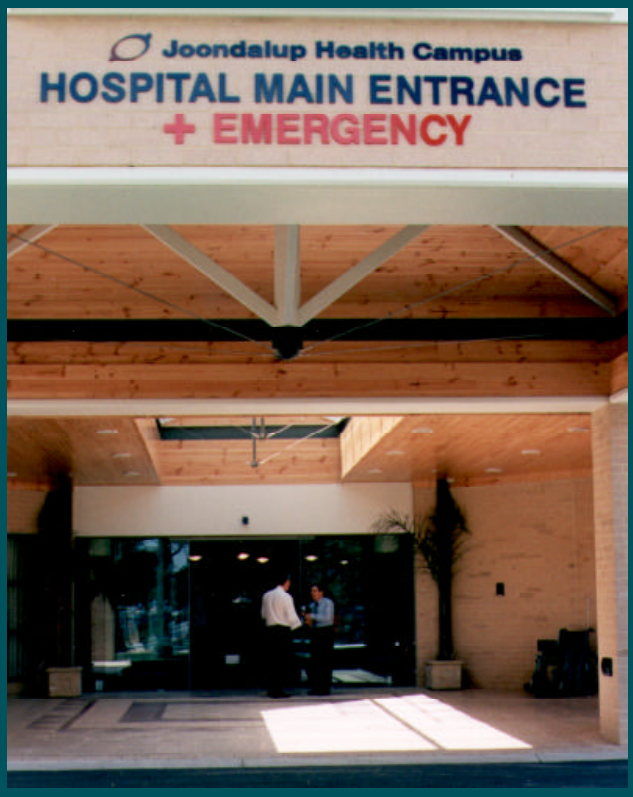
PRIVATE CARE FOR PUBLIC PATIENTS



The Joondalup Health Campus

Performance Examination

Report No 9 – November 1997

AUDITOR GENERAL

Western Australia

AUDITOR GENERAL

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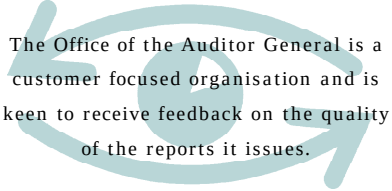

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Performance Examination

PRIVATE CARE FOR PUBLIC PATIENTS

The Joondalup Health Campus

Report No 9 – November 1997

AUDITOR GENERAL

Western Australia

THE SPEAKER
LEGISLATIVE ASSEMBLY

THE PRESIDENT
LEGISLATIVE COUNCIL

PERFORMANCE EXAMINATION — PRIVATE CARE FOR PUBLIC PATIENTS – The Joondalup Health Campus

This Report has been prepared consequent to examinations conducted under section 80 of the *Financial Administration and Audit Act 1985* for submission to Parliament under the provisions of section 95 of the Act.

Performance examinations are an integral part of my overall Performance Auditing Program and seek to provide Parliament with assessments of the effectiveness and efficiency of public sector programs and activities, thereby identifying opportunities for improved performance.

The information provided through this approach will, I am sure, assist Parliament in better evaluating agency performance and enhance Parliamentary decision making to the benefit of all Western Australians.

D D R PEARSON
AUDITOR GENERAL

November 25, 1997

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Executive Summary

Background

Involving the private sector in the provision of public services and infrastructure has received much greater attention in recent years, and it is beyond question that this can be a legitimate government approach to meeting community needs.

The Joondalup Health Campus contract signed in April 1996 involves the private sector in the provision of hospital services and facilities for public patients. It will result in an upgraded hospital providing locally to the Joondalup community an increased quantity and range of services.

The contract has a net present value that is expected to exceed $300 million with about 90 per cent of this for the purchase of services. Under the contract the private sector Operator has taken over the running of the former 84-bed Wanneroo Hospital and is to build and operate for 20 years an upgraded 335-bed hospital which will provide services for public and private patients.

The combination of service and facilities provision in one contract, the collocation of services for public and private patients, the size of the Hospital and the duration of the contract distinguish this project from more traditional projects involving the Health Department of Western Australia (the Department) and the private sector.

The performance examination has been conducted to help ensure that the contract provides benefits to the State and that future developments in the health sector and elsewhere benefit from the Joondalup experience. It focused on the:

- Department's planning of the project;
- contractual arrangements; and
- Department's management of the contract.

The contract was signed by the Minister for Health on behalf of the State of Western Australia. This report addresses the role of the Department advising and acting on behalf of the Minister. It is possible that the Operator under the contract will change and discussion in the report of possible future actions by the Operator refer to whatever entity is the Operator at the time.

Executive Summary

Overall Findings and Conclusions

Planning the project

The project was set in the context of a 1993 review which identified the need to provide additional hospital services for Joondalup residents, and a Government policy to encourage greater involvement of the private sector in the provision of hospital services. Detailed planning for the project commenced in late 1994 and the Minister provided policy direction in May 1995. The Department developed these directives into a statement of objectives for inclusion in the *Request for Proposals*, however the statement is not sufficiently specific to indicate how their achievement is to be assessed.

The Department examined a range of models for involving the private sector, and two models were selected as a basis of seeking proposals. Model 1 bundles together all aspects of the provision of services and the availability of facilities to enable the contract to be signed with a single private sector entity. It was the preferred model. Model 2 is similar except that the facility for public patients is to be operated and managed by the public sector.

A model involving the public sector in its traditional role in relation to both the provision of facilities and services was included in considerations through a benchmarking exercise based on existing cost data. It was not tested against the models involving the private sector through a competitive bid developed by the public sector.

The *Request for Proposals* made clear the risks that the Department wished to see transferred to the private sector. It also outlined the criteria for evaluating proposals. These reflected a mix of capability, price and quality factors and the proposed transfer arrangements for public sector employees.

The Department received and evaluated four bids under each of the two selected models. A preferred proponent was selected following initial negotiations with the number one ranked proponent under Model 1 and according to the estimates used by the Department the project would have a significant net present value saving, almost entirely due to savings in relation to capital costs.

Executive Summary

The Department conducted a detailed planning and evaluation process and extensive negotiations regarding the content of the contract. It drew on advice from health experts, central agencies and external consultants and is of the view that the evaluation was comprehensive and sufficiently robust, and that it gained experience that has been invaluable to other projects involving the private sector within and external to the health industry.

However, the planning phase of the project has provided only limited assurance that the contract provides the best benefits to the State as the Department only subjected the two Models to competitive bids and treated one of these as the preferred Model.

The Department's submissions setting out the case for proceeding with the project did not include comprehensive evaluations of the benefits, costs and risks involved.

The contract

The contract establishes a legally binding relationship between the State as purchaser and the Operator as provider of services and facilities. While it shifts the role of provider from the public to the private sector, it leaves the State responsible for the delivery of health services to public patients.

One of the main benefits expected to result from the collocation of facilities for public and private patients was a reduction in the capital costs to Government by sharing certain facilities and equipment.

At the time the contract was signed it was the Department's view that the capital costs represented a $21 million net present value saving which is approximately 40 per cent of the public sector benchmark used by the Department. It is possible that private sector costs could be significantly lower than traditional public sector design and building costs, but the size of this difference raises doubts about the validity of the benchmarking exercise.

While there may be savings in the capital component relative to the public sector alternative, the benchmark figure used by the Department to estimate the capital saving has a number of limitations so that there is no reliable estimate of the extent of any savings.

Executive Summary

The contract does not provide any direct savings in service prices. It creates the potential for the Department to negotiate substantial quantities of additional services at reduced prices to provide savings. However, it remains unclear if this will provide savings relative to public sector provision as reduced prices have also been used when funding additional services at public hospitals.

Risks have been transferred to the Operator, including design and construction risks, running costs, labour relations, some market risks and some public liability risks. The transfer and sharing of risks with the Operator has the potential to represent a significant benefit to the State relative to the public sector alternative.

Additional risks to the State compared to public provision of services and facilities include:

- reduced flexibility and lack of competition for new services and facilities;
- limited contractual control over the quality of services;
- fixed availability charge with limited control over service quantity;
- guaranteed offer to purchase a minimum quantity of services (although the minimum quantity can be gradually reduced);
- financial incentives for the Operator to influence admission, treatment and discharge patterns; and
- potential overpayments because of incorrect coding of treatments.

Major **tangible benefits** of the contract relative to the public sector alternative are: claimed savings in capital costs; potentially lower costs for additional services; transfer to Government of the private component after 40 years at no cost; legally enforceable quality requirements; and clear separation of responsibilities for purchasing and provision of services.

Major **tangible costs** are: additional costs in planning and developing the contract; staff transition costs; reversion of the private component extended from 20 to 40 years; opportunity cost of land for the private component; and additional costs of private finance.

Executive Summary

There is not, however, reliable information to establish that the contract provides net tangible benefits to the State relative to the public sector alternative from either services or facilities.

The State *may* benefit from a range of risks transferred to the Operator, a potential for savings in relation to the cost of services and a number of wider potential benefits, including:

- the potential impact of competition on the efficiency of public sector hospitals; and
- a stimulus for reform of the planning of hospital services across the metropolitan area and the delineation of roles for each hospital.

However, there are risks to the State related primarily to reduced flexibility, ensuring the quality of services, selective treatment of patients and cost shifting.

Contract management

The extent to which the contract will deliver net benefits depends critically upon whether the Department:

- through its management of the contract, succeeds in minimising the impact of the additional risks; and
- is able to negotiate each year substantial quantities of additional services at prices that are lower than the costs elsewhere.

The Department needs to document a strategy and procedures for managing the contract to ensure consistency and continuity over the term of the contract and needs to undertake an immediate risk analysis of the contract.

Regular reporting by the Department is essential to enhance accountability for its management of the contract, and help Parliament and the community to judge whether the benefits that the Department expects are being delivered.

Summarised Recommendations

Where in future the Department is involved in major service and infrastructure projects having the potential to involve the private sector it should:

- **follow without omission a logical sequence of planning stages;**
- **seek to make meaningful comparisons of private sector bids with the public sector alternative; and**
- **inform key decisions with comprehensive evaluations of the benefits, costs and risks involved.**

The Department should manage the Joondalup Health Campus contract to ensure that:

- **desired quality standards are achieved;**
- **prices paid for services reflect potential efficiencies in the facility;**
- **the potential for selective treatment of patients, cost shifting and incorrect coding is minimised; and**
- **future new service types or upgrades to the Hospital are competitively priced.**

The Department should:

- **report publicly key performance indicators for the Joondalup Health Campus contract;**
- **clarify organisational responsibility for management of the contract; and**
- **develop, document and implement a risk based contract management strategy.**

Introduction

Involving the private sector in the provision of public services and infrastructure has received much greater attention in recent years.

The Western Australian community has long been accustomed, for example, to the use of specialist private companies to design and/or build certain government facilities or infrastructure.

In some cases, new initiatives to involve the private sector may appear as a re-invention of a past which is well within memory: thus, for example, the notion of private bus companies providing passenger services is something which has recently returned after an absence for a generation or two.

In other cases the approach may be new, in Western Australia at least, and may involve the use of a contractually-based agreement, the company receiving a measure of government financial support or even monopoly in return for its undertaking to provide certain services of a certain quality for a certain period of time, direct to the public. It may also involve private companies in the financing and provision of public infrastructure on its own or in conjunction with the provision of related services.

That involving the private sector can be a legitimate government approach to meeting community needs is beyond question.

However, the approach raises important, and generally complex, issues. Foremost is the issue of whether these arrangements will provide an overall benefit to the community.

Also, there is the potential that the involvement of the private sector becomes an objective in itself. In turn, this creates a risk that the job is seen to be done when the private entity is in place, and that the long-term provision of the community service is overshadowed by a project which revolved around the signing of a contract. So long as government recognises and retains its role as instigator and funder of a particular community service, it also retains responsibility for the quality and cost of that service.

A contract with a private entity in no way reduces the government's responsibility and accountability for the services provided on its behalf. Equally, and by direct extension, the government department is not relieved of its responsibility and accountability when the contract is signed — it is only the process of delivery which has changed.

Introduction

For many government departments and their officers, this necessarily enters difficult areas. One significant aspect is the management of relationships — relationships with a government and its ministers, of understanding and rendering practicable the various political imperatives and expectations, of creating workable relationships with prospective private tenderers, of creating and nurturing shared visions, keeping the 'big picture' in mind, and in developing skills and structures to ensure that the winning tenderer continues to help meet the relevant departmental and governmental objectives as well as its own corporate objectives.

A second, related aspect is the management of risks. The engagement of a private entity is likely to transfer certain risks from the State to the private sector. On the other hand, the engagement will almost certainly introduce other new risks for the State. What if, for example, it proves impossible to negotiate changes in service nature, quantity or technology during the life of the contract? Or what if the private entity gets into financial difficulties?

However, many risks which can be identified through the establishment of the contractual relationship involving the private sector have direct parallels in public sector service provision, even if the risks in the latter context have not been identified previously.

It is within these contexts that the following performance examination of the Joondalup Health Campus project has been made. The experience of the Health Department of Western Australia (the Department), it is felt, may be widely instructive. By any measure it is important that the knowledge base should rapidly expand.

Background to the project

The provision of hospital and health services in Western Australia comprises the biggest single area of expenditure in the State's annual budget. In 1997–98 the Department has a budget allocation of $1.6 billion and only the expenditure of the Education Department is of similar magnitude.

To enhance value for its health dollar, the State Government has a policy commitment to encourage greater involvement of the private sector in the provision of health services for public patients.

Introduction

Joondalup has more than 200 000 residents and is the area in Perth with the largest growth in population. In response to this growth the Department identified the need for expanded hospital services in the Joondalup area consistent with its objective to provide health services close to where people live.

A competitive process was instigated to help identify how the private sector might best assist to meet this objective, and to identify a suitable private sector participant. The Department invited proponents to submit, as part of their bids, detailed proposals for a private hospital, medical centre and upgraded public hospital on the site of the then Wanneroo Hospital. It required that the collocated facilities should provide a specified range of health and support services to public patients.

The Department selected and then conducted detailed negotiations with a preferred proponent. In April 1996, on the advice of the Department and with the approval of Cabinet, the Minister for Health signed a contract with a private sector entity to take over the operation of the existing 84-bed Wanneroo Hospital and to finance, design, build, occupy and operate for 20 years an upgraded 335-bed hospital which will provide services for public and private patients (the Hospital).[1]

Facilities and services at the Joondalup Health Campus

The appointed Operator took control of Wanneroo Hospital and the surrounding site on June 1, 1996. Construction of the upgraded facilities is expected to be completed by early 1998, ahead of the previously scheduled date of June 1998.

The Hospital has been licensed as a private hospital, but will cater for both public and private patients (Figure 1). When completed it will comprise:

- *70 beds exclusively for private patients*
  the services to be provided for private patients will be at the discretion of the Operator.

[1] The Minister for Health signed the contract acting on behalf of the State of Western Australia. This report addresses the roles of the Department advising and acting on behalf of the Minister in the development of the contract and managing the contract on behalf of the Minister.

Introduction

- *265 beds primarily for public patients*
  the services for public patients provided under the contract include surgery, general medicine, obstetrics, mental health, aged care, intensive care and emergency medicine.
- *an upgraded emergency department*
  which is to provide an enhanced level of service.
- *shared facilities*
  such as operating theatres and kitchens, which serve both public and private patients.
- *a medical centre*
  providing services for both private and public patients.

It will provide a number of new services including intensive care and psychiatry as well as increased quantities of the services provided by the former Wanneroo Hospital.

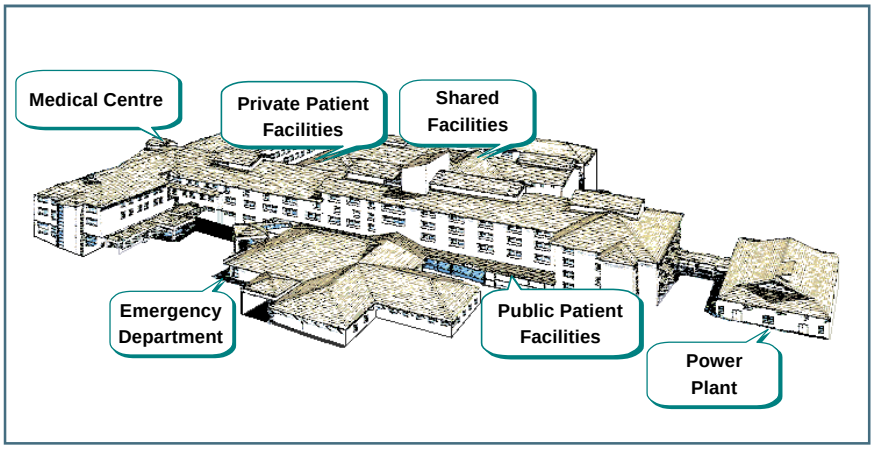

Figure 1: The Hospital at the Joondalup Health Campus

The Hospital comprises facilities to provide services for public and private patients.

Source: The Operator and OAG

The contract also provides for the construction of new community health facilities which will be leased and operated by the public sector.

Collectively, the Hospital along with other proposed health facilities on the site, such as an ambulance depot and a nursing home, are referred to as the Joondalup Health Campus.

Cost of facilities and services

Under the contract, the State pays the Operator at intervals over the term of the contract:

- *a service charge* – for the actual treatment of public patients, to reflect prices and volumes agreed each year; and
- *an availability charge* – a fixed sum for making the facility available for the treatment of public patients.

On a full year basis the payments under the contract represent approximately two per cent of the Department's budget. Based on the estimates used by the Department at the time the preferred proponent was appointed, the net present value of the contract is expected to exceed $300 million (representing the current value of the estimated cashflows over the term of the contract). About 90 per cent of this is for the purchase of services. A similar sized commitment would have existed if the Hospital had been upgraded and operated by the public sector, however the commitment would not have been embodied in a legally binding contract.

The combination of service and facilities provision in one contract, the collocation of services for public and private patients, the size of the Hospital and the duration of the contract distinguish this project from more traditional Departmental projects involving the private sector. There have, however, been similar projects in other States.

The Department commenced paying the service charge to the Operator when it handed the Hospital over in mid-1996. From the date of completion of the facilities upgrade, the Department will also start to pay the Operator the availability charge.

After 20 years, availability and service charge payments will cease and the public component of the Hospital (the bulk of the facilities) will revert to the control of the State. Control of the private component of the Hospital (primarily the medical centre and wards reserved for private patients) will pass to the State after 40 years. Throughout the period of the contract, however, the State remains the legal owner of all land and buildings.

Roles of the State and the Operator

The contractual relationship between the State and the Operator does not diminish the ongoing responsibility of the State for the quality and cost of services provided to public patients.

At its heart, the arrangement shifts key functions from the public to the private sector. Under the contract, the State is (as previously) responsible for specifying and funding the health care to be provided for public patients at the Hospital. However, the role of actually providing the care and facilities, of managing, developing and staffing the Hospital and carrying out the day-to-day activities in the Hospital, shifts from the public sector to a private contractor.

In addition to Joondalup, the private sector has recently become involved in hospitals at Peel and Bunbury. It is possible that other developments involving the private sector in the provision of health services and facilities will follow.

It is timely to examine the Joondalup experience thus far, with a view not only to helping ensure that the Joondalup Health Campus provides benefits to the State, but also that future developments in the health sector and elsewhere benefit from the Joondalup experience.

Examination scope and approach

This performance examination addressed whether the Joondalup Health Campus contract is likely to achieve the Department's aims and provide benefits to the State.

The examination focused primarily on the benefits, costs and risks of the signed contract. The report addresses:

- the Department's planning of the project;
- the contractual arrangements for provision of hospital facilities and services for public patients; and
- the management of the contract.

Introduction

The examination included:

- review of contract and supporting documentation;
- examination of planning and management documentation held by the Department, its financial and legal advisers, and other public sector agencies involved;
- interviews with key staff of these organisations; and
- discussions with a wide range of stakeholders.

Planning the project

Key Findings

- ***In support of the Government's commitment to encouraging private sector involvement, the Joondalup Health Campus project shifts the roles of service and facility provision to the private sector.***
- ***Measurable objectives were not developed for the project before a competitive bidding process between prospective private operators was commenced.***
- ***Competitive tenders were constrained to a limited range of models for the provision of the facilities and services.***
- ***Advice provided by the Department did not include comprehensive evaluations of the benefits, risks and costs involved.***

The decision as to the best way of meeting the identified needs for hospital services for Joondalup residents would ideally comprise a number of different elements. These include:

- clearly understood Government policies;
- up to date Departmental strategies for metropolitan health services;
- establishment of a suitably resourced project team within the Department;
- clearly identified objectives and criteria against which to assess alternative approaches; and
- a rigorously applied evaluation of all reasonably practical alternatives against the identified objectives, with particular attention to benefits, costs and risks of the alternatives.

Like any such project, the various activities break down into a hierarchy, commencing with broad Government policy and progressively refining down to comparatively minor decisions about the particular project (Figure 2). Although some processes may be progressed simultaneously, failure to satisfactorily complete a step in the hierarchy may cause difficulties later on.

Planning the project

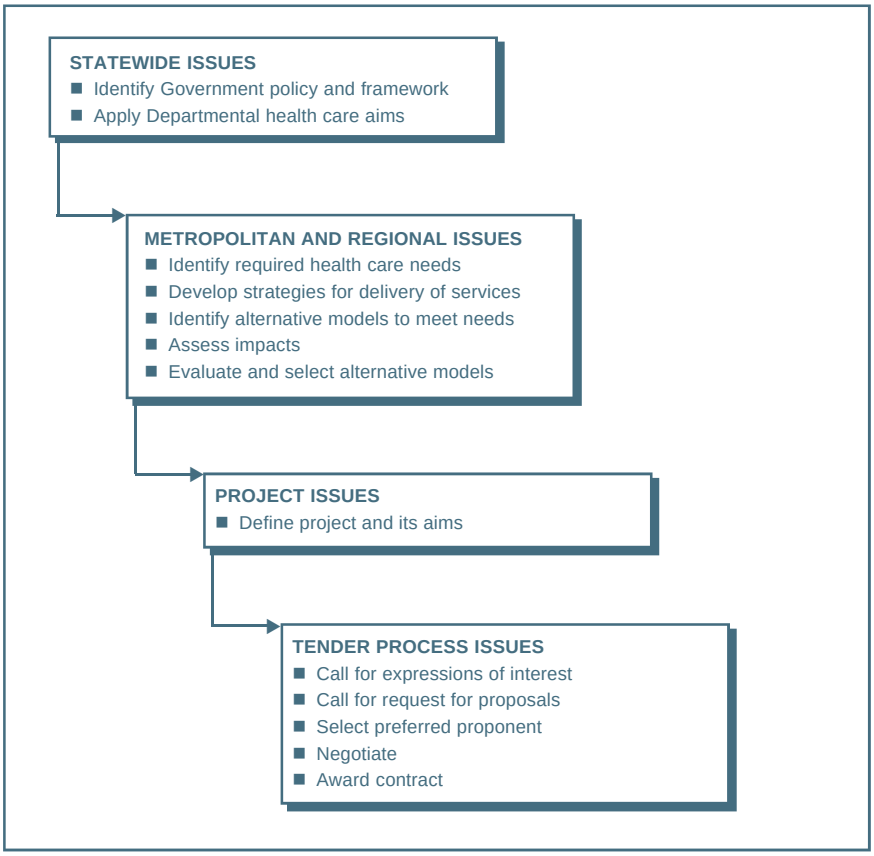

Figure 2: Planning hierarchy for the project

A hierarchy of activities is required to underpin planning decisions for the project. Failure to satisfactorily complete one step jeopardises subsequent decisions.

Source: OAG

This chapter examines the Department's planning process in the Joondalup Health Campus project in relation to this hierarchy.

Planning the project

Statewide policy and health care aims

The Government's Health Policy, published in June 1993 by the Minister for Health, provided a context for the Department as to the approaches sought by Government:

> **"The Government will ensure that Western Australians have access to affordable health care of the highest quality when needed. The Government is committed to:**
> - **freedom of choice of health care provider; and**
> - **the fair allocation of the available resources for health".**
>
> **"The Government is committed to encouraging the greater involvement of the private sector in the provision of competitive health and hospital services within the framework of the Medicare scheme."**

In June 1994 the Premier and Treasurer launched the public sector wide Strategic Asset Management initiative noting that:

> **"There is now the opportunity for both the public and private sectors to form working partnerships in the supply of assets and services."**

The Department's focus on meeting the needs of Joondalup residents for hospital services fell squarely within the Government's policy to increase the involvement of the private sector.

Establishing a need for services

A wide-ranging review of the North Metropolitan Health Region by the Department in 1993 found significant shortfalls in the hospital services available within the Joondalup area. A 1995 review of activity was based on a Joondalup catchment area and showed that the local Wanneroo Hospital supplied less than one quarter of the requirements for public inpatient services in 1994 for these Joondalup residents. The remaining requirements were met by hospitals outside the Joondalup catchment area (Figure 3).

Planning the project

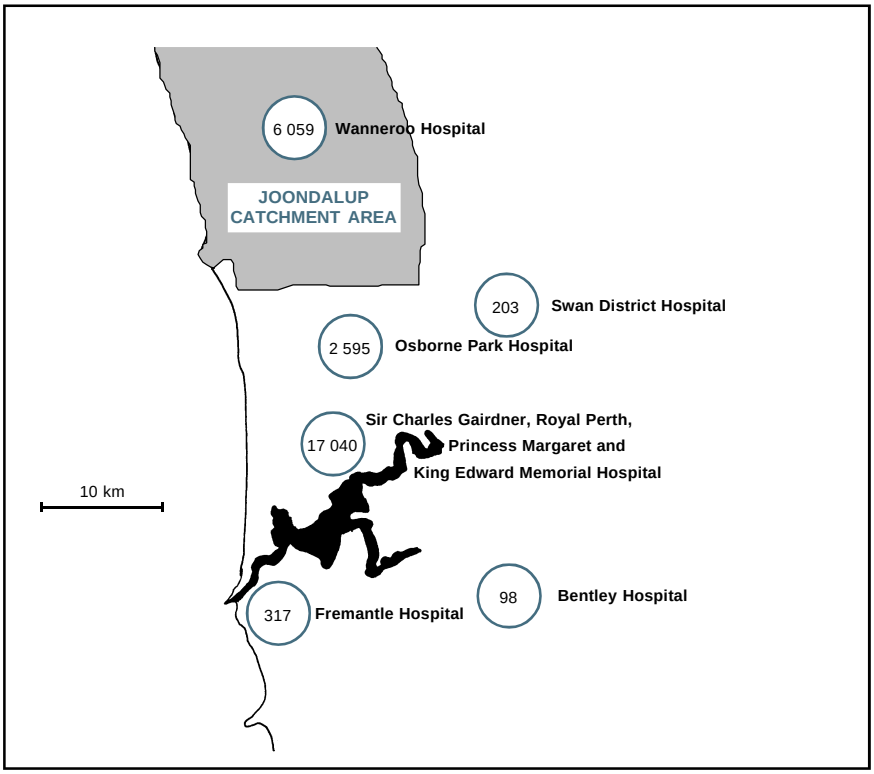

Figure 3: Where and in what numbers Joondalup residents were treated in metropolitan public hospitals in 1994

In 1994, approximately 80 per cent of inpatient treatments for Joondalup residents occurred outside the Joondalup catchment area.

Source: The Health Department and OAG

Metropolitan and regional planning

Nothing compels the residents of one region in the metropolitan area to seek health care services from the nearest public hospital. A decision to introduce new hospital facilities in one region can have significant implications for facilities in other regions. Planning of new facilities within the metropolitan area should occur within up to date strategies for health services.

The need for comprehensive and strategic plans for health has recently been acknowledged by the Government's establishment of a health services planning committee to develop a plan for the metropolitan area to the year 2020.

Planning the project

During 1994–95, when the Department made key decisions regarding the project, it was developing statewide and regional purchasing plans for health care. The planning model based on regional service delivery emerging at this time provided the basis for the planning involved.

However, the Department did not link the project to up to date strategies for the delivery of health services across the metropolitan area. For instance, the future role and impact of an upgraded hospital on other hospital and related health services, and the possible involvement of the private sector were not considered fully.

Planning calculations for the project were primarily based on the following assumptions for inpatient services:

- all services to Joondalup residents previously provided by other non-teaching metropolitan hospitals (principally Osborne Park) would be provided by the upgraded hospital; and
- ten per cent of the services to Joondalup residents previously provided by teaching hospitals would be provided by the upgraded hospital.

As a result the proportion of Joondalup residents receiving hospital services as public patients at the Hospital was expected to approximately double from 20 to 40 per cent.

Establishing the project team

Having identified the need to begin planning for a project to provide additional hospital services for Joondalup residents, the Department established a Project Control Group reporting to the Commissioner of Health. A Project Director who was responsible for day-to-day direction and completion of the project and who reported to the Group was appointed in November 1994. Consultants were engaged to progress the bulk of the project management and technical work involved.

Project objectives

Armed with broad Government policy, but without the guidance of an overall set of strategies for service delivery, the Department needed to identify clear objectives for the project.

The Project Control Group sought written guidance regarding policy objectives four months after its formation, and in May 1995 the Minister directed that, in developing tender documentation and evaluating proposals, the Department should consider whether proposals:

- led to improved resource utilisation;
- supported the underlying objectives of the Health System;
- protected or enhanced the rights of individuals and their access to health care services;
- encouraged private sector involvement, on terms that are favourable for both public and private sector interests; and
- met Commonwealth Government requirements.

The Minister also directed at that time that the project be based on a collocation of a public hospital, private hospital and medical centre, with the private hospital and medical centre to be managed by the private sector and the public hospital to be under either private or public management.

The Department developed these directives into a statement of objectives for the project that was included in the *Request for Proposals* as follows:

- "To substantially upgrade the existing public hospital facilities at Joondalup.
- To design, construct and commission a private hospital and medical centre on the same site as the public hospital. This will assist in attracting and retaining medical, nursing and other health professionals to the region on a resident or visiting basis, and reduce the upfront and ongoing capital commitments of the Government by sharing certain facilities and equipment.
- To ensure the most efficient and effective provision of an appropriate range and level of high quality public patient services.
- To ensure future capacity for the expansion of facilities and services in response to growth in demand."

Planning the project

The Minister's directives provided an important framework within which the Department could then have drawn up specific objectives to enable assessments of overall benefits to the State. The objectives developed by the Department provide additional detail, but are not sufficiently specific to indicate how their achievement is to be assessed.

At the time the Minister issued the directives, he approved proposals to establish a Ministerial Overview Panel to enhance decision making. The Panel, chaired by the Minister, comprised senior representatives of the Department, the Minister's office, the Public Sector Management Office and Treasury. Decisions by the Panel do not appear to include any additional policy directives by the Minister in relation to the project.

The documented objectives of the project do not indicate any specific intent for the project to have wider impacts in the metropolitan health system. Nevertheless, the potential for this clearly exists and might include:

- the potential impact of competition on the efficiency of public sector hospitals;
- changes arising from the ability of a private operator to introduce revised work practices;
- the potential to introduce new benchmarks against which public sector performance can be assessed;
- a stimulus for a review of the role of licensing private hospitals and consideration of an equivalent scheme for public hospitals; and
- a stimulus for reform of the planning of hospital services across the metropolitan area and the delineation of roles for each hospital.

Expressions of interest and the Request for Proposals

The tender process commenced with the calling of expressions of interest from the private sector. Following receipt of expressions of interest, the Department examined a range of models for the involvement of the private sector, including similar projects elsewhere in Australia. This helped the Department to apply lessons learnt and avoid pitfalls.

Planning the project

The requirement that the project must be based on a collocation of public and private hospitals and a medical centre could be met by solutions as diverse as entirely separate buildings for each on the one site, to all three being contained in a single building. The *Request for Proposals* suggested a possible concept design but indicated that there was no requirement for bids to be strictly in accordance with this design (Figure 4).

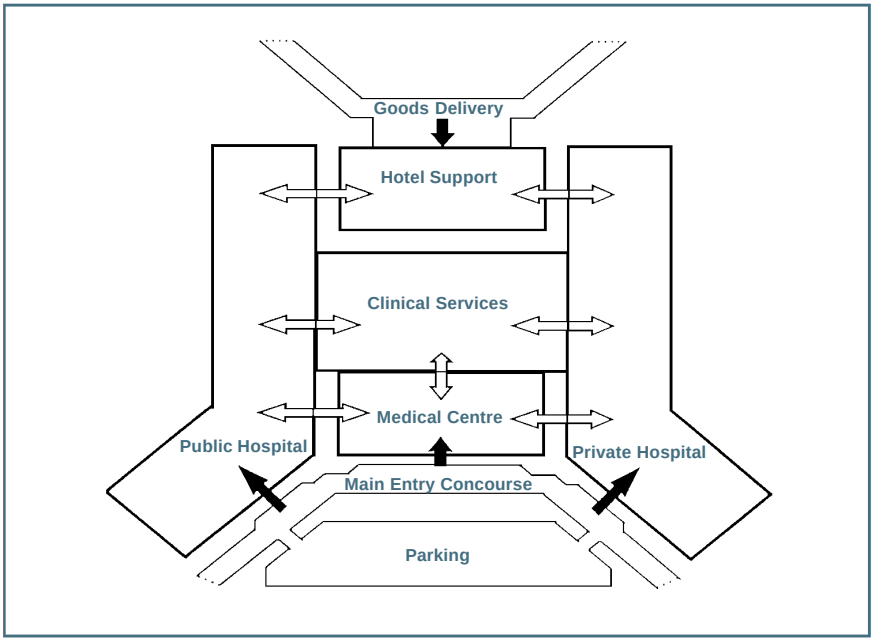

Figure 4: The concept design for the collocated facilities suggested in the *Request for Proposals* document

The suggested configuration had private and public hospital facilities located around a core of shared facilities. It was indicated that there was no requirement for bids to be strictly in accordance with this design.

Source: Request for Proposals and OAG

There were four basic models available to the Department for private and public sector roles in relation to the public hospital component of the collocated facilities (Figure 5). None would appear to be inconsistent with Ministerial directives.

Planning the project

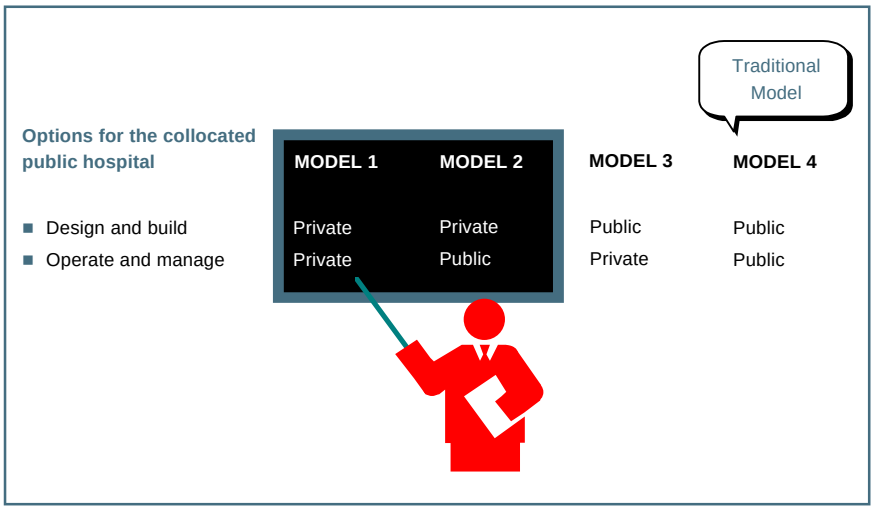

Figure 5: The four basic models available to the Department for private and public sector roles for the collocated public hospital[2]

The four models appear to be consistent with the Ministerial directives and have different mixes of private and public sector involvement. Two models were selected and only these two were subjected to the competitive process.

Source: The Health Department and OAG

Two models were selected as a basis of seeking proposals from short-listed proponents:

- Model 1 – the public hospital to be operated and managed by the private sector; and
- Model 2 – the public hospital to be operated and managed by the public sector.

Model 1 bundles all aspects of the provision of services and the availability of facilities to enable the contract to be signed with a single private sector entity. It was the model preferred by the Department and this preference was presented as part of a package to members of the Ministerial Overview Panel.

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[2] At the time the *Request for Proposals* was being developed in 1995 the Department expected that the facility for public patients would be a public hospital. It was decided in early 1996 that the whole facility would be licensed as a private hospital. The reasons for this included the Operator's concern to avoid being subject to Ministerial direction and the effect on the Operator's business case of any loss of taxation benefits if it was a public hospital.

Planning the project

Model 4 has the public sector in its traditional role in relation to both the provision of the facilities and services. It was included in considerations through a benchmarking exercise based on existing cost data. It was not tested against the models involving the private sector through a competitive bid developed by the public sector.

The *Request for Proposals* document set out requirements in broad terms. It specified the types of services required but left proponents to estimate expected service quantities from data for 1993-94 and indicative data for 1997-98. The indicative service quantity data enabled a measure of cost per unit of service to be obtained from each proponent in a form that could be evaluated. The document invited proposals under each of the two selected models and indicated that the model ultimately adopted "will be the one that achieves the best result for the Government, according to all of the relevant criteria".

Detailed proposals were required, including information on:

- the facility design, costings and financing arrangements;
- confirmation that the required patient and support services would be provided;
- procedures and policies to ensure quality service;
- the proposed price for services and the availability of the facility;
- the proposed staffing profile; and
- the financial standing of the proponent and relevant experience.

The document made clear the risks that the Department wished to see transferred to the private sector. It also outlined the criteria for evaluating proposals. These reflected a mix of capability, price and quality factors and the proposed transfer arrangements for public sector employees.

Evaluation process

An evaluation team was established and assigned weightings to the criteria prior to the receipt of proposals.

The Department received four bids under each model. These were subjected to thorough and detailed evaluation against the criteria to enable the team to separately rank the bids for each model. Net present value estimates were prepared for each proponent's bid over 20 years based on the sum of separate estimates for the services and facilities components.

The bids were compared with the public sector benchmark, which was also the sum of separate estimates for services and facilities. None of the proponents submitted contract prices as low as the benchmark cost for the public sector.

The Department informed each proponent of the approximate extent to which its bid fell short of the benchmark and invited it to reconsider its prices and submit revised proposals.

The revised proposals were evaluated and an assessment was made of the net present value of each bid under each model. No analysis was performed of the relative merit of the bids across both models. The Department was of the view that Model 2 was considered to be the fall-back if none of the proponents' bids under Model 1 met the Government's objectives.

The highest ranked bid under Model 1 had a net present value that was calculated to be marginally ($3 million) below that of the public sector benchmark. In October 1995 the Minister approved the Department's recommendation that negotiations be commenced with the number one ranked proponent under Model 1 to seek to resolve some key issues.

Appointment of the preferred proponent

The Department sought to negotiate improved prices with the number one ranked proponent under Model 1. It opened its negotiations with a reminder of the need "to demonstrate that the private sector provision of public hospital services is more cost effective than the public sector alternative". The Department suggested "that there may be some scope for a trade off between a reduced utilisation fee and an increased availability charge" and offered to extend the period before reversion of the private component of the Hospital to assist the proponent to meet the benchmark for services.

The number one ranked proponent agreed to reduce the service charge by a further amount on the basis of:

- the reversion of the private component of the Hospital to Government occupation after 40 years, instead of the originally proposed 20 years;
- an increase in capital costs of $4.1 million, for modifications to the design identified by the evaluation team and as a shift of costs from the service charge – the increase to be paid for by the State via an increased availability charge; and
- a reduction in margins.

According to the estimates used by the Department, the combined effect of the changes in the service and availability charges achieved through these negotiations reduced the net present value of the lead bid relative to the benchmark by $19 million.

This calculation did not include an estimate of the value of the concession made during the negotiations. In addition to allocating part of the site for the additional period, there are restrictions on the State's use of land and premises and the Operator has rights to use the facilities for public patients and support services during the second 20 year period.

Following these negotiations the Department recommended to the Minister Mayne Nickless Limited as the preferred proponent to design, build, operate and manage the facility under Model 1. The Minister received Cabinet

Planning the project

approval in early November 1995 for the recommendation of Mayne Nickless Limited as the preferred proponent on the basis that the Department would then negotiate a formal contract for the project.

The State Supply Commission assessed the process up to the stage of the Department's recommendation of the preferred proponent as a result of public comments about the process. It found that having examined the matters raised, there had been compliance with the Commission's supply policies and that the supply process for the project was "open, competitive and fair to all participants".

Contract negotiations

The Department negotiated with Mayne Nickless Limited the details of the contract based on the content of the *Request for Proposals*, the successful bid and the specific variations agreed in the lead-up to the appointment of the preferred proponent.

Concessions were made during this phase regarding the leasing arrangements. The land on which the facilities for private patients and the medical centre were to be built were leased at a nominal rent rather than at market value, and any potential revenue from sub-leases to commercial entities was foregone.

Outcome of the planning phase

The Department conducted a detailed planning and evaluation process and extensive negotiations regarding the content of the contract. It drew on advice from health experts, central agencies and external consultants and is of the view that it gained experience that has been invaluable to other projects involving the private sector within and external to the health industry. It has recently established a Contract Management Reference Group reporting to the Commissioner of Health to ensure that these (and other) lessons are incorporated into present and future projects of this nature.

However, the planning phase of the project has provided only limited assurance that the contract provides the best possible benefits to the State as the Department only subjected two Models to competitive bids and treated one of these as the preferred Model.

The case to proceed

At the end of the negotiation process the Department again made a submission to the Minister, this time recommending the signing of the contract. The contract signed by the Minister in April 1996, with Cabinet approval, established Mayne Nickless Limited as the Operator.[3]

Both this and the November 1995 submission to the Minister set out the case for proceeding with the project, including the estimated net present value of savings. The Department holds the view that the evaluation was comprehensive and sufficiently robust. However, the evaluation presented with the submissions did not include assessments of:

- the net impact of the project, in terms of services and costs, on the metropolitan health system;
- transition costs for the transfer of the existing hospital staff from the public to the private sector (estimated to be at least $1.1 million);
- costs associated with the planning and development of the contract (estimated to be $1.2 million);
- the full costs and benefits of the public sector managing the contract compared with managing a public hospital;
- the risks transferred to the Operator and any new risks accruing to the State; and
- the sensitivity of projected outcomes to changes in underlying assumptions.

[3] As it is possible for the ownership of a publicly listed company to change, and for the Operator under the contract to be changed by agreement, any discussion in this report of possible future actions by the Operator refer to whatever entity is the Operator at the time.

Planning the project

Advice provided by the Department regarding the selection of the preferred proponent and finalising the contract did not include comprehensive evaluations of the benefits, costs and risks involved.

Recommendations

Where in future the Department is involved in major service and infrastructure projects having the potential to involve the private sector it should:

- **follow without omission a logical sequence of planning stages to ensure that broad policy objectives, detailed strategies, regional-wide consequences, Government directives and step-by-step planning are each integrated with the other;**
- **seek to make meaningful comparisons of private sector bids with the benefits and costs of the public sector alternative, either by calculating reliable and relevant benchmarks against which the private sector bids may be compared, or by inviting a public sector "bid" as part of the competitive process; and**
- **inform key decisions with comprehensive evaluations of the benefits, costs and risks involved.**

The contract

Key Findings

- ***While shifting the role of service provider from the public to the private sector, the contract leaves unchanged the State's responsibility for the delivery of health services to public patients.***
- ***The estimate of savings for the facilities component of the project is not considered to be reliable, so that a meaningful assessment of overall project costs relative to the public sector alternative is not available.***
- ***The State may benefit from a range of risks transferred to the Operator, a potential for savings in relation to the cost of services and a number of wider potential benefits. However, there is not reliable information to establish that the contract provides net tangible benefits and there are risks to the State related primarily to reduced flexibility, ensuring the quality of services, selective treatment of patients and cost shifting.***

The contract establishes a legally binding relationship between the State as purchaser and the Operator as the provider of services and facilities which can only be changed by mutual agreement.

While it shifts the role of service provider from the public sector to the private sector, it leaves the State's responsibility for the delivery of health services to public patients unchanged.

The Operator as a private sector entity will be subject to different requirements and influences than would a traditional public hospital. For instance, it is subject to:

- private hospital licensing provisions; and
- requirements to act in the best interests of its shareholders

but not to the various legislation governing public sector behaviour and processes.

The contract

Whether this new contractual relationship results in overall improvements will largely depend on:

- the content of the contract; and
- the management of the contract.

These will comprise the focus of each of the remaining two chapters of this report. This chapter focuses on the capital costs and savings, the type, quantity and quality of services, and service prices arising from the contract.

Capital costs

The total capital cost of the public component of the Hospital forms the basis of the availability charge that the State will pay the Operator for making the facilities available for the treatment of public patients.

At the time of recommending the preferred proponent it was the Department's view that the capital costs represented a $21 million net present value saving relative to the cost of the public sector providing facilities, the benchmark cost to the public sector of building facilities to meet the *Request for Proposals* being $51 million.

Estimates of the total capital cost of the public component have increased from the Operator's original proposal of $27 million, to $39 million when the contract was signed in April 1996. Current estimates stand at $42 million. The increases are due primarily to changes in the Department's requirements and the cost of modifications to address shortcomings in the Operator's proposal identified by the evaluation team (Figure 6).

The contract

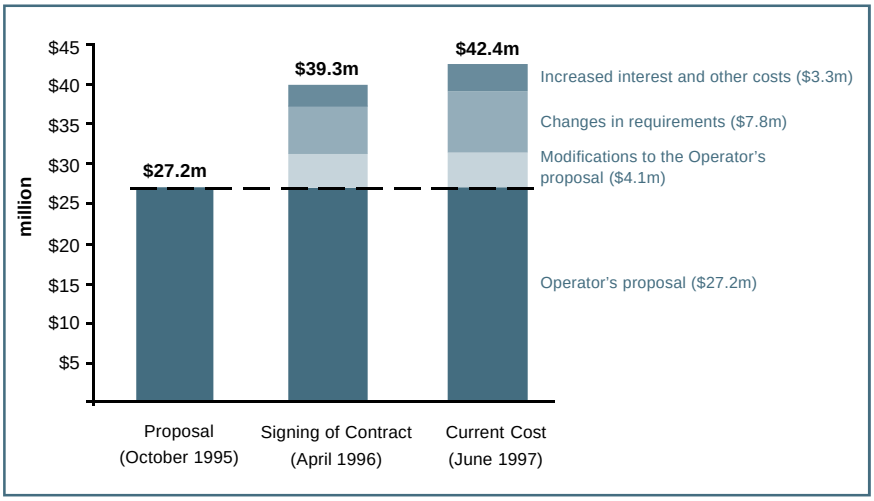

Figure 6: Sources of increased capital costs for the public component of the Hospital

Capital costs have increased by $15 million due primarily to changes in the Department's requirements and the cost of modifications to address shortcomings in the Operator's proposal identified by the evaluation team.

Source: The Health Department and OAG

The changes in requirements for the public component of the Hospital ($8 million) relate primarily to mental health and aged care services. Similarly, the capital cost of the community health facilities (which the State will lease from the Operator) has increased by approximately $4 million (to a total of $5 million) due to changes in the Department's requirements. These changes arose primarily because of the lack of detailed planning and consultation by the Department in these areas prior to the issuing of the *Request for Proposals*, and could have arisen in a similar manner if the more traditional approach of the public sector having responsibility for the design and construction of the facilities.

In total, since the Department recommended the preferred proponent in October 1995, the capital costs of the public component of the Hospital have increased by approximately $15 million and those for the community health facility by approximately $4 million. More than one third of the current estimate of capital costs has arisen outside the competitive process.

Capital savings

One of the main benefits expected to result from the collocation of facilities for public and private patients was a reduction in the capital costs to Government by sharing certain facilities and equipment.

The estimate of a capital saving of $21 million for facilities for public patients represents approximately 40 per cent of the public sector benchmark. Whilst it is possible that private sector costs could be significantly lower than traditional public sector design and building costs, the size of this difference raises doubts about the validity of the estimated savings. Alternatively, the capital component of the Operator's bid may have been below cost as part of an overall bidding strategy.

THE ESTIMATE OF CAPITAL SAVINGS

The benchmark figure used by the Department to estimate the capital savings was derived from cost estimates provided by the then Building Management Authority. The primary purpose of the costing model is to assess the financial reasonableness of individual proposals, and not to estimate the savings achieved in capital costs. The costing model is based on traditional generic practices and does not reflect cost savings that might be expected if a competitive public sector bid had been developed for a collocated facility.

Furthermore, the estimate used by the Department was based on the construction of a new stand-alone public hospital rather than for facilities which were part new and part refurbished. In effect, the comparison did not take into account the value (identified as $10 million at December 31, 1994 in the *Request for Proposals* document) and utility of the existing hospital buildings.

The comparison made to estimate savings was based on the Operator's original proposals, when estimated capital costs stood at $27 million, rather than at $39 million when the contract was signed.

It is the Department's view that a very detailed examination against the best available benchmark at the time was conducted and that the savings

The contract

relative to the public sector benchmark arose from the Operator's bid reflecting a willingness to pay for a greater component of the shared facilities and innovation in their design.

The benchmark figure used by the Department to estimate the capital saving of $21 million has a number of limitations.

While there may be savings in the capital component of the project relative to the public sector alternative, there is no reliable estimate of the extent of any savings.

The implications of private financing

In inviting proposals for the Joondalup Health Campus development, the Department made clear that it would favour those that required little or no Government contribution to capital financing.

The Operator's proposal involved it arranging private finance to pay for the design, construction and related costs of the public component of the Hospital. This arrangement is incorporated in the contract and following the opening of the upgraded facility the State will pay the Operator an availability charge such that after 20 years the financier will have recovered the capital plus interest costs of building the public component.

Based on estimated capital costs of $39 million when the contract was signed, and the interest rate set for the first 10 years of the 20 year period, the estimated net present value of the additional cost of private finance (compared with the cost of funding through the traditional means of State borrowing) is approximately $2 million, or 5 per cent of the cost of having the facilities for public patients provided.

Contractual arrangements can result in the liability for future availability charge payments not being included in the Department's balance sheet. This can be achieved under current accounting standards if the risks and benefits incidental to property ownership are predominantly borne by the private sector. It would also result in a reduced level of State debt as the availability charge payments would only be recognised in the year they were made.

The contract

THE ACCOUNTING TREATMENT OF THE AVAILABILITY CHARGE

The Department has acknowledged that there was not a sufficient transfer to the private sector of the risks and benefits incidental to ownership to warrant that the liabilities be off the Department's balance sheet. The reasons for this include:

- **the availability charge is payable at a fixed rate irrespective of the quantity of services provided for public patients;**
- **the likelihood of events occurring which could lead to the interruption of the availability charge is remote;**
- **regulatory changes which result in the need for structural work will increase the State's availability charge liability; and**
- **in reverting to its control after 20 years, the State carries the risk that the facilities become obsolete or incur a loss in realisable value.**

However, a small transfer of risk from the State to the Operator has been achieved because under certain limited circumstances payment of the availability charge can be interrupted. The Department did not evaluate whether this risk transfer warranted the premium paid for private finance.

There is no evidence of benefits outweighing the additional costs of private finance.

Range of services and future upgrading of the Hospital

Services provided under the contract for public patients include acute inpatient services (such as surgery, general medicine and obstetrics), mental health, aged care and emergency medicine. For each service the contract sets out minimum requirements in terms of the type or level of service to be provided. These are based on the current assessed needs of the Joondalup population and on technology presently available.

The contract

There is no provision in the contract for a generic outpatients' service after completion of the facilities upgrade other than physiotherapy, the Department keeping under review the funding of such services at the Hospital.

Over the 20 year term of the services component of the contract, it is likely that needs will change, and that new or enhanced services will become available. To continue to meet the needs of the Joondalup population, it was estimated in 1994 that the level and complexity of 70 per cent of the services which were subsequently specified in the contract will have increased by the year 2010.

Furthermore, it is probable that the Department will seek further additions or enhancements to the facilities.

In these circumstances the contract provides for the two parties to negotiate desired changes to the Hospital. These changes will occur without the benefits of competitive processes controlled by the public sector. If agreement cannot be reached no changes will be introduced, and the Department might need to look elsewhere to purchase the new services or establish separate facilities.

These contractual provisions have the potential to limit the range of options available to the State for the future development of services in the metropolitan area. The Department will need to monitor the need for new service types and seek to negotiate their introduction at competitive prices.

In the absence of competition, the Department will need to take steps to help ensure that any future upgrades to the facilities are competitively priced, for instance by identifying meaningful benchmarks or developing reliable cost estimates.

Service quality

A number of factors at work in the contract and in the marketplace will influence the quality of services provided by the Operator. The quality of services will depend on the relative balance of these forces, which may vary over the life of the contract.

The contract

The contract contains a range of measures that seek to ensure an acceptable standard of service quality. They include requirements for the Hospital to be accredited, to meet quality standards and to provide for the rights of public patients.

It is a requirement of the contract that the Hospital be accredited by the Australian Council of Health Care Standards. Accreditation by this industry-based body provides some assurance that quality oriented processes are in use.

The contract requires the Operator to meet specified quality standards. They are primarily based on clinical indicators established by the Council and over time will be added to or modified by Council decisions. The quality standards also draw on wider sources such as National and State Goals and Targets as published from time to time, including *Clinical Health Goals & Targets for Western Australia 1994* and require the Operator to operate and maintain the Hospital and provide services in accordance with:

- the *Hospitals and Health Services Act 1927*;
- all Australian standards relevant to the operation of private hospitals; and
- where services are not regulated by these provisions or the quality standards, good clinical practice at a group of peer hospitals.

It is the Department's view that these measures are adequate and appropriate to ensure service quality, and that the quality standards in the contract are higher than those for public hospitals.

The Department drew on the best indicators available at the time the contract was being finalised. The quality standards as currently defined have a limited scope but provide some control over the quality of services and are legally enforceable. In the absence of a comprehensive set of quality standards the Department has a limited ability to ensure the quality of services in hospitals.

The contract

LIMITATIONS OF QUALITY STANDARDS

Although progress has been made in Australia and elsewhere, measures of the quality of hospital services are not sufficiently advanced to address improvements in the health of patients.

Most measures in use focus on clinical procedures and misadventures such as unplanned return to the operating theatre and the rate of hospital acquired infection. They are of limited rigour as they involve judgements on issues such as an incident being "unplanned" or whether an infection is present, and currently only a small proportion have thresholds.

Given these limitations, the quality indicators in the contract provide only limited control. Where thresholds exist they generally involve a very low level of performance.

Other quality standards drawn from documents such as National and State Goals and Targets and the contractual requirements relating to applicable legislation and standards, and the requirement in some cases to match good clinical practice at a group of peer hospitals are general in nature and provide only limited control over service quality.

The quality standards for public hospitals can be changed over time at the discretion of the Department, however, the contract restricts how standards may be changed at the Hospital.

As appropriate indicators and thresholds become available these should be considered for adoption for public hospitals, and where possible the Department should seek to have them applied under the contract to public patients treated at the Hospital.

In certain circumstances a failure by the Operator to meet the quality standards specified in the contract can result in a reduction in the prices paid for the services involved. Loss of accreditation and failure to meet quality standards may result in a contract default by the Operator.

The contract

In general the contract provides rights for public patients treated at the Hospital similar to the rights enjoyed by patients treated at public hospitals. In particular, patients are covered by the Medicare Agreement provisions for access to services on the basis of clinical need and the Charter of Patient Rights.

The legally enforceable requirement on the Operator to maintain accreditation provides some assurance regarding the quality of services provided. However, given the limitations of the other provisions regarding quality, the contract may not prove effective in ensuring desired service quality.

Quantity and price of services

Under the contract the Department sets the quantity of each type of service it wishes to purchase in the forthcoming year.

Although the Department can gradually reduce the quantities involved, the contract effectively guarantees an offer to purchase a minimum quantity of services each year, partially protecting the Operator from any adverse impacts of future changes in Government policy. This represents a risk to the State. Given current projections the risk is small, however, it is not possible to reliably predict the impact of possible changes in public policy affecting the role and coverage of the public health system and changes in medical technology over the lifetime of the contract.

Under the terms of the contract, the Department specifies a maximum payment amount each year that it will pay the Operator for services provided. This amount reflects the mix and quantity of services required and the price for different services agreed by the parties for that year (Figure 7).

The contract

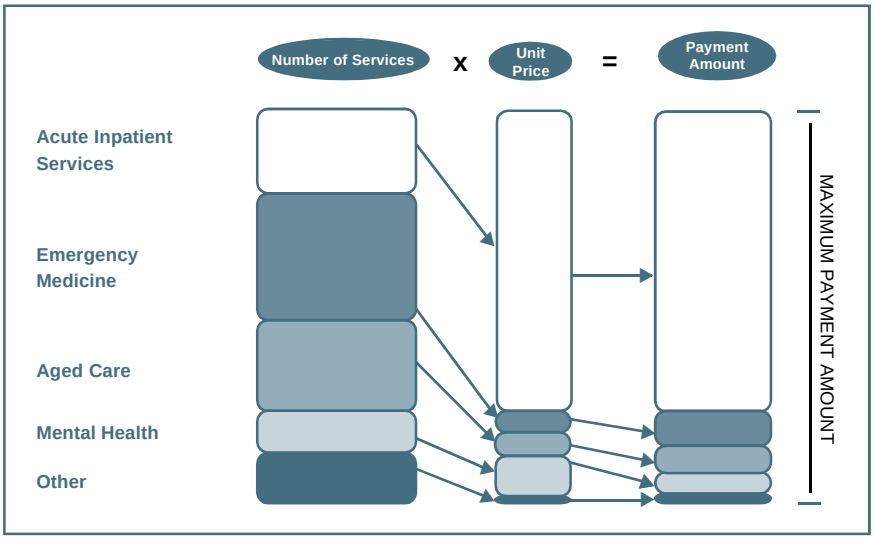

Figure 7: Relationship between the maximum payment amount and the mix, quantity and unit price of services[4]

The Department plans the type and quantity of services required, negotiates unit prices with the Operator, and controls the maximum payment amount.

Source: Contract and OAG

The Department pays for services actually provided, with the overall cost to the Department in that year controlled via the maximum payment amount. The Department can purchase additional services during the year, outside these arrangements, subject to the agreement of both parties.

Acute inpatient services represent the largest cost component. For these services the Department pays the Operator on a weighted basis which reflects the fact that inpatients' conditions vary widely in terms of complexity and severity. The complexity of a case substantially affects the resources required to treat it.

Other services are purchased in units of output which are not weighted for complexity. The contract contains a commitment to develop a payment system for these services similar to the weighting system used for acute inpatient services.

[4] Proportions in this diagram are based on indicative figures in the contract for the year following the opening of the Hospital.

The contract

Service prices are re-negotiated each year.

As one of its primary objectives, the contract states that demand for acute inpatient services above a baseload quantity (the estimated minimum need for services) should be met at a cost lower than at benchmark hospitals. Although this objective is set out in the contract, the wording is such that there is doubt that it is contractually binding.

The baseload quantity corresponds to approximately 135 beds. With approximately 220 beds available for acute public inpatient care, there is potential for the provision of substantially more services to public patients than is specified in the baseload quantity.

The potential for reduced unit costs to the State from the purchase of increased quantities of acute inpatient services under the contract arises for both the availability and service charges (Figure 8).

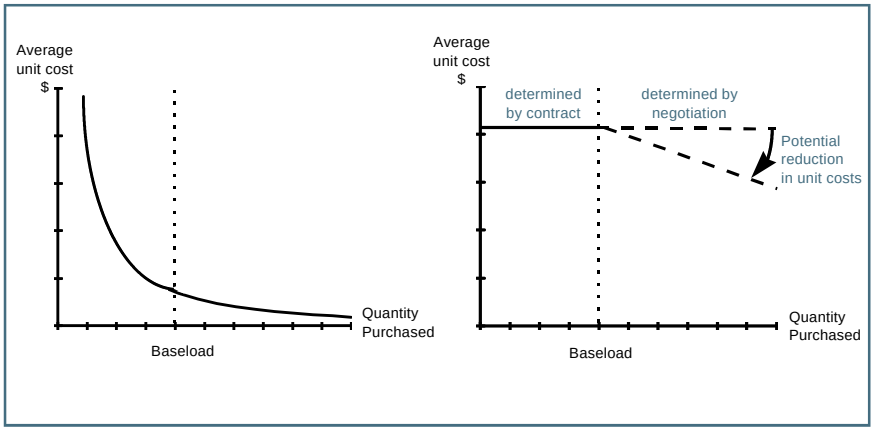

Figure 8: Effect of increased acute inpatient service quantities on the average unit cost of services

The purchase of increased quantities will reduce the average availability charge per unit of service. However, the average service charge per unit will only reduce if lower prices are negotiated for quantities above the baseload.

Source: Contract and OAG

The contract

THE POTENTIAL FOR REDUCED COSTS

The average availability charge per unit of service reduces with every additional unit purchased, representing a greater utilisation of the State's payments for the public component of the Hospital.

The service charge per unit is set by the contract up to the baseload quantity. For additional quantities, the contract indicates that the service charge should lead to lower unit costs. This is where the Department has an opportunity to negotiate the purchase of additional quantities at prices substantially less than those it pays for services up to the baseload quantity. However, net benefits to the State will only accrue if the prices agreed are lower than could otherwise be negotiated with an alternative provider.

To date the majority of services have been negotiated at benchmark prices. However, on occasions agreement has been reached that limited quantities of services would be conducted at less than the benchmark price. This illustrates the potential for the purchase of services at reduced prices but it remains unclear if this will provide savings relative to public sector provision as reduced prices have also been used when funding additional services at public hospitals.

The potential exists for the Department to negotiate substantial quantities of additional services at reduced prices to provide savings and to enable it to get better value from its fixed availability charge payments.

The contract does not stipulate, however, how much lower prices for additional quantities should be. Therefore the outcome will depend on the Department's success in negotiating reduced prices with the Operator.

For pricing acute inpatient services the contract defines the benchmark hospitals as the six metropolitan public non-teaching hospitals. To the extent that the Hospital treats a mix of acute inpatients with more serious conditions than the benchmark hospitals in a way that is not captured in the weighting system, the State may gain better value for its payments to the Operator. The Department believes that this will arise as the Hospital includes services such as intensive and coronary care whereas this is not (at least at present) the case for the benchmark hospitals.

The contract

The contract does not provide any direct savings in service prices from the potential for the Hospital to operate more efficiently than the benchmark hospitals due to the benefits of collocation, or due to benefits to the Operator in attracting patients and staff to the facilities for private patients. The Department is of the view that it is likely that the value arising from more serious conditions being treated in a way that is not reflected in the payment weighting system exceeds the potential benefits of collocation.

Control of acute inpatient services

The Operator has a financial incentive to influence admission, treatment and discharge patterns (Figure 9) in order to increase the proportion of more profitable treatments, and to:

- structure patient treatment to optimise the number and nature of episodes of care;
- code information from medical records to attract the highest possible prices; and
- discharge and transfer patients in a way that optimises profitability.

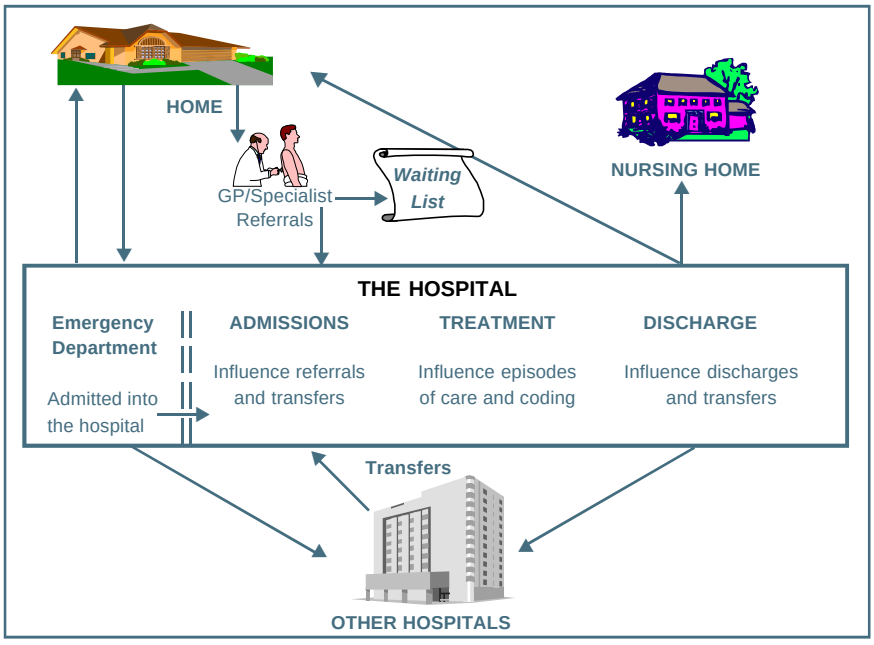

Figure 9: Opportunities to influence patient treatment at the Hospital
There are financial incentives for the Operator to influence admission, treatment and discharge patterns.

Source: OAG

The contract

The contract requires the Operator to provide appropriate care to patients requiring urgent or essential treatment. However, it does not contain a clear obligation on the Operator to provide elective surgery or other services up to the quantities sought by the Department. It is possible therefore for the Operator to seek to limit the quantity of services provided where, for example, the Operator considers it not to be in its commercial interests. In these circumstances patients would either go onto waiting lists or be treated elsewhere.

In a range of circumstances patients may be treated as a single episode of care or as multiple episodes attracting single or multiple payments respectively. Admission policies and classification of treatments as acute inpatient care rather than outpatient care could result in very different payments to treat the same condition.

The accuracy of payments for services delivered to acute inpatients depends critically upon accurate coding from medical records. Therefore, the Department needs to institute satisfactory controls to verify or validate the accuracy of clinically coded data which are submitted in support of the Operator's invoices for payment. Current coding structures allow a single episode of care to be coded in different ways. This provides considerable leeway for interpretation in the coding of complex medical conditions.

Reducing patients' length of stay in hospitals is a common trend associated with improved health technology, and can improve the overall efficiency and quality of health services to patients. Early discharge therefore can be an appropriate strategy where adequate community support is provided.

However, in order to minimise operational costs, without affecting the price received for services, there is a risk that the Operator might seek to discharge some patients inappropriately early. This practice could have a negative impact on the overall quality of care for the patients concerned and could increase the cost of community health services funded by the Department (Figure 10). It could also shift costs to Commonwealth funded General Practice services and to community members providing any additional care to the patient at home.

The contract

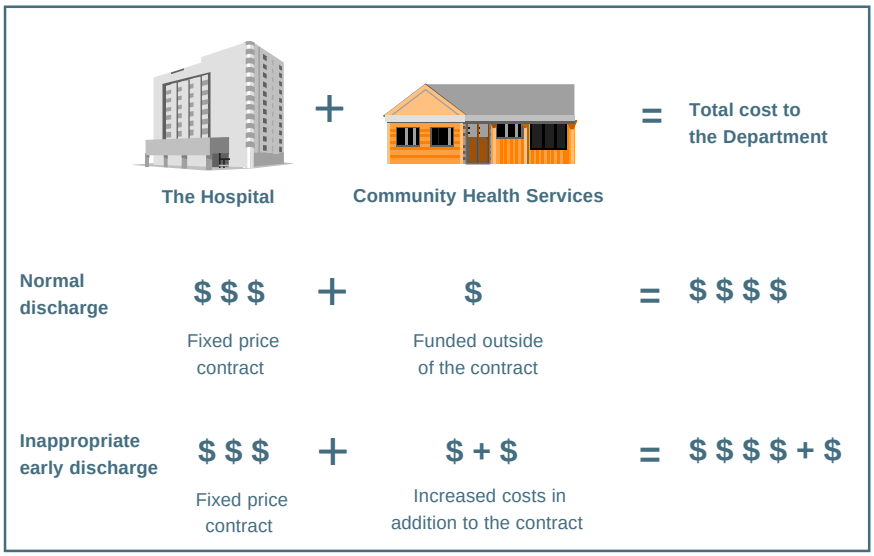

Figure 10: The effect of inappropriate early discharges on costs to the Department

Early discharges by the Operator can shift costs to community health services without affecting the prices paid under the contract. This would result in higher overall costs to the Department.

Source: OAG

Monitoring quality indicators and average lengths of stay at the Hospital may help to identify any instances of inappropriate early discharge, however the Department may also need independent clinical review processes to assess individual cases.

Although publicly operated hospitals may also seek to influence admission, treatment and discharge patterns to improve their financial position, the incentives are less pronounced than for a private operator required to maximise its financial return. Clinically inappropriate practices are therefore particular risks associated with the contract, which the Department needs to manage.

Although the Department does not have specific powers under the contract that would prevent such practices by the Operator, it is able to monitor them and bring pressure to bear to discourage such practices during price and volume negotiations for the subsequent contract year.

Selective treatment of patients and cost shifting are risks that the Department will need to manage.

Contract risks

The contract has a range of measures to protect the interests of the State including a range of legally enforceable undertakings given by the Operator to:

- comply with all applicable laws;
- permit visits and inspections; and
- keep proper records.

Various risks related to the facilities and service delivery are transferred to the Operator (Table 1).

Risks transferred to the Operator
■ Design, construction and commissioning including environmental and authority approval risks
■ Running costs including maintenance of equipment and facilities
■ Labour relations
■ Some market risks
■ Some public liability

Table 1: Examples of risks transferred to the Operator

Source: Contract and OAG

Although the majority of ownership risks rest with the State, where appropriate the contract provides for the transfer to the Operator of substantial risk in relation to the facilities. Risks associated with design, construction and commissioning are largely transferred to the Operator.

The direct risks to service delivery associated with labour relations and the risk of running costs exceeding those for the benchmark hospitals are transferred to the Operator, as is the potential benefit of achieving running costs below the benchmark.

Risks associated with insufficient public patients presenting for treatment are shared, low patient numbers could reduce benefits to both the Operator and the State. The State only pays for services delivered with a provision for a percentage increase in prices if services for public patients are below a baseload quantity.

The contract

Public liability risks for both the facilities and services have been shared but the contract makes provision for insurance to cover certain aspects of the State's public liability.

The transfer and sharing of risks with the Operator has the potential to represent a significant benefit to the State relative to the public sector alternative.

The previous sections of this chapter have identified the following additional risks to the State given the shift from public to private provision of services and facilities:

- reduced flexibility and lack of competition for new services and facilities;
- limited contractual control over the quality of services;
- fixed availability charge with limited control over service quantity;
- guaranteed offer to purchase a minimum quantity of services (although the minimum quantity can be gradually reduced);
- financial incentives for the Operator to influence admission, treatment and discharge patterns; and
- potential overpayments because of incorrect coding of treatments.

In addition, there are a number of inherent risks to the State in entering into a long-term contract with a private operator. These include non-performance of contractual requirements, a change of Operator ownership, Operator insolvency leading to loss of indemnity, and litigation between the State and the Operator.

These risks should be viewed in the context of the legally enforceable and therefore more onerous requirements placed on the Operator through the contract than apply to public hospitals.

While the State may benefit from a range of risks transferred to the Operator, additional risks relative to public sector provision of services and facilities may impact adversely on the State.

Beyond those identified here, there are undoubtedly a range of risks which the Department will need to manage. Some may not even become clear until the contract has been running for some time.

Tangible benefits of the contract

The contract is likely to meet the requirements of the 1995 Ministerial directives. Specifically, the contract should:

- lead to improved resource utilisation;
- support the underlying objectives of the Health System;
- protect or enhance the rights of individuals and their access to health care services; and
- meet Commonwealth Government requirements.

However, the extent to which the contract has been let on terms that are favourable for the State is less clear. This will ultimately be assessed in terms of the overall efficiency and effectiveness of the service delivery achieved by the Department through the contract. At this early stage in the life of the contract it is possible to assess in general terms both the tangible benefits and costs and the wider impacts of the contract. Given the Minister's directive to *encourage private sector involvement, on terms that are favourable for both public and private sector interests,* comparisons between what has been achieved through the contract relative to the public sector alternative warrant particular consideration.

The contract will result in the delivery of hospital services close to Joondalup residents and will involve payments over 20 years with a net present value that is expected to exceed $300 million. In addition to the range of risks transferred to the Operator and the additional risks relative to public sector provision of services and facilities, there are tangible benefits and costs of the arrangement relative to the public sector alternative (Table 2).

The contract

Benefits

- Claimed savings of $22 million relative to the public sector alternative
- The potentially lower costs for additional services
- Transfer to Government of the private component of the Hospital after 40 years at no cost
- Legally enforceable quality requirements
- Clear separation of responsibilities for purchasing and provision of services

Costs

- Additional costs in planning and developing the contract
- Staff transition costs – at least $1.1 million
- Reversion of the facilities for private patients extended from 20 to 40 years
- Opportunity cost of land for facilities for private patients
- Additional cost of private finance – $2 million

Table 2: Summary of tangible benefits and costs relative to the public sector alternative

As set out in the contract the overall balance of benefits and costs is indeterminable.

Source: Contract and OAG

According to the estimates used by the Department at the time of appointing the preferred proponent the overall bid was estimated to be $22 million below the public sector benchmark, $21 million of this associated with savings in relation to capital costs. Table 2 lists the claimed savings at $22 million, however there is no reliable estimate of the extent of any savings.

The net tangible benefits of the contract to the State relative to the public sector alternative are indeterminable. In terms of both services and the availability of the facilities, there is not reliable information to establish that the contract provides net tangible benefits to the State.

Wider impacts of the contract

The contract has introduced a private sector operator as a significant provider of hospital services to public patients in the metropolitan area. While some competition for funds and patients already exists between public hospitals, the introduction of private sector approaches to the management and delivery of hospital services may stimulate additional competition and efficiencies within the public hospital system.

The potential to establish new performance benchmarks against which public hospitals can be assessed may be achieved in terms of the prices agreed for additional services and the reporting of quality information. The use of cost data from benchmark public hospitals for the pricing of baseload quantities of acute inpatient services (as distinct from direct price bidding for services) limits the ability for benefits in this regard.

However, the linking of service charges under the contract to the operating costs of benchmark public hospitals adds a further stimulus for the Department to encourage those public hospitals to improve their cost efficiency.

The introduction of a private hospital providing relatively large quantities of services to public patients amongst the network of public hospitals creates new opportunities for co-operation and partnering between institutions outside the terms of the contract. Sir Charles Gairdner Hospital has already recognised this potential and has been involved in exploratory discussions. Public hospitals that seek to enter into co-operative relationships with the Hospital will need to plan carefully to ensure that the interests of the individual hospital and the public hospital system more generally are protected adequately.

The recent establishment of the Metropolitan Health Service Board with a focus on increasing co-operation and rationalising services across metropolitan public hospitals emphasises the need to clarify the basis of relationships between public and private providers of services for public patients.

The contract

While much has been done by the Department to develop and implement the contract, it remains to be seen whether it will deliver the tangible and wider benefits that have been identified.

Recommendations

The Department should apply the terms of the contract to seek to ensure that:

- **desired quality standards are achieved;**
- **prices paid for services reflect potential efficiencies in the facility; and**
- **the potential for selective treatment of patients, cost shifting and incorrect coding is minimised.**

In the absence of competition, the Department should take steps to help ensure that future new service types or upgrades to the Hospital are competitively priced, for instance by identifying meaningful benchmarks or developing reliable costs estimates.

Making the contract work

Key Findings

- ***The full potential benefits for the State will only be realised through consistent and skilful management of the contract.***
- ***The Operator is not required to report any performance indicators to Parliament that have been subject to independent audit — the Department will need to develop suitable mechanisms to report publicly on the services involved.***
- ***There continues to be some uncertainty as to the organisation split of purchaser and provider roles within the health portfolio, and this may be accentuated by recent proposals to shift the management of the contract from the Department.***

Contract information

The contract requires the Operator to provide a range of information to facilitate the Department's monitoring of performance.

The Hospital is not required to report performance indicators for public patients which are subject to audit by the Auditor General. Regular public reporting by the Department, therefore, is essential to enhance accountability for its management of the contract, and help Parliament and the community to judge whether the benefits that the Department expects are being delivered over the period of the contract.

This reporting will need to detail annually:

- the outcome of negotiations with the Operator;
- the Operator's performance in delivering services to public patients; and
- key performance indicators for the Department's role in purchasing services under the contract consistent with reporting for public hospitals.

To minimise the risks in the contract, the Department should be seeking to ensure that services are delivered in accordance with the requirements of the contract, and that it is paying only for services actually delivered.

Making the contract work

The Department receives monthly invoices from the Operator which are supported by details of the services provided. The Department checks these against the contract, against other information supplied by the Operator and, in the case of transfers between hospitals, other hospitals' records. However, to date, the Department has not instituted a means of routinely verifying, independent of the Operator, that the services they are paying for have actually been provided.

The contract allows the State to appoint an independent auditor to audit non-financial records in relation to the Operator's performance under the contract and the basis for payments.

Given the risks, the Department will need to establish an independent process to audit the Operator's records in support of invoices on a routine basis.

Contract disputes and termination

To a large extent, the successful management of the contract will depend on the two parties negotiating in good faith. In recognition that such negotiations will not always result in agreement between the respective contract managers, the contract includes comprehensive dispute resolution procedures. These indicate that the parties wish to work in partnership in order to resolve areas of disagreement and minimise the risk of contract litigation.

In the event of an unremedied contractual default by the Operator, the State can terminate the contract. In these circumstances the State can choose, subject to conditions relating to settlements for the assets involved, either:

- to take over the whole facility to provide health services;
- to take over the facilities for public patients to provide health services; or
- to abandon the facilities for public patients with the Operator having a right to occupy these facilities.

In the circumstances of a default by the Operator, the contract requires the Operator to indemnify the State for all reasonable costs arising from the default. Where the reason for the default is the Operator's insolvency, the State carries the risk that the Operator will be unable to pay the indemnities in full.

If a default by the State leads to termination of the contract by the Operator, the State is required to take over the whole facility and pay the Operator compensation.

The contract's dispute and termination clauses reduce the prospects of litigation by providing comprehensive dispute resolution procedures.

Responsibilities for managing the contract

The contract requires that the State assigns the role of its contract manager to a named individual. The contract manager is supported by a small team and reports to a steering committee, which comprises senior representatives of the Department's Operations and Mental Health Divisions. Should it be required, the contract manager also has access to legal advice.

Although good practice suggests that the nominated contract manager should have been party to contract negotiations and in post before the contract became effective, the Department did not appoint its first nominated contract manager until July 1996. Because of other commitments, the manager did not fully take up post until October that year, and resigned four months later. The current post-holder took up the post in February 1997.

The present contract manager has relevant experience, previously having been responsible for managing a contract for the purchase of public patient services from a private provider. The steering committee also has relevant expertise. It includes individuals who have responsibility for managing the purchase of services from public hospitals and the individual who had the lead responsibility for developing the Joondalup Health Campus project and contract.

Making the contract work

There was initial uncertainty as to which Government agency – the Department, the Wanneroo Health Service or the Lower North Metropolitan Health Service – would be responsible for administering the contract, before it was decided that the Department should have the responsibility.

The Government has subsequently announced its intention to transfer responsibility for the contract to the new combined North Metropolitan Health Service in conjunction with the establishment of the Metropolitan Health Service Board. This proposal highlights uncertainty as to purchaser and provider roles in the new structure. To the extent the North Metropolitan Health Service has a primary role as a service provider, the Health Service could face confused responsibilities when involved in decisions which affect the allocation of resources for the Hospital and Osborne Park Hospital.

There is a need to develop clearly defined responsibilities and accountabilities for the public sector's role in relation to services provided under the contract.

The Joondalup Health Campus project has highlighted a number of other accountability issues. The tabling of the bulk of the contract and a number of related documents in Parliament soon after it was signed is a positive contribution to accountability as it opened the decisions involved to public scrutiny.

The contract has been structured so that it is evident that the Minister and Department remain accountable for the provision of services to public patients. Under the terms of the contract the Minister has access to any information required for performance of Ministerial duties including the answering of questions in Parliament. Given the nature of the contract, it might be expected that the scope of the Minister's responsibilities encompass issues related to the effectiveness of services provided to public patients and the value for money achieved. In general, the Minister would not be expected to be accountable for the efficiency of the Operator.

A strategy for managing the contract

The extent to which the contract will deliver net benefits depends critically upon whether the Department:

- through its management of the contract, succeeds in minimising the impact of the additional risks; and
- is able to negotiate each year substantial quantities of additional services at prices that are lower than the costs of equivalent services being provided by an alternative provider.

In the first year of the contract, the Department has slowly established a contract management function. It is important that the Department document a strategy and procedures for managing the contract to ensure consistency and continuity over the term of the contract. This is necessary to ensure that over the life of the contract:

- key risks are addressed;
- key controls are identified and exercised properly;
- the Department acts consistently in its dealings with the Operator; and
- changes in personnel do not disrupt the effectiveness of the contract management function.

The Department has developed a contract management manual for public hospitals and has commenced the process of adapting this manual with the intention of providing comprehensive performance monitoring and management strategies for the Joondalup contract.

To be in a position to address the risks involved in the contract the Department needs to undertake an immediate risk analysis of the contract, and should periodically update this analysis as part of its ongoing management of the contract.

Recommendations

The Department should report publicly on:

- **the Operator's performance in delivering services to public patients;**
- **the outcome of any negotiations with the Operator; and**
- **key performance indicators for the Department's role in purchasing services under the contract**

in a way that enables comparisons over time.

The Department should establish an independent process to audit the Operator's records in support of invoices on a routine or sample basis.

The Department should review and clarify organisational responsibility for management of the contract to address potential confusion of responsibilities if managed by the North Metropolitan Health Service.

The Department should develop, document and implement a risk based contract management strategy. It should undertake an immediate risk analysis of the contract, and periodically update this analysis as part of its ongoing management of the contract.

Performance Examination Reports

	Tabled
1995	
Legal Aid Commission	April 5, 1995
Police Department Operations Centre	May 4, 1995
Management and Control of Minicomputer–based Systems in Western Australian Government Agencies	May 23, 1995
Management of the Public Bank Account Investments	August 23, 1995
Value for Money in TAFE	August 30, 1995
Public Sector Travel Corporate Card Cabcharge Facilities	September 19, 1995
Hospital Emergency Departments	November 1, 1995
Contracting for Services	November 22, 1995
Public Dental Services	December 6, 1995
1996	
Improving Road Safety	May 1, 1996
The Internet and Public Sector Agencies	June 19, 1996
Under Wraps! – Performance Indicators of Western Australian Hospitals	August 28, 1996
Guarding the Gate – Physical Access Security Management within the Western Australian Public Sector	September 24, 1996
For the Public Record – Managing the Public Sector's Records	October 16, 1996
Learning the Lessons – Financial Management in Government Schools	October 30, 1996
Order in the Court – Management of the Magistrates' Court	November 12, 1996
1997	
On Display – Public Exhibitions at: The Perth Zoo, The WA Museum and The Art Gallery of WA	April 9, 1997
Bus Reform – Competition Reform of Transperth Bus Services	June 25, 1997
Get Better Soon – The Management of Sickness Absence in the WA Public Sector	August 27, 1997
Waiting for Justice – Bail and Prisoners in Remand	October 15, 1997
Public Sector Performance Report 1997	November 13, 1997

On request these reports may be made available in an alternate format for those with visual impairment.