ANZSOG CASE PROGRAM

On Solid Ground? Using a Public Private Partnership to build a new flagship hospital in Adelaide

2019-205.1

Kevin Foley was a worried man. It was November 2008 and the South Australian State Treasurer had been advised that there might not be funds available globally to build the New Royal Adelaide Hospital. The reputational stakes for South Australia were high. The new hospital would be one of the most expensive buildings being constructed anywhere in the world at that time.[1] It presented an opportunity for the State to provide international leadership in health facility design.

The decision to use a Public Private Partnership (PPP) to procure the new facility would also test the ability of a small provincial government to generate commercial appetite for its flagship project and to use that mechanism to deliver value for money for its taxpayers. For that to happen, the developers would need to access international capital markets. But as the value of the Australian dollar plummeted following the Lehman Brothers' collapse, and the Global Financial Crisis (GFC)[2] accelerated, he was disconcerted to hear that those funds might have dried up.

At the same time, political pressure over the idea of a new hospital showed no signs of abating. The use of the PPP procurement method was working as a sub-issue allowing the project's opponents to attack it.

[1] https://www.abc.net.au/news/2017-01-24/new-royal-adelaide-hospital-all-you-need-to-know/8206416

[2] The Global Financial Crisis was described by the Reserve Bank of Australia as the deepest recession since the Great Depression in the 1930s for the major advanced economies while "…financial markets became dysfunctional as everyone tried to sell at the same time and many institutions wanting new financing could not obtain it." https://www.rba.gov.au/education/resources/explainers/the-global-financial-crisis.html

This case was written by Tim O'Loughlin, Carnegie Mellon University Australia, with input from Helen Galindo, for the Australia and New Zealand School of Government. It has been prepared from field research and published materials for educational purposes. Cases are a narrative account of events and do not constitute an evaluation of a situation. Views expressed by individuals or organisations are included to highlight issues and are not necessarily those of the author or ANZSOG. The assistance of Kevin Foley and David Panter is appreciated, but ANZSOG is responsible for the final contents. While care has been taken to ensure accuracy at the time of publication, subsequent developments may mean that certain details have since changed.

A new hospital for the capital of South Australia

The genesis of the new hospital began in 2002, when Lea Stevens (Minister for Health for the recently elected Labor government) appointed the Generational Health Review Committee 'to develop a framework to guide the South Australian Health System over the next 20 years.'[3]

The committee's report, delivered the following year, found that, 'on a per capita basis South Australia spends more money, and has higher utilisation rates, more health professionals and more beds than other states and territories.'[4]

South Australia was spending 3.7% more on the health per person than the national average and had 3.4 hospital beds per 1000 population compared to the national average of 2.8. Spending on health consumed 24% of the state budget, a level that the review committee considered unsustainable for a state with 12% lower per capita income than the Australian average. They also found that South Australians had hospital utilisation rates 15% higher than the national average. The reasons included South Australia's relatively old population and the suggestion of supplier-induced demand[5] being greater in South Australia than in other states.

The large number and geographical distribution of Adelaide's hospitals was a product of both population-based demand and political considerations which prioritised local access to services. These factors were also largely responsible for the proliferation of more than 70 statutory hospital and health unit boards, each looking after their own territory, resulting in duplication of specialist care. This had safety implications, with clinicians in the smaller units getting less procedural exposure, leading to increased risk of error and adverse events[6]. The Generational Health Committee concluded in 2001 that 'significant system reform' was required and made a series of recommendations to develop a more coordinated approach to healthcare provision in South Australia.

Over the next year, further research within SA Health[7] confirmed the findings. Public health costs were increasing at 7-9% per annum. It was estimated that, if spending continued to grow at this rate, SA Health would be consuming the entire State Government's budget by 2032.[8] Almost all the expense came in the form of operating costs, driven by increasing demand for, and cost of, health care. This exacerbated the pressure on capital expenditure (capex) required to maintain hospital infrastructure and to support innovation and service delivery redesign that might contain costs.[9]

The Generational Health Committee's review was the foundation of the South Australia Health Care Plan 2007-2016[10]. It set out the service reconfiguration and the infrastructure developments needed to turn the situation around, including construction of a flagship new hospital. It would be the most significant single investment in health care in South Australia's history.

Infrastructure investment

South Australian public finances had taken a battering from the collapse in asset prices in the late 1980s, but by 2004 had recovered to the point where the state's AAA credit rating had been restored. With operating surpluses now re-established in the Forward Estimates, the government had started to renew the state's infrastructure including hospitals.[11] Rebutting the Opposition's criticisms of financial profligacy, Treasurer Foley was fond of quoting the

[3] Menadue, J. L. and South Australian Government 2003 South Australia. Generational Health Review. and. Department of Human Services. Better choices, better health: final report of the South Australian Generational Health Review Dept. Human Services Adelaide 2003 http://www.health.sa.gov.au/sahealthreform/Portals/57ad7180-c5e7-49f5-b282-c6475cdb7ee7/GHR_Main_Report_WEB.pdf p. iii.
[4] Ibid, p.5.
[5] Richardson JR, Peacock SJ, (2006), 'Supplier Induced Demand', *Applied Health Economics and Health Policy* 5(2), pp.87-98.
[6] SA Generational Health Review, 2001 p.11.
[7] SA Health is the entity comprising the Minister's department and all public health delivery services. It is the largest employer in South Australia with some 40,000 staff.
[8] Government of South Australia 2012 SA Health's Response to the Hospital Budget Performance and Remediation Reviews Safe, Quality, Affordable Health Care.
[9] These included design factors that decreased length of stay and reduced hospital-acquired infection.
[10] Government of South Australia. 2007. *South Australia's Health Care Plan 2007-2016*. 2007.
[11] The *Strategic Infrastructure Plan – Building South Australia* (2005) included economic and social infrastructure projects including prisons, schools and hospitals.

international rating agency Standard and Poor's analysis of South Australia: 'Given the strength of the state's balance sheets, they can well afford to pursue their capital expenditure programs.' [12]

The investment in a newly-built public hospital servicing Central Adelaide was to be the flagship project for the State's social infrastructure investment program. It was sorely needed as the existing hospital, the Royal Adelaide, was 150 years old and showing its age. Wards had been designed in a different era for a different model of health care, one more focused on the needs of staff rather than patients. For instance, patients were often moved through the hospital in their ward beds many times during an admission. Furthermore, existing buildings were in a sorry state as maintenance had been neglected by successive governments during the lean years.

Frustrated with repeated requests for large injections of capex for the Royal Adelaide Hospital, Treasurer Foley and the new Minister for Health John Hill agreed something had to be done. Foley commissioned external advice comparing the capex needed to fully upgrade the existing hospital to 21st century standards with the cost of building a brand-new hospital on a site within, or close to, the inner city. The advice from consultants KPMG confirmed a greenfield site as the best option. An important consideration was time: rebuilding the Royal Adelaide Hospital would take an estimated 15 years, with endless disruption to services, while a new hospital could be built in 6. Premier Mike Rann announced the project in June 2007 with an initial projected cost of AUD$1.6 billion.[13] But as private finance became harder to find, it looked like the new hospital project delivered as a PPP could be in danger.

Procurement options

Foley had always been open about his preference for using PPP for the hospital project:

> 'What I like about a PPP is that you get a degree of fiscal rigour. You get a degree of transference of risk so that the price of risk is transferred to the private sector. The issue of cost overruns and error, in terms of estimating and delivering a project, that risk is transferred to the private sector.'[14]

The government had no recent experience of managing a hospital project on this scale. Foley was therefore attracted to the procurement method which he saw as offering allocation of construction risks, particularly that of overspend, to the private sector, albeit at a price. In preferring this option Foley was also conscious of South Australia having little experience with this form of project delivery, unlike Australia's largest state governments which were world leaders in PPP design and application.

Before the Global Financial Crisis, evidence both from Australia and the UK seemed to support his preference. Both countries had experienced some spectacular PPP failures. However, the overall case for using PPPs was becoming more compelling as its use matured in both jurisdictions. In the UK, the National Audit Office had reported a greater percentage of Private Finance Initiative (PFI) projects – the UK equivalent of PPPs – coming in on time and on budget.[15] Likewise, a 2008 National PPP Forum Benchmarking study conducted by the University of Melbourne[16] confirmed construction cost and time outcomes for 25 PPPs had outperformed 42 comparable traditionally-procured projects from contract signature to delivery in terms of cost control and timeliness.

Nevertheless, even before the escalation of financial risk due to the GFC, the use of PPPs was not a 'done deal' in South Australia. Foley had been on the front foot in answering questions in the Parliament about how the hospital project would be managed:

> 'The departments of Health and Treasury and Finance will commence the process by establishing a project team to commence with the development of the PPP business case, drawing on external expert assistance if required. The business case identifies the key elements of what would be required to establish a successful PPP contract, including:

[12] Forward Estimates Committee, Hansard-4-162, p.71.2007.
[13] This initial costing was revised several times before the project was procured.
[14] Forwards Estimates Committee, Hansard-4-162 2007, p77.
[15] 'PFI: Construction Performance' Report by the Comptroller and Auditor General. HC 371 Session 2002-2003: 5 February 2003 https://www.nao.org.uk/wp-content/uploads/2003/02/0203371.pdf
[16]'National PPP Forum – Benchmarking Study, Phase II: Report on the performance of PPP projects in Australia when compared with a representative sample of traditionally procured infrastructure projects' Duffield, C 2008, accessed 13 May 2018 http://infrastructureaustralia.gov.au/policy-publications/publications/files/PC_Submission_Attachment_K.pdf

- reviewing precedent hospital PPPs in Australia and overseas to identify current best practice in delivering hospitals through a PPP arrangement;
- refining the project scope and expected capital and lifecycle costs;
- defining the services to be deliverable by the private sector, including hospital accommodation and infrastructure services in the form of an output specification;
- developing a preliminary risk allocation between the public and private sector to identify the key risks that may be managed by the private sector;
- identifying the key performance criteria for the PPP operator;
- completing the final model for the project, which would be applied as the project benchmark should it proceed as a PPP, and to identify the potential value for money from a PPP delivery based on the risk assessment.'[17]

This was conventional PPP methodology as defined by the Australian Government's National Public Private Partnership Guidelines[18] and endorsed by Infrastructure Australia as well as by all State, Territory and Commonwealth Governments. Most importantly, the project methodology was not to be confirmed as a PPP until value for money had been established.

Scoping the project

The project team for the new hospital – led by David Panter, Chief Executive Officer for Central Northern Adelaide Health Service – focused on developing a theoretical design-and-build 'Master Plan'[19] which would be used for cost comparison against private sector bids. The plan was drawn up by MAAP Architects,[20] specialists in health facility design.

The project team's recommendations were reviewed and endorsed by a Steering Committee whose membership included the chief executives of the Departments of Health, Infrastructure and Treasury as well as the Crown Solicitor's Office. In December 2007, Cabinet approved development of the project as a PPP providing value for money was secured. The next stage was to develop the project brief and contractual documentation, incorporating the information from the business case and feedback from stakeholders. Officials, including Panter, and Ministers Foley and Hill, had previously visited overseas facilities built under PPP arrangements, both to reassure themselves about private sector delivery and to seek inspiration about what might be possible.

The development of the Master Plan refined the scope of the project and the deliverables for hospital environmental standards, accommodation and services that were required. These were expressed in the form of output specifications to encourage innovation from the private sector bidders in determining inputs. A first draft of the Master Plan was released in August 2008 for community and stakeholder feedback. It reflected the project's aspirational objectives, including commitments to "a very high quality patient environment, low energy and ecologically conscious design.'[21]

According to standard tender processes for PPPs in Australia, following the release of the Master Plan, an expression of interest would be issued to the market. This was delayed for several months as a result of the uncertainty created by the GFC.

Foley had invested considerable political capital in promoting a PPP as the preferred procurement method for building the new hospital. Now the GFC was making it increasingly hard, if not impossible, for the construction and services operators to find the private equity and debt finance they would need to bid for the project.

The private advice coming to Foley was to remain firm and by March 2009, it appeared that Australia was escaping the worst effects of the GFC. The Government decided to test the market response. The acquisition plan for the new hospital PPP project was approved by the State Procurement Board in May 2009 and a tender for Expression of

[17] Forwards Estimates Committee, South Australian Parliament Hansard-4-162, 2007 p.75.
[18] Department of Infrastructure and Regional Development. 2008. *National Public Private Partnership Guidelines* Australian Government. https://infrastructure.gov.au/infrastructure/ngpd/files/Overview-Dec-2008-FA.pdf
[19] The Master Plan is also referred to as the Reference project and is the basis for the Public Sector Comparator.
[20] MAAP Architects is a UK-based firm that David Panter had worked with on UK health projects prior to his arrival in South Australia.
[21] MAAP architect, Mungo Smith, https://www.maaparchitects.com/royal-adelaide-hospital-masterplan

Interest was released in July that year with three shortlisted respondents considered capable of delivering the project announced in November 2009.

During this period, Treasury continued to consider options for the project procurement to be brought back closer within government. Specifically, a case was made for using the more traditional method of Design, Build, Operate and Maintain. It was said to have two advantages. First, it would reduce the risk of finance not being available as a AAA-rated government should be in a stronger position to raise capital than private sector entities. Second, even if the finance could be found privately, the cost of raising it under the PPP option could be prohibitive for both the government and taxpayers.

Some consideration was given to the option of the Government lending AUD$1.5 billion (almost the entire cost) to the private provider itself. Foley described this as 'mind bending', as it brought into question why the PPP approach had been chosen in the first place. He dismissed this option on the basis that he thought it would not withstand scrutiny from the Auditor General.[22]

In the event, finance was found by all three bidders who were shortlisted from the EOI. The eventual winner had 25 separate banks stitch together sufficient funds for their bid.

Risk transfer and value for money

As Foley had reminded parliament on more than one occasion, PPP methodology is proposed as a mechanism to deliver governments with better value for money than traditional government direct procurement. Essentially the private sector is engaged to make defined services available for a fixed period and receives annual payments from government for providing that service. In the case of the hospital, these services were making the facility available and maintaining it to a specified standard. The government was to retain responsibility for the provision of clinical services.

Deciding whether the public or private sector would deliver best value for money requires estimating the government's cost of delivering the service and comparing it with that of the private sector. For this project, this estimation would be based on the cost of Master Plan plus a premium representing the assessed cost of the material risks involved with the project.

Calculating value for money requires allocating each of the component risks to the public or private sectors. This allocation is decided on the basis of an assessment of which sector is best-placed to manage each specific risk. The cost to government of both the assessed cost in the Master Plan and the risks to be retained by government is cash-flowed over the concession period and then converted into a single net present value. This value is then compared to quotes received from the private sector and an assessment made of which of the delivery alternative which provides government with the best value for money. The general methodology used is elaborated in Appendix A.

The effectiveness of the transfer of the usual risks associated with the costs and timelines for delivery of the hospital would be debated long after the hospital commenced operating in September 2017. However, at the time the project was presented to the market, the government faced a different set of risks created by the highly-charged political environment in which the case for the hospital and its delivery as a PPP was being prosecuted.

Foley was also the State's Minister for Industry, Investment and Trade. He was acutely aware of the political dangers of any investor perceptions of the government itself being a risk. The spectre of sovereign risk threatened to add a risk premium to the bids from the private sector, making the achievement of value for money even more difficult. Equally important was the potential for such perceptions to spill over into investor perceptions of the state more generally.

South Australia had long prided itself on the attractiveness of its investment climate for investors, partly in response to its historic difficulty in attracting capital investment in the same proportion to the other mainland states. Labor Governments were particularly vulnerable to perceptions of failing to attract investment capital and Foley was determined to keep shoring up the Government's reputation in this area. In this context, he was particularly sensitive to any suggestions of sovereign risk. He told Parliament:

> 'The Leader of the Opposition is, of course, on the public record as saying that if he gets into government, he will seek to renegotiate a contract. The sovereign risk element of that is enormous, and the risk that puts to

[22] Interview conducted with former Treasurer, Kevin Foley, on 18 April 2018.

> our state's financial position is enormous. That was one of the most reckless things that any opposition leader or shadow treasurer could say.'[23]

Foley pointed to the financial penalties for renegotiating a contract[24] and defended committing taxpayers to long-term expenditure by pointing to the benefits future generations would enjoy.[25]

In the case of the new Royal Adelaide Hospital, the publication of the Master Plan in August 2008 gave the public more access to details of the proposed new hospital, and opposition began to intensify. The fact that it was a new hospital had never been secret, but now it became prominent.

Taking on health reform is always risky for governments. Highly educated and articulate, clinicians speak with authority when it comes to public healthcare and can be expected to protect their specialities. The plethora of statutory hospital and health unit boards in South Australia allowed many of these clinicians to gain skills in management and policy roles. Thus, they were no strangers to the political discourse. As Foley later joked, 'put 100 medical experts in a room and you will get 100 expert opinions – all of them different'.[26]

Research on staff practice required for the Master Plan had been gathered through a program of consultation over eighteen months. It had involved over 400 doctors, nurses and allied health professionals from the existing Royal Adelaide and the Queen Elizabeth Hospital – a large general hospital located in the suburbs to the west of the city. When the resulting proposed Model of Care for the new hospital was announced by Health Minister John Hill in November 2008,[27] it was presented as the result of a highly consultative approach. The plans delivered by the preferred provider had to achieve the model.

Later, as they worked towards financial close,[28] the project team ran workshops with the preferred provider and clinicians to review the plans. These followed strict protocols to ensure that Panter, as the Project Director, was the only person who could sign off on any alteration to the plans.[29] At this stage disagreements between some clinicians and the government were supressed by commercial-in-confidence privileges that surrounded the negotiations. In this way, the PPP had effectively placed a lid on some of the controversy. The flipside was that it would inadvertently contribute to the escalation of the political debate in the public arena.

In the first years of South Australia's Health Care Plan 2007-2016, measures such as the rationalisation of over 70 statutory hospital and health unit boards into five administrative regions were achieved. It was when the reform started to affect specific service delivery that clinicians began to re-act and the closure of the Royal Adelaide hospital became one focus of resistance to change. As the project developed, it became more apparent that not everyone agreed a new hospital was the answer and dissent flared.

Minister Hill had anticipated this eventuality. Mindful of the longstanding rivalry between the two tertiary hospital sites, the Royal Adelaide Hospital and the Queen Elizabeth Hospital, he sought to defuse resistance by a change of name. When the new hospital was announced by Premier Rann in 2007, it was named the Marjorie Jackson-Nelson hospital to honour the then-State Governor and to provide, 'a way that the two institutions could come together on neutral territory'.[30]

But local media – who had delighted in the headline writer's gift, 'Taj Marj' – rallied behind the launch of a 'Save the RAH' campaign in January 2009. Coverage of the campaign was extensive and led to Governor Jackson-Nelson asking for her name to be removed from the project.[31] The subsequent news that the new facility would retain the Royal Adelaide Hospital brand only added fuel to the fire. The 'Save the RAH' campaign was led by Jim Katsaros, a surgeon and Director of the Department of Plastic and Reconstructive surgery at the RAH. The campaign insisted the old hospital should be preserved, 'where it is … rebuilding rather than relocating, improving mental health and country

[23] Forwards Estimates Committee, Hansard-4-162 2007 p.80. The Leader of the Opposition did not accept that this was a correct representation of his views.
[24] Ibid.
[25] Interview with Kevin Foley op. cit.
[26] Foley interview op. cit.
[27] South Australia, House of Assembly Debates 11-2799 11 November 2008, Hansard, p. 808.
[28] Financial close refers to the point in the project where the contract is signed by both parties.
[29] Unpublished interview with Dr. David Panter 11 December 2017
[30] Hill, J 2016 On Being a Minister Wakefied Press ISBN 9781743054154
[31] Up until this point, the new hospital had always been referred to as the Marjorie Jackson-Nelson hospital

services, building on the strength of the hospital and the Frome Rd facilities, fixing the mismanaged health system.'[32] The 'Save the RAH' campaign also launched an independent single-issue party in February 2010. In the 2010 State election, it ran candidates in 11 of the 47 lower House seats, including nine doctors.[33]

With a state election fast approaching in March 2010, the political risk to the government intensified. The New Royal Adelaide Hospital threatened to become a vote loser for the Labor party in a tight 2010 election contest. 'The name was never road tested … and the hospital itself had become a net negative for the 2010 election campaign … we couldn't believe it' explained Kevin Foley.[34]

Despite the controversy, the Government scraped home to win, albeit with a swing against it of more than 8%. It also lost the seat of Adelaide in which the hospital was located, where the swing was 14.5%.[35] The 'Save the RAH' campaign failed to gain traction with the voters achieving less than 1% of the vote across the State, possibly because the Liberal Party had committed to stick with the old site.

After the election, the Labor government pressed on with the new hospital project, announcing ProjectCo as the preferred provider in November 2010. State-funded work on the site began in February of the following year. Financial close was finally achieved on 6 June 2011, and work commenced. Construction continued for the next six years, and the new Royal Adelaide Hospital finally opened its doors on 5 September 2017.

The opening was sixteen months later than the first official opening date and followed months of often bitter dispute between the public and private partners. The project subsequently moved into the Operate and Maintain phase, but the benefits of the New Royal Adelaide Hospital remained highly contested. Moreover, it would take years of operating experience would be needed before a proper assessment of value for money could be made.

Even then, a final conclusion would be impossible as no-one could ever know with certainty what a project delivered as a PPP would have cost if had been delivered via conventional procurement. Recent calls for the assessment of procurement options to be broadened beyond the Value for Money criterion alone presented further complications.[36] These calls reflected the argument that complex projects often have significant risks that are most efficiently managed collectively, rather than by allocation to either private or public party.[37]

Epilogue

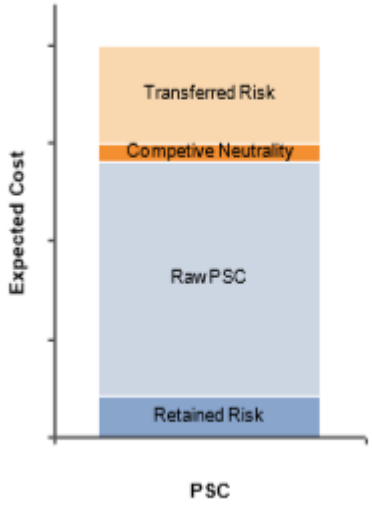
Later, Foley reflected on the unusual mix of issues created by the decision to build a new hospital using a PPP to deliver it: "It felt like we were bouncing between global financing issues and the most local of political issues. It was self-evident that the Government would have to manage the political issues. I remember Jim Katsaros being reported as asking the people of the state to take ownership of the issue[38]. That may have been partly a reflection of the use of a PPP putting some distance between the project and its opponents. It could have been a factor in some of the clinicians taking their case directly to the people but no-one can tell for sure. I guess the overall conclusion is that procurement matters, not just for the normal reasons of cost and efficiency. The process has a political impact which has to be managed."[39]

[32] Save the RAH Mission statement 2010 http://savetherah.blogspot.com/
[33] In the event, the party was never a credible threat, receiving only 0.55% of the state-wide vote and 0.97% for the Legislative Council.
[34] Foley interview op. cit.
[35] Megarrity L 2010 The South Australian election 2010. Parliament of Australia. Parliamentary Library https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/BN/0910/SAElection2010
[36] PwC Australia (November 2017). 'Reimagining Public Private Partnerships'. Place of publication, p. x.
[37] Ibid.
[38] "Minor parties, big ambitions" The Advertiser February 3 2010.https://www.adelaidenow.com.au/archive/news/minor-parties-big-ambitions/news-story/f240258d6879dbcbd2c2805b4102730e
[39] Foley interview op. cit.

APPENDIX A: PUBLIC PRIVATE PARTNERSHIPS: ASSESSING VALUE FOR MONEY

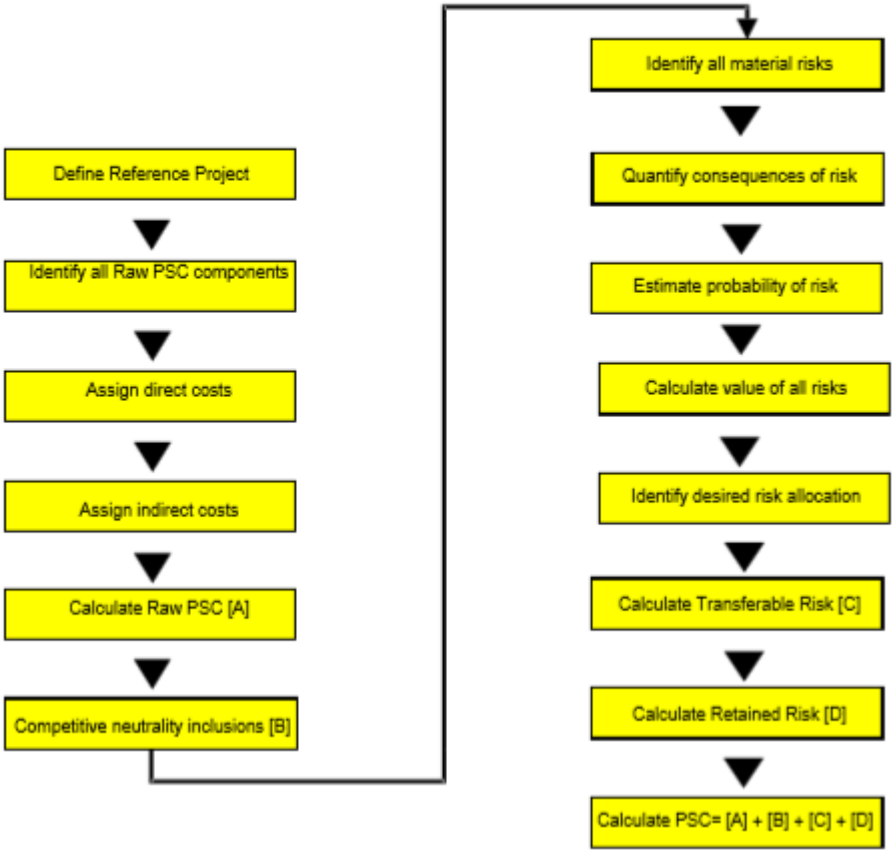
A key assessment in deciding to use a PPP is whether it will deliver government value for money. The following is a selection of excerpts from guidelines issued by Infrastructure Australia in 2008.The first stage is deciding on the preferred procurement method. The process is summarised in the following diagram:

Assuming that PPP emerges as the preferred method from this process, it is then necessary to establish the price at which it presents value for money for the government. The standard method for making this assessment is to construct a Public Sector Comparator (PSC). According to the Guidelines “the PSC is an estimate of the hypothetical, risk-adjusted whole-of-life cost of a public sector project if delivered by government” (P.40) Its components are set out as follows:



The general method for calculating the required data follows[40]:

Figure 2-2: The PSC development process

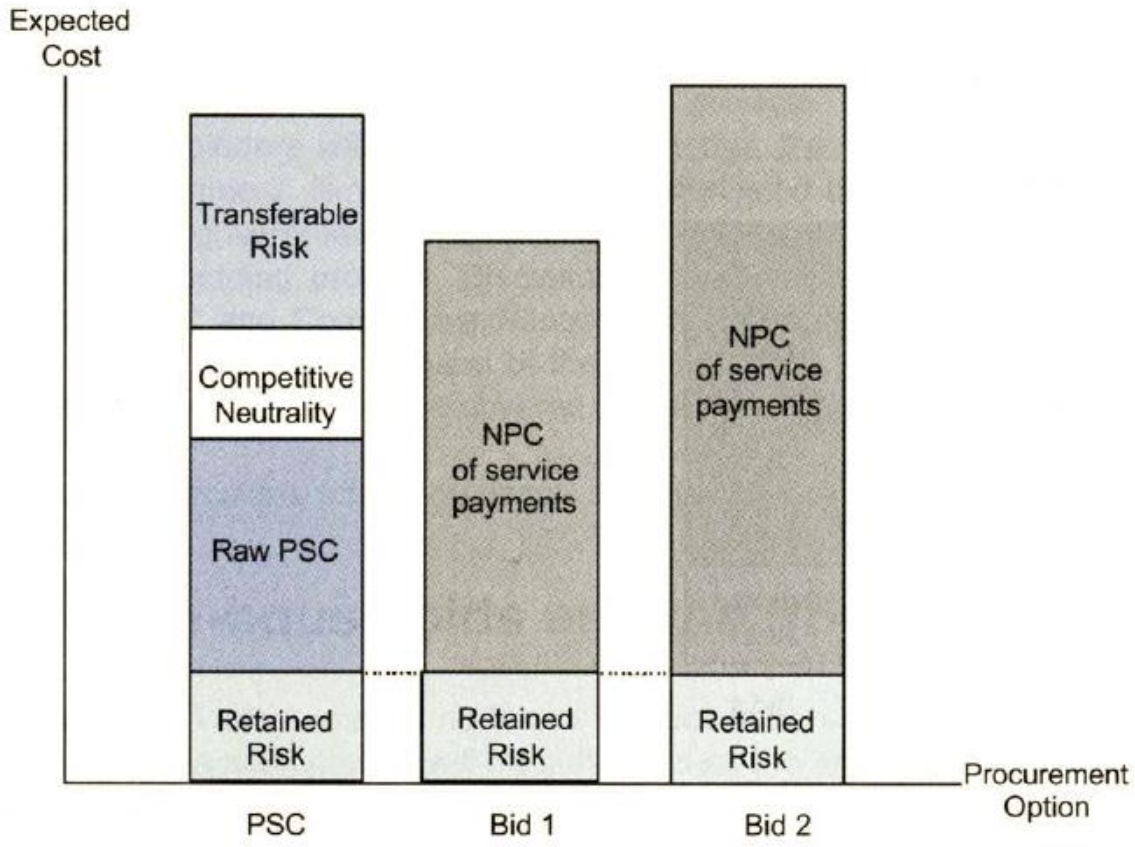


The overall aim is to decide whether the PSC offers value for money by comparing it with prices offered by the private sector. The concept is illustrated as follows[41]:

[40] National Public Private Partnership Guidelines. 2008. Australian Government Department of Infrastructure and Regional Development Volume 4 Public Sector Comparator Guidance P.9.

[41] Department of Treasury and Finance, Partnerships Victoria: *Public Sector Comparator Technical Note* (Melbourne: Department of Treasury and Finance, June 2001). P.11 as quoted in Gomez-Ibanez J and Davidoff I 2006 *Partnerships Victoria: The Public Sector Comparator*. Kennedy School of Government Case Program. CR 14-06-1822.0.

Exhibit 2
Comparison of Public Sector Comparator and Private Bids



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