

Public Private Partnerships in Healthcare Summit

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I am indebted to the Institute for sponsoring me to attend the Public Private Partnerships (PPP) in Healthcare Summit. The two-day conference on 26/27 March 2007, Melbourne provided access to a number of high calibre presentations on a topic of considerable interest. Interestingly, not all presenters were in favour of PPP's. The resulting debate, both within and outside the formal presentations, confirmed the diversity of views on this still controversial form of procurement, making attendance a refreshing and stimulating experience. In all 17 papers were presented. The limited time and space available for this report means that an exhaustive review of all presentations is not possible. Instead I will attempt to provide some observations about the presentations and discussions during the conference which I think are of interest to Institute members. I will do so under the headings of government PPP policy:

- partnerships,
- cost efficiency of project delivery and
- value for money.

But first, what is a Public Private Partnership? Simply put, it is a procurement model where a private consortium pays for the design and construction of, say, a new hospital. The government 'leases' the new facility from the consortium for 25-30 years and also pays for the facility management services provided by the consortium over the life of the contract.

Background of public private partnerships

Professor Ian Forbes, National Director of Health, Woodhead International, in his presentation *Hospital Design Under PPP's*, identified the early 1990s, when the Thatcher Government in the UK was faced with an horrendous backlog in health infrastructure investment, as the genesis of PPP's. Using Thatcher's private sector philosophies, it was decided to prevent a government borrowing spree by treating hospital procurement as a commercial development. Hospitals were to be built and maintained by the private sector and "leased" by the government for 25-30 years, the so called Private Finance Initiative (PFI). A contributing factor in the selection of this procurement model was the perceived inability of the public sector to complete major projects on time (this conveniently overlooked the fact that stop/start funding by government was often the cause of project delays). Forbes found that the participants in his study were in agreement that the objective of upgrading hospital infrastructure in the UK had been met.

Government policy

Government policy for PPP's (or Partnerships Victoria) can be summarised as follows:

- To create *partnerships* between government and the private sector in which improved value for money is

achieved by utilising the innovative capabilities of both to deliver performance improvements and efficiencies

- Focus on whole of life costing and full consideration of the benefits of risk allocation to the private party, resulting in optimum *cost efficiency of project delivery*
- Private bids are compared with the costs that would be associated with government procurement of the desired outputs. The financial benchmark for assessing the *value for money* of private bids is the public sector comparator. It includes the value of risk allocation to the private party.

Using the headings of *partnerships, efficiency of project delivery and value for money*, I will attempt to relate some of the relevant concepts discussed at the conference, either in the presentations or in the informal discussions during the breaks in proceedings.

Partnerships

John Seed, Senior Associate, Advisory Group, Connell Wagner, quoted James Mansergh, Birmingham Corporation, as saying that, 'nowadays with big contractors likely to tender for PPP jobs, extra claiming has become a fine art. I believe that they employ experts, who from the moment the contract is commenced, are engaged exclusively in devising and formulating such claims'. This adversarial attitude arises from the opposing aspirations of client and contractor:

Client	Contractor
Low price	High price
Short program	Long program
High quality	Low cost

The resulting problems can be ameliorated by adopting the partnering approach.

John Seed found that partnering benefits included a reduction in the adversarial culture, value engineering, value management, more innovative design and construction, better buildability / lean construction and better working relationships (trust, transparency).

Dr Paul Woodhouse, Director of Policy Development, AMA Victoria, suggested that the single most important component of partnerships is the need for goodwill, flexibility and a degree of trust on both sides. Authentic partnerships involve combining the competitive efficiency strengths of the private sector with the responsibility and accountability strengths of the public sector.

It needs to be stressed however that the advantages of partnering in health facility capital developments have been well understood and successfully applied in an increasing number of non PPP projects.

Efficient project delivery

Whilst John Seed argued that in general partnering would result in innovative design and better construction, he concluded that this had not always been achieved in PPP's. His research had found that completed facilities did not always meet stakeholders' needs, weren't architecturally innovative and were subject to scope reduction during negotiations without stakeholder consultation.

He also found that procurement cost was high, probably as a result of the risk allocation premium and the higher cost of finance. Procurement period is too long because of the lengthy time required for contract negotiations and bid preparation.

Gerard Blood, Managing Director, Billfinger Berger Concessions, said that in his experience the rigorous reviews by the financiers result in bids that achieve on-time and on-budget construction; a well considered maintenance regime and a robust commercial proposal.

Peter Fitzgerald, who completed a highly regarded review of Victorian PPP's, agreed that his evidence suggests that innovative design, on-time and on-budget delivery and whole-of-life maintenance are benefits that can arise from PPP's.

Forbes believed that innovations in design of PPP hospitals were derived as a result of the integration into one team of all parties responsible for the outcome of the building solution. In particular the presence of facility management firms was important. This meant that decisions about the cost of materials, engineering systems, finishes, fixtures and fitments were made on the basis of genuine life cycle cost analysis, not lowest initial cost. He found that many projects in the UK and Australia reported the introduction of innovative engineering systems, resulting in energy savings, improved environmental conditions and reduced maintenance costs.

Notwithstanding, Forbes found that there are many disincentives to good design in PPP's. The focus of concern during the UK PPP design has not been on the design aspects that reduce operating costs, since that is not the cost that the consortium has to bear. The focus has been on increased efficiency for the facility manager. Design solutions often addressed material distribution systems, not clinical flow patterns. Ultimately for the government, the real cost savings from the hospital will not accrue from its facility management savings, but from operational savings.

In the PPP tender process the Brief, which has traditionally been the essential guiding document in the design, was not always thoroughly tested with the client user groups before tender close. This has been consistently cited as the major problem with PPP design outcomes. To meet probity requirements, there is limited interaction between designers and end users. Therefore there is little feed-back on the design. In addition, representatives of the end users are involved, not the end users themselves. This appears to explain why design solutions have failed to achieve greater efficiencies and innovation than are now seen in non PPP designs. Forbes concluded that if better hospitals are to be achieved, more thought and interaction between designers and end users must occur.

The lack of incentive and the lack of time during the frantic and expensive bid phase means that operational innovations and the provision of healing environments are not examined. Design solutions are frequently based on current best practice and the letter of the Brief, regardless of its quality. Unless alternative models of care and healing environments have been specifically demanded in the bidding documents, then the PPP will not ordinarily allow operational innovation to occur. Achieving the lowest overall hospital cost still makes the PPP tender lower regardless of NPV, so the design must gain a competitive edge in the tender price.

Value for money

Dr Paul Woodhouse said that a review of 29 PFIs in the UK showed that there was an average estimated savings in the *Full Business Case* compared to the *Public Sector Comparator* of 17%. (The Public Sector Comparator is the cost that would be associated with government procurement of the desired outputs, it includes the value of risk allocation to the private party) However, the savings are sensitive to the risk transfer valuations that accounted for 60% of the forecast savings. In six cases, value for money determinations were entirely dependent upon the risk transfer valuation.

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An analysis of 14 PFI projects found that the margin between the actual PFI contract (as opposed to Full Business Case) and the Public Sector Comparator benchmark averaged only 1.7%. This is extremely sensitive to the discount rate which is used.

Peter Fitzgerald, Director, Growth Solutions Group, objected to the smoke and mirror trick with the selection of the discount rates. To illustrate the sensitivity of Value for Money to the selected discount rate, he demonstrated how, in a theoretical case study (\$100 million capital expenditure), by selecting two discount rates (5.7% and 8.7%), the Net Present Cost was either \$188 million (or 6% higher than the PSC), or \$150 million (or 9% below the PSC).

Further, he maintained that governments are entitled to transfer risk, but should be open, honest and transparent about the price they pay for it. Finally, he emphasised that the residual risk will always remain with the government anyway because the political risk for providing the service (ie healthcare) lies with the government, which inhibits its ability to extract its contractual entitlement to the last pound of flesh.

Forbes added that the major concern for the government evaluators of PPP bids is the funding approaches offered by the tenderers, not the design solutions. Regulators and treasuries become absorbed by the legal and financial aspects, rather than clinical outcomes. The designs required for changing complex clinical processes are far more difficult to evaluate and are shifted into the background, placing a big question mark over the real value for money.

Some concluding thoughts

PPP's are here to stay but they will continue to evolve. The emphasis in the medium term is on how to improve the model. Areas of focus include:

- improved public disclosure
- review of bid costs ('the financiers are eating the builder's lunch')
- contract management issues, including refinancing, changes of ownership, modifications, performance management.
- consistent or standard legal and commercial documents
- national pipeline for all PPP's
- sharing of design knowledge

The advantages attributed to PPP's ie partnering; on time / on budget; innovative design; lifecycle based design; guaranteed level of maintenance for 25-30 years; value for money; can all be (and have been) achieved in conventional procurement contracts, especially the managed documentation and construction form of procurement. Importantly these advantages were achieved without the high cost of finance, the high cost of risk transfer, the cost of bids (1% of project costs) and the inflexible, very long term contracts. Another advantage ascribed to PPP's is the rigorous process leading to the Business Case. But this rigorous process too has been successfully applied in non PPP projects.

It appeared to me (and to many other conference delegates) that one of the few really compelling reasons for using the PPP process is lack of public money to fund health infrastructure projects.

Institute members will be interested to learn that the whole-of-life maintenance regime embedded in the PPP process was consistently identified as one of the benefits of this procurement model. The maintenance requirements in the PPP contract are rigorous and output based. At the end of the 25-30 year contract the facility is to be handed back to the government in an as-new condition. From my personal involvement in a PPP bid, I can confirm that replacements ranging from floor coverings to air conditioning chillers in the final years of the contract formed a major part of the consortium's bid.

Sally Evans from Medirest / Compass Group believed that in the facility management area there were a number of PPP benefits to the state. The value for money concept is defined by the PPP methodology by aligning risk, price and quality; the payment mechanism determines which quality and risk measures matter; when key performance indicators are not achieved payment is reduced; integration of design, construction and facility management allows operational facility management efficiencies to be designed-in; design and technology decisions can be made on a 25-year life cycle, avoiding the usual trade-off between capital and operational expenditure.

I would like to leave the final word on PPP's to Kenneth Davidson, who, writing in *The Age* on 7/8/06 about the new Southern Cross Railway Station had this to say about PPP's, 'If the government is so hopelessly inefficient that it can no longer put infrastructure projects out to tender, it follows that it doesn't have the expertise to specify a PPP contract that sets in concrete the rights and the responsibilities of the government and the private consortia over a 30-year period. The risk of entering a 30-year service contract which can only be varied by the government at great cost during the life of the contract, requires far greater foresight than and a far greater degree of risk to the government than a competitive tender. The service provider holds all the commercial cards in the negotiation of the required variation to the contract. It may be possible to transfer the financial risk to the private consortium, but that will come at a price, and as far as the consortium is concerned, the risk premium will be fully factored into the contract. The consortium's liability is limited to its equity. The political risk for providing the service always remains with the government.' Davidson calculated the risk premium for transfer of construction risk to the private consortium of the Southern Cross Railway Station at \$122 million.

Many delegates at the conference, other than those with a vested interest, expressed similar views.