The WA Experience: Public Private Partnerships (PPPs)
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Dr D J Russell-Weisz
Chief Executive
Fiona Stanley Hospital Commissioning

Delivering a Healthy WA
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; same or enhanced quality of care
- 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

Features
• Upfront planning
• Payment on delivery
• Locked in capital and operating costs
• Competition

Potential Benefits
• On time and budget delivery
• Optimal risk allocation
• Whole of life asset management
• Innovation

Objective
• Value for Money
Potential Risks of PPPs

Potential Risks
- Never transfer all risk
- Benefits can be eroded
- Intrusion by others
- Reduced flexibility
- Efficiencies not shared

• ULTIMATE RISK ALWAYS REMAINS WITH STATE

Strategies For Success
- Clearly understood objectives
- Benchmarking
- Contract management role clear and supported
- Identify and Manage risks
- Emphasis on building partnerships which recognise mutual benefits

Building
- Partnership

Contract Management
PPPs IN WESTERN AUSTRALIA
MODELS USED
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 (QEIIIMC) 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
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 29 non clinical services
  ➢ Design and deployment of some 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

Delivering a Healthy WA
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 307 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
 QEIIIMC 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: $4.3B over 20 years
- 29 hospital service lines – not Medical, Nursing, Allied Health, Corporate
- Not typical “Hard FM” PPP – includes significant “Soft FM”
- 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 ($515M over 20 years).
- Delivers quality strategic asset management framework
- More complex than JHC/MHC – “touch points” with State, soft FM, some contractual issues still to be resolved
New Midland Health Campus Site

Midland Railway Workshops

Train Station

Bulky Goods Stores

Midland Health Campus Site

Police

Lego Stores

Harvey Norman
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 construction
• Service delivery
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
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
Outcomes: Joondalup & Midland

- 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
- Procurement Analysis critical: PPP or no PPP?
- Choose the correct PPP model
- Know Accounting Rules (not necessarily off balance sheet)
- Competitive market
- Cheapest is not necessarily best
- Service delivery focus, not infrastructure dominated
- Capable team – establishment and ongoing management
- Right Agreement/Contract
- Contract needs to be watertight for both parties
- Contract draft at RFP stage – proponents to mark up
- Proactive contract management
- Proactive Relationship management