experience: Public Private Partnerships (PPPs)

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Delivering a Healthy WA

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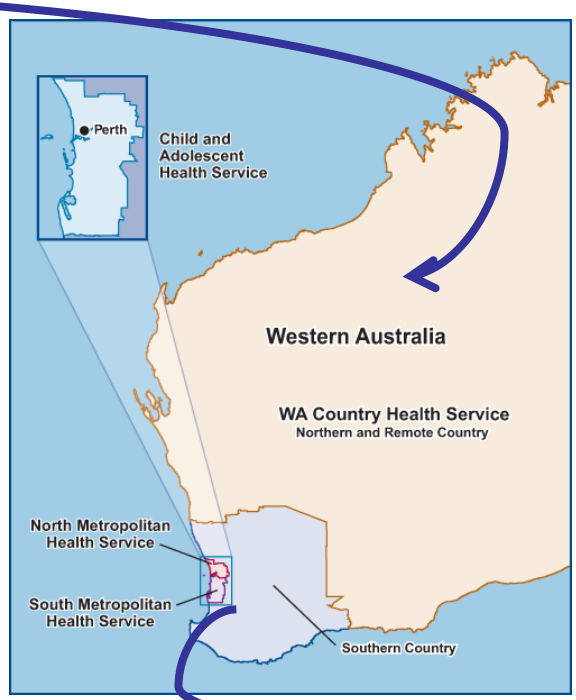
Government of **Western Australia**
Department of **Health**

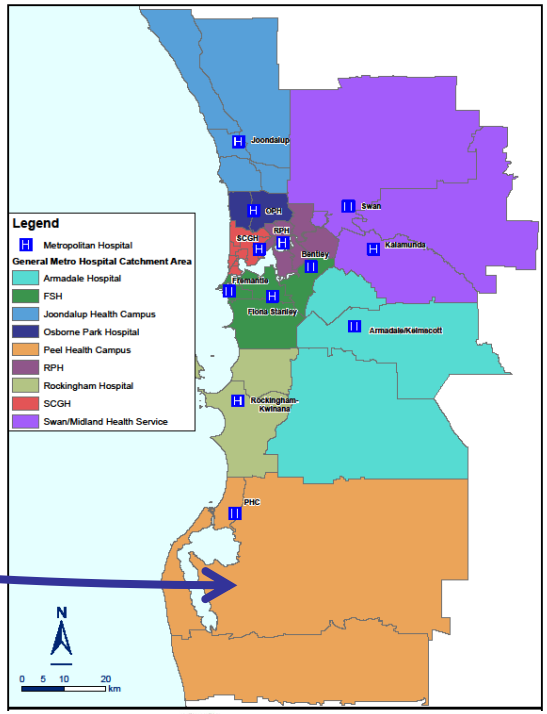
Overall Contents

- Why PPPs
- Models used in Western Australia
- Recent Examples of PPPs in Western Australia
- Key components of PPPs
- PPPs – What can go wrong
- Potential outcomes

Down Under


Darwin
Territory
Queensland
Western Australia
Australia
Brisbane
South Australia
New South Wales
Perth
Sydney
Adelaide
ACT
Canberra
Victoria
Melbourne
Tasmania
Hobart


Perth
Child and Adolescent Health Service
Western Australia
WA Country Health Service
Northern and Remote Country
North Metropolitan Health Service
South Metropolitan Health Service
Southern Country


Legend
Metropolitan Hospital
General Metro Hospital Catchment Area
Armadale Hospital
FSH
Joondalup Health Campus
Osborne Park Hospital
Peel Health Campus
RPH
Rockingham Hospital
SCGH
Swan/Midland Health Service
Joondalup
Swan
Kalamunda
Bentley
Fremantle
Fiona Stanley
Armadale/Kelmscott
Rockingham-Kwinana
PHC
N
0 5 10 20
km

WHY PPPs

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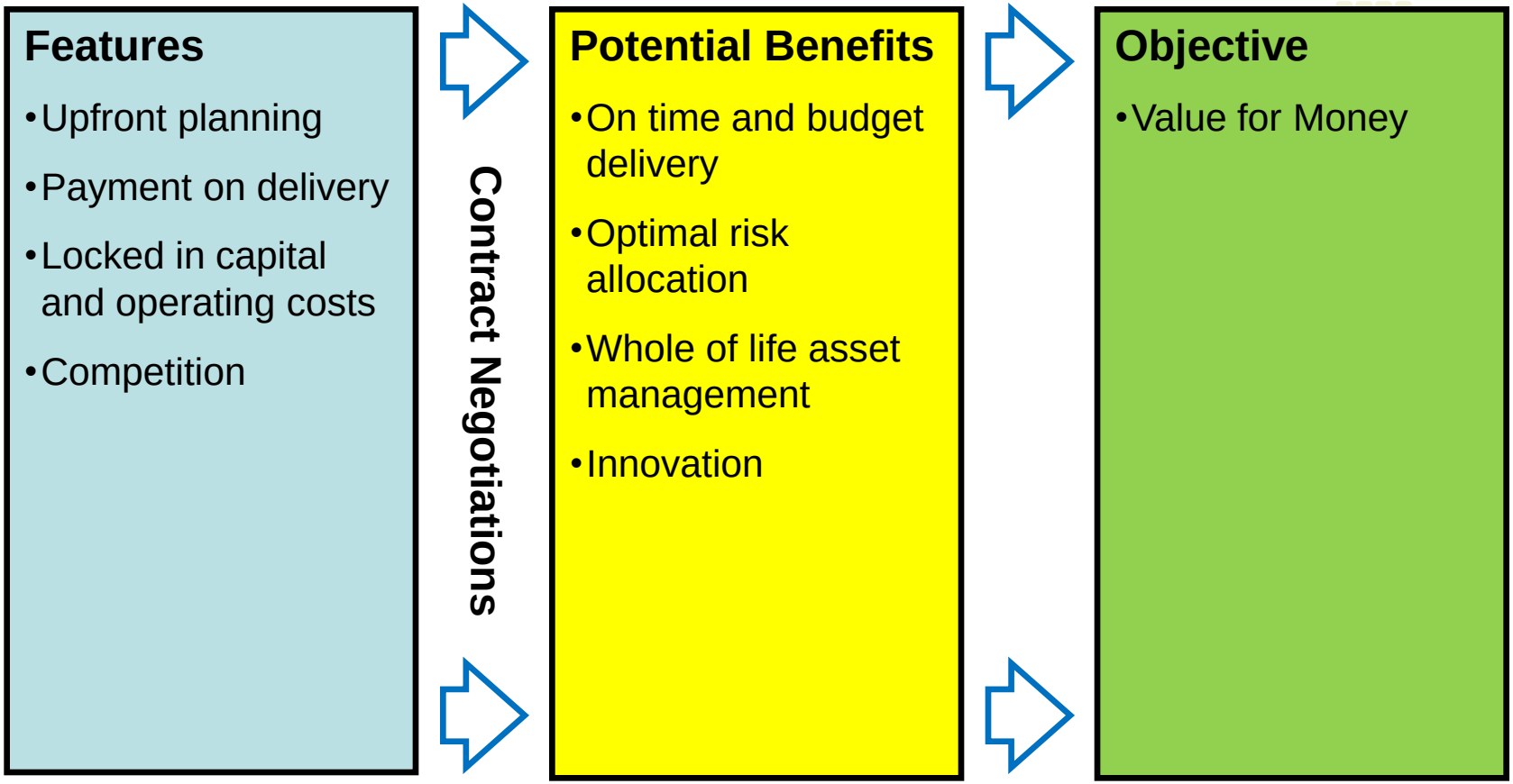
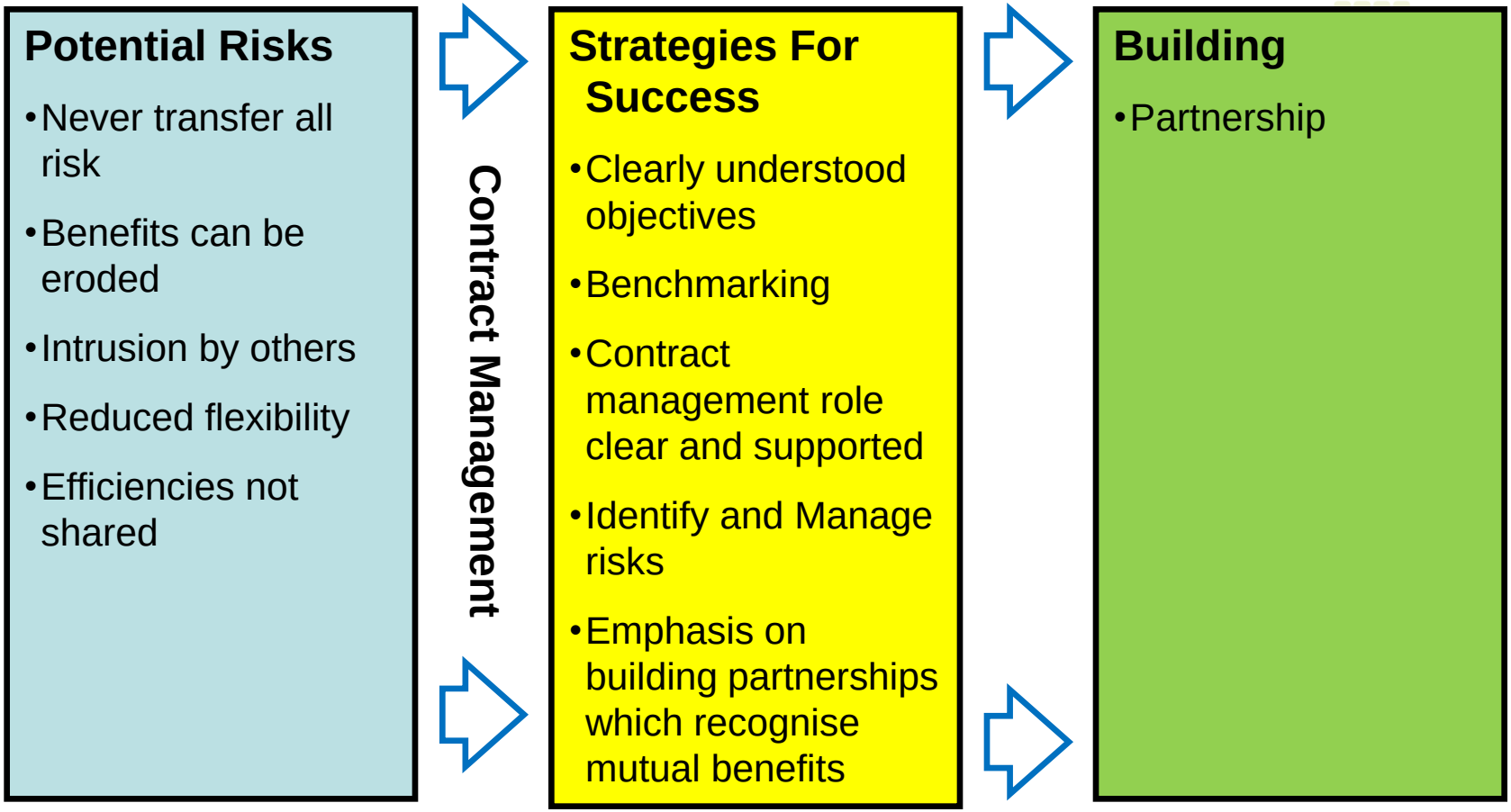
PPPs

- 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

Potential Benefits of PPPs



Potential Risks of PPPs



PPPs IN WESTERN AUSTRALIA
MODELS USED

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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 (QEIIMC) 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

Design Build Finance Maintain (DBFM)

- Private sector designs, builds, finances and maintains for an agreed set period of time
- Private sector contracted to provide all facility maintenance (hard FM) for the period of the contract
- Private sector may also be contracted to provide all or some back of house services (soft FM), for example cleaning, food and porterage services, scheduling, help desk and coordination services
- Public sector delivers clinical services and those hard or soft FM services not to be provided by the private sector
- Public sector pays back capital cost through an availability payment over time
- Facility usually transferred to the State at the end of the contract, subject to agreed handover conditions
- Enduring examples are most Victorian style PPPs
- No health examples in Western Australia although Midland explored

Design and Construct (D&C)

DB or D&C

- Private sector designs and builds/constructs the facility but has no role in service delivery
- Can include fit out and procurement
- Public sector provides the required capital funding and operates all services after the building is commissioned
- A variant may be for the private sector to provide facility maintenance (hard FM) services
- Enduring examples are Nickol Bay and Northam (country hospitals in WA)
- Current examples are Fiona Stanley Hospital and Albany Hospital both through forms of ECI (i.e. early contractor involvement), on a “Managing Contractor” basis

Design Build Maintain (DBM)

- As for DBFM but capital funding by the public sector.
- No specific health examples in Western Australia

Alliance

- Public and private sector come together to deliver an agreed mix of shared services and facilities
- Enduring examples are South West Health Campus (Bunbury)
- No pending example in WA although Busselton explored

Service Contracts

- Public sector contracts specific services from the private sector
- Clinical examples are radiology, radiotherapy, chemotherapy and dialysis
- Non clinical examples are metropolitan linen
- Most significant example in WA is the Facilities Management contract with SERCO for the provision of all non clinical services for the new tertiary Fiona Stanley Hospital, including:
  - Design and provision of 28 non clinical services
  - Design and deployment of agreed ICT infrastructure
  - Design and deployment of an entire FM application solution
  - Procurement and commissioning of all clinical and non clinical equipment
  - Recruitment and training of FM workforce (1,000+ staff)
  - Recruitment assistance, induction and training of FSH clinical staff

PPPs IN WESTERN AUSTRALIA
RECENT EXAMPLES

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Joondalup Health Campus – Project Snapshot

- Originally an 80 bed public “district” hospital
- Substantially expanded and redeveloped to a 280 public bed hospital in June 1996 via DBFO PPP (JDHSA 1)
- Rapid population growth and increased demand for emergency services and beds necessitated renegotiation of PPP mid 20 year term
- Increase to 471 public beds and major ED
- Plus 145 bed private hospital development
- Total campus practical completion 2013
- Redevelopment commenced 2009 via revision to existing PPP agreement as a DBOM - PPP (JDHSA 2) - expansion of facilities and services
- Considerable negotiation required with existing private partner re expansion approach
- JDHSA 2 total capital budget $229 million – State funded public component and its proportion of shared infrastructure
- State continues to pay availability charge for JDHSA 1 infrastructure
- State continues to buy required public hospital services but for new 20 year term

Midland Health Campus – Project Snapshot

- New campus with 310 beds for public patients (plus 60 private beds)
- Swan Hospital (180 beds) will be closed
- Capital budget $360m comprised of $20m transaction cost and $340m infrastructure
- Jointly funded by State & Commonwealth Governments; led by State

- Procurement via DBOM PPP, including a D & C component and a 20 year full service contract to provide public services
- Two operators selected from Expressions of Interest (EOI) and comprehensive competitive Request for Proposal (RFP) submitted by both
- Contract closure reached mid 2012 and construction has commenced
- Building estimated completion 2015 + 20 year health service contract

QEIIMC Carparking – Project Snapshot

- The new car park will deliver 3,140 new undercover parking bays in 4 stages, commencing in October 2012 - total reserve capacity will be increased to over 5,000 bays by the end of 2015
- The new car park will also contain a 90 place child care facility and a small retail centre

- The project was procured using a “BOOT” PPP delivery model
- The project has been fully funded by the private sector with no State financial contributions
- Contracts were executed on 5 July 2011 with Capella Parking
- Capella will also reconfigure and manage all bays on site
- Capella has been granted a 26 year project term to recoup its investment
- Demand risk has been transferred to Capella - the State has not committed to support or underwrite patronage risk
- At the end of this period, the new car park will revert to the State for nil consideration
- Competitive parking charges have been “locked in” and subject only to annual CPI increases - any changes to parking charges require State consent

Fiona Stanley Hospital FM- Project Snapshot

- New 783 bed comprehensive tertiary health campus, including State rehabilitation
- Budget $1,762 million plus $256 million for State Rehab component
- Procurement by two stage management contract
- Construction commenced September 2009
- Practical completion late 2013, open to service 2014

- All FM services contracted out in a single agreement with SERCO
- 29 hospital service lines – not Medical, Nursing, Allied Health, Corporate
- Term 20 years (10+5+5) - Pre Operations 3.25 years & First Term Operations 6.75 years
- Output-based contract with set service standards
- 100% of service $ at risk through poor service quality and/or asset unavailability
- Provides overall value-for-money for FM Services.
- Enables more efficient clinical services & transfers significant ICT & operational risk
- Transfers risk of facility commissioning and operating - State focus on clinical services
- Locks-in fixed price for non-clinical service below the historic cost growth rates
- Delivers quality strategic asset management framework

PPPs IN WESTERN AUSTRALIA
KEY COMPONENTS

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Overall Process

- Need and commitment
- Governance and management
- Communications and stakeholder engagement
- Industrial strategy
- Market sounding
- Expressions of interest
- Request for proposal
- Contract close
- Facility and service delivery

Design and 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

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

Contracting Structure

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

Commercial Model

- Commercial principles
- Commercial model
- Design and construct payment
- Service payment
    - Learnings from initial PPPs
    - Pricing: Tendered v Benchmark
- Public Sector Comparator (PSC)

PPPs – WHAT CAN GO WRONG

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Port Macquarie Base Hospital – The PPP

- First PPP hospital - commissioned in November 1994
- Built on public land
- Differed from archetypical DBFO because:
  - Perpetual private ownership of hospital asset. After 20 years, the owner of the hospital can sell to any interested parties.
  - Delivery of core services by private provider
    - → 80% public : 20% private
    - → DOH to purchase health care services for 20 years.
    - → State becomes health service purchaser not provider
- 31 January 2005 - after paying 10 years of unitary charges, the Labor Government bought back PMBH for $35M

PMBH - What Went Wrong

"The government is, in effect, paying for the hospital twice and giving it away". (NSW Auditor – General 2000)

- **Cost**
  - PMBH cost taxpayers $6M more in recurrent funding compared to the average public hospitals
  - PPP contract locked DOH into long term commitment to guarantee a private consortium with an annual, risk-free return of 13.71%
  - Hidden costs in the calculation of "availability charge" → DOH to compensate for all tax expenses. This compensation was itself taxable
  - DOH would have to buy back PMBH at market value

PMBH - What Went Wrong

"The government is, in effect, paying for the hospital twice and giving it away". (NSW Auditor – General 2000)

- **Performance**
  - Consistently under-performed its peers.
  - In 1998 – PMBH's waiting times for elective surgery was more than double the State average
  - Cost Savings v Services/Service quality ?

Latrobe Regional Hospital – The PPP

- PPP for design, build and maintenance of hospital, provision of clinical and related ancillary services to public patients (co-located with private service provision), casemix funding model
- Term 20 years plus additional 5 years, 99 year lease
- Operator paid for land and development including fit-out
- Commenced operations September 1998 on schedule and on budget
- After 6 months - Operator approached State seeking additional recurrent funding
- June 2000 - State recognised Operators financial problems
- Late 2000 - State agreed to assume all operational and financial risk
- 2002 – Ownership and responsibility for operations formally transferred to State.
- Operator paid State $2m

Latrobe - What Went Wrong

- Failure of Latrobe highlighted weaknesses in the expectations and processes of Government and private operators
- Operator underestimated staffing requirements, payroll tax and costs
- Operator wrongly assumed:
  - Sales tax exemption applicable to publically run hospitals would apply
  - Private sector pay awards would apply
  - State would renegotiate the contract
- Operator failed to understand Victorian casemix funding model
- Failed to take into account how constantly declining per-bed funding of public hospitals is built into casemix-funding model.
- Operator bid at a discount to the normal public hospital acute care service payment mechanism (placed Operator at severe disadvantage and made adequate returns unlikely)
- A pure casemix-funding model provides inadequate funding to sustain adequate health services at public hospitals
- “Top up” funding by State for shortfalls was not open to privately contacted service providers (Operator at further financial disadvantage to public hospitals)

PMBH & Latrobe - Conclusions

- Example of failed PPP hospital where the infrastructure was surrendered to / bought out by the State after service levels declined as the hospitals proved more expensive to operate than the private sector anticipated
- Clear need for greater attention to the risk of failure
- “Off-balance sheet” treatment ≠ guaranteed VFM
- **Political risk remains with the State**
- Wake-up call to Government about the need for transparency
  - in pre-bid process to determine VFM
  - risk transfer
  - most appropriate accounting treatment

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