

GAP TASKFORCE ON GOVERNMENT HEALTH PROCUREMENT

Increasing efficiency and value in public healthcare procurement



Prepared by Global Access Partners

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REPORT

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ABSTRACT

There is significant scope for improvements and savings in Australia's public health procurement. This paper outlines opportunities for reform by highlighting some of the inefficiencies of current tendering processes and suggesting more efficient or innovative approaches. A more rational tendering process would reduce costs and waste in the system while improving the quality and safety of care.

DISCLAIMER

This document summarises the deliberations of the GAP Taskforce on Government Health Procurement - a cross-jurisdictional and multidisciplinary group of stakeholders brought together in 2015 by public policy and implementation institute Global Access Partners.

The report represents the diverse range of views and interests of the individuals and organisations involved. Given the different perspectives of Taskforce members, it should not be assumed that every member would agree with every argument or recommendation in full.

The report has been prepared in good faith on the basis of information available at the time of writing and sources believed to be reliable. However, it should not be used as a substitute for independent professional advice and further consultation with industry experts. Evaluation of the material is the sole responsibility of the reader.

ABBREVIATIONS AND ACRONYMS

ACCI	Australian Chamber of Commerce and Industry
ACHR	Australian Centre for Health Research
ACT	Australian Capital Territory
AHSPO	Association of Healthcare Supply and Procurement Officers
CAPEX	Capital expenditure
CT	Computerised tomography
DRG	Diagnosis-related group
EDI	Electronic Data Interchange
GAP	Global Access Partners
HealthPACT	Health Policy Advisory Committee on Technology
HPV	Health Purchasing Victoria
ICT	Information and communication technologies
ITS	Implementing technical standards
MRI	Magnetic resonance imaging
MSAC	Medical Services Advisory Committee
MTAA	Medical Technology Association of Australia
NSW	New South Wales
OPEX	Operating expenditure
PET	Positron emission tomography
RTF	Request for tender
SMEs	Small to medium-sized enterprises
TGA	Therapeutic Goods Administration

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EXECUTIVE SUMMARY

The procurement of medical products, equipment and technologies in the public health system is complicated by suboptimal, duplicated or repetitive processes which increase costs and delays for all stakeholders. Several attempts at reform have been undertaken in the past, but their effectiveness has been undermined by a failure to implement them consistently, given the fractured and complex nature of Australian public health care.

The simplification and standardisation of terms and conditions, the rationalisation of duplicate processes and a requirement to employ best practice across diverse purchasing authorities would reduce costs, increase efficiency and reduce the growing pressure on state health budgets, given rising patient needs and expectations.

Governance arrangements should not only ensure transparency and probity in the tendering and procurement process, but allow for greater cooperation between health providers and equipment suppliers to explore modern service-based solutions. The skills of health decision makers must not only be improved, but supported by drawing on industry expertise and working collaboratively with the supplier base to achieve better procurement outcomes.

Reforms are required across the states, as well as within them, to achieve greater consistency and efficiency. Procurement processes should be optimised for the medical context, but also be integrated into health planning overall. Equipment purchases account for just 9% of overall recurrent expenditure in public hospitals¹, and so holistic, evidence-based solutions which take account of staffing and wage costs will be more cost effective than equipment purchases undertaken in isolation from other significant cost and efficiency factors.

The need to base purchasing decisions on long-term population planning cannot be over-stressed. Budgets currently support short-term equipment needs, but should be aimed at mapping and catering for long-term holistic needs. Spending money on improving diagnosis, for example, can be more effective than spending more on treatment for conditions which have been allowed to deteriorate undetected.

People are living longer than before, and have different expectations of care, and the system must evolve to cater for their changing needs. Purchasing decisions must therefore be based on long-term, data-based projections of population needs, rather than clinician demand, lowest price or technical specifications. A greater emphasis on preventative measures, early diagnosis and monitoring and treatment in the primary

¹ See Medical and surgical suppliers, Figure 5: Recurrent expenditure, public hospitals, 2012-2013; Australian Institute of Health and Welfare, www.aihw.gov.au/haag/12-13/public-and-private-hospitals/

sector would support patient health and reduce the eventual, if not immediate, need for expensive acute procedures.

The GAP Taskforce on Government Health Procurement urges a number of specific reforms to improve the procurement process and maximise value from equipment purchases. These include:

- A simplification and standardisation of tendering rules and specifications to reduce compliance costs and encourage innovation.
- A relaxation of strict divides between capital and operational expenditure to allow the purchase of service-oriented solutions.
- The distribution of superfluous, but still capable equipment from larger city hospitals to smaller regional centres to extract maximum value from its use.
- The use of blank Implementing Technical Standards (ITS) templates could facilitate discussions with vendors regarding desired outcomes, create more relevant tenders and help businesses address them more effectively.
- Improved population health planning data should be collected and analysed to anticipate future shifts in demand for equipment and services.
- Agreement regarding commoditised elements which can be standardised, and those regarding a more sophisticated and holistic solution, should be secured within and between state public health purchasers to build a more predictable and uniform approach to purchasing decisions.
- Investment to standardise practices and infrastructure across states and the nation should be funded by both governments and business to allow supply chain processes which are commonly used in other industries – such as barcoding inventory – to be adopted across the health system.

INTRODUCTION

GAP Taskforce on Government Health Procurement

Growing budgetary pressure demands a renewed focus on the Australian public health system's performance and efficiency. Modernised procurement practices could generate significant savings as well as improve standards of equipment, service provision and quality of care. The challenge is to find new solutions to address broad problems with procurement as a whole, rather than better ways to manage traditional approaches in specific situations.

Most public healthcare procurement in Australia is undertaken by the states, but differences in agency structures and local practices increase costs for both purchasers and suppliers. No central body coordinates state procurement in the interests of efficiency and quality. Public service administrators and industry stakeholders acknowledge major opportunities to improve costs and efficiency. However, efforts to maximise value remain hampered by transactional issues, high tendering costs, arbitrary funding cycles and overly restrictive specifications designed to minimise risk and 'future-proof' purchasing decisions.

To address the issue, independent public policy and implementation institute Global Access Partners established a cross-sectoral multidisciplinary taskforce in April 2015 to analyse public health procurement and offer practical proposals for reform. The GAP Taskforce on Government Health Procurement brought together senior executives from government, industry and academia to consider:

- The complexity, cost and inefficiencies of current tendering processes for medical equipment;
- The drivers and metrics shaping procurement and investment decisions;
- The ageing of public health infrastructure and resulting clinical risks;
- The global context of domestic health procurement and the need to support Australia's SMEs as well as multinationals;
- Opportunities to cut costs, improve efficiency and maximise patient health outcomes.

The Taskforce was co-chaired by Ms Kate Carnell AO, Chief Executive Officer of the Australian Chamber of Commerce and Industry (ACCI) and Mr Peter Fritz AM, Group Managing Director of TCG and Chairman of GAP. The Taskforce met four times between April and October 2015 in Sydney, Melbourne and Canberra. Meetings were hosted by GAP, GE Healthcare, Health Purchasing Victoria and the office of the Hon. Sussan Ley MP, Minister for Health at Parliament House. The deliberations of the Taskforce formed the basis of this report.

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CONTEXT

Maximising value in equipment procurement

Public hospitals buy a vast range of items from equipment providers, from consumables such as surgical gowns, syringes and bandages to operating theatre equipment, implantable devices and monitoring technology to complex and expensive MRI and PET machines. Australia's States and Territories retain their responsibility for public hospital provision, but vary in their policies and procurement processes. Victoria, for example, has 76 different health entities driving purchasing requests through Health Purchasing Victoria (HPV), while procurement in NSW tends to be more centralised and panel-driven.

The diversity of procurement bodies means that major suppliers of medical equipment are burdened by an unnecessarily expensive, protracted and repetitive procurement process which tends to increase costs to the public health system. Firms report spending weeks responding to requests for information through the tender process, with up to 30% of their working time consumed on bureaucratic and non-productive activities².

However, problems are not limited to the mutual costs of disparate and complicated procurement processes. Assets are commonly 'sweated' between funding cycles and the overly complex and prescriptive specifications which tenders insist upon in an effort to ensure fitness for purpose often preclude the offer of more imaginative and effective solutions.

State government's understandable attempts to maintain transparency and ensure commercial propriety mean that providers are kept at arms' length, but their exclusion from discussions of the best ways to achieve medical outcomes mean that outdated methods are pursued through force of habit when more modern and effective solutions are available. Many larger providers are shifting their focus from 'selling boxes' to offering complete solutions, but the adoption of such service agreements remains hampered by archaic procurement expectations and processes.

State governments have sought to reduce costs and reform purchasing activities, but without major industry providers represented at the table, such solutions can prove ineffective, counter-productive or create as many problems as they solve. Ways to support individual or infrequent purchasers of equipment in the public hospital system through utilising the experience of major industry players can be employed without jeopardising the credibility of the purchasing process.

² GAP Taskforce on Government Health Procurement, 2015

Arrangements which see the leasing, rather than the purchasing of expensive equipment, have proved successful in aviation and other industries, for example, and could be explored in health. Paying providers to achieve set numbers of procedures, rather than purchasing machines to achieve such targets, would give providers an incentive to innovate and find more effective ways of delivering services, while shifting risk from the public health system to private industry. Paying a provider to guarantee a certain number of X-ray images, for example, might offer scope for the company to employ lateral thinking and more imaginative solutions than simply buying a number of X-ray machines for public hospitals.

Attention must be paid to the problems the health service as a whole must solve, rather than individual hospitals focusing on their individual funding and buying equipment piecemeal. Reform must work across departments, regions and states as a whole to produce effective solutions.

OVERVIEW OF ISSUES DISCUSSED

Revisiting OPEX and CAPEX

Public hospitals are often prohibited from using operating expenditure (OPEX) for capital expenditure (CAPEX) or reusing older equipment in smaller hospitals. The strict divide between the use of funds to cover OPEX and CAPEX can reinforce inflexible and inefficient procurement practices. When buying technology designed to last a significant period of time, clinical and public purchasers tend to seize the opportunity to secure the most comprehensive system they can. This leads to them over-specifying their needs, 'overbuying' technology and then retaining the asset for much longer – usually 7 to 10 years – than their commercial counterparts.

By comparison, the private sector spends less up front, but is more flexible thereafter - cascading, moving, upgrading, swapping and changing systems on a more regular basis to stay up to date and match capacity with needs. The public sector's purchase of highly specified products with comprehensive capabilities means they maintain a 'long tail' of old technology and public buyers are hamstrung by their inability to move capital expenditure into operating expenditure to secure a more efficient outcome.

The treatment of CAPEX and OPEX should be more flexible and reflect changing health needs to allow the purchase of new equipment through the operating budget where required. The public health system should work as a single entity, albeit comprised of discrete organisations. The supply chain must operate as a system to maximise delivery to patients, rather than merely meet individual input specifications. Asset management should be improved to avoid the CAPEX/OPEX conundrum to ensure equipment is replaced at the right time. All stakeholders are delivering the same thing – patient care – and should cooperate to that end.

Optimising Resources

Public organisations are also hampered by their inability to manage their fleet of equipment across their network. The equipment needs of the Royal Melbourne Hospital, for example, are more sophisticated than those of smaller sites in regional locations. Equipment which is obsolete in Melbourne might be very welcome in a smaller regional hospital which lacks the funds to buy it new or usage to justify the purchase. However, it is difficult to cascade or trade equipment down through the system to address different needs and make the most of older assets, given the political stigma attached to hand-me-downs and 'offcuts'. A greater ability to trade old assets to maximise their use and think creatively about moving technology around a broader network should be developed to maximise the value of past purchases.

Strategies honed in the fleet optimisation of large domestic companies and multinationals should be applied to the public sphere. When a state's busiest or most sophisticated hospital receives state-of-the-art equipment, it should not dispose of the equipment it replaces, but be able to disperse its superfluous but still capable kit to smaller centers as required, to ensure all aspects of the state's health provision remains fit for purpose. Such planning is hampered by the lack of holistic planning and cooperation between individual institutions in a state, however, and entirely blocked between the states in terms of public hospital provision.

Overcoming Over-Specification

While detailed input specifications allow for fairness between tenderers and reduce the perception of bias in the allocation of public spending, they may reduce outcomes rather than risk and are often impenetrable for those involved on both sides.

Suppliers frequently receive tender requests with hundreds of detailed technical specifications they are expected to respond to. Supplier companies may be compelled to produce large documents to be assessed by evaluation committees in the form of complex spreadsheets which are often irrelevant to the task at hand. Procurement should become truly evidence-based, with registries offering good sources of reliable and patient data to ensure fairness and transparency.

Highly detailed input specifications for public tenders reduce flexibility and should be replaced by a more output-focused approach. However, the political realities driving many medical purchasing decisions must be acknowledged.

Although specification-based tenders may give the appearance of a level playing field, the specifications demanded by many tenders can often appear to be a *fait accompli* in favour of particular long-established firms or products. As an alternative, open dialogue between vendors and purchasers should establish consensus on key outcomes and the sharing of risk, and facilitate innovative approaches to achieve them. Alignment on these points would empower health purchasers to buy services to deliver these outcomes, rather than pursue an RFI process which all companies try to influence to suit their product.

Adopting Outcome-Based Procurement

Patient-centred solutions can be achieved at less risk to the public purse by encouraging the use of outcome-based procurement and holistic service agreements with vendors. Rather than issue a tender for the supply of a set quantity of artificial knee replacements, for example, a health purchaser might stipulate a desired outcome – perhaps a successful recovery and ten years of use - with the supplier bearing some of the cost of a replacement operation. This would shift the burden of risk from the state health purchaser to the company providing the service and offer a powerful incentive to improve the quality of prosthesis supplied.

While vendors would be faced with a more complicated risk assessment when tendering for such solutions, and inevitably seek to factor in the cost of additional operations into their initial quote, the competition and innovation it would stimulate should tend to reduce costs while improving patient outcomes. However, risk should be balanced between all stakeholders, and shifting it entirely to the private provider would be as counterproductive as burdening the public service, or the patient, with the risk of penalty. Companies should not be forced to offer guarantees for services which assume an undue share of risk, given that the government accounts for 40% of the economy. Australian companies can be wholly owned subsidiaries of foreign firms, and while such multinationals may span the globe, they can have relatively few employees, leaving them unwilling to incur extra risk in Australia which is not required elsewhere. Risk sharing between providers and companies need not be a one-way street, and companies offering breakthrough or high-cost drugs or treatments should be able to negotiate a shared exposure and capitation on the number of patients treated.

Outcome-based procurement is a promising approach, but cannot be considered in isolation. Patient outcomes, additional costs to the system and opportunity costs should be taken into account in purchasing decisions. Efficiency gains must be assessed alongside patient experiences and other factors to produce a complete account of the episode of care, including pre- and post-treatment factors. Patient outcomes must be considered in a system-wide approach and this data used to drive change in the system overall, otherwise every silo will only look at their own particular costs and outcomes.

Encouraging Long-Term Relationships with Suppliers

Any set of procurement reforms should acknowledge and accommodate the need for public purchasers to develop long-term relationships with suppliers, rather than rely on ad-hoc, tender-by-tender approaches. Once a tender for a specific piece of equipment is issued, then 99% of the decisions have been made before suppliers can become involved. It would be more productive to call for expressions of interest to solve problems, allowing suppliers to produce innovative solutions, than issue overly complex and restrictive specifications for equipment to achieve the same goals.

Purchase decisions by public health organisations should be based on population future needs, and suppliers should be involved in the process at a much earlier stage to help design and deliver more effective and holistic solutions. Discussions with industry players should involve as many stakeholders as possible to maximise their value and minimise any suspicion of collusion. However, concerns over probity should not prevent a company which sells a product ten times a day advising an institution which might make a single purchase every five years on its best options. Probity should allow purchasers to talk to all vendors, while prohibiting the limitation of such conversations to a select few. Small changes to specifications can generate significant cost savings, with a relaxation of location tracking accuracy for devices worn by clinical staff in one hospital from three to five metres reducing costs by 80%.³

An effort to convince the government that tenders for equipment⁴ should be developed in two phases – defining a problem and inviting output-based solutions from suppliers – might be more effective. This has been proven, as outlined previously, in co-design philosophy in other sectors. Purchasers go to the market with a request for a solution to a problem, not a tender with specifications. A solution can be worked on in partnership with a vendor and purchased if appropriate, or abandoned for an alternative in the market if not. Companies risk giving up IP in their discussion of a co-design with the government, but once agreed, they can produce a fully specified solution.⁵

Vendors are already being brought into the process at an earlier stage than before in some circumstances as part of market information gathering and analysis and where suppliers are releasing new technology discussions. However, it remains true in most cases that the more innovative and imaginative the solution, the less likely it is to be adopted for procurement.

³ GAP Taskforce on Government Health Procurement, 2015

⁴ The Taskforce acknowledged that this particular option might only favour larger companies and that there are other potential options to benefit all players.

⁵ One Taskforce member thought this would create a risk of targeted specification.

A blank ITS template would allow discussion with industry vendors about desired outcomes, help frame more useful tenders and allow businesses to compile the data required to compete for them. Such a process should help to ensure contacts are maintained by the whole industry, rather than a small number of dominant multinationals, although there are additional costs in running three or four different fleets of equipment, rather than one. Above all, by informing more reasonable technical specifications, more final tenders might allow for commoditised rather than bespoke solutions and allow the considerable cost savings that implies.

However, although plausible in theory, experience shows it is difficult to achieve such cooperation between public purchasers and private providers in practice. One company recently offered to fund an independent academic analysis of existing data on prosthesis failure rates to a state health department, but was rejected due to fears over probity, despite the inclusion of data from the company's competitors.

Prioritising Population Health Planning

Parochial purchasing decisions are often driven by senior medical staff in hospitals and can be based on current experience or past tradition, rather than future needs. The problem is not the tendering process as much as what hospitals are tendering for and why they are doing it. Hospital administrators are concerned with maximizing the capacity of their own institution today, rather than the needs of the overall health system in five years' time.

Attempts to reform the purchasing process should not reinforce the 'widget' mentality which bedevils health provision, and state governments and major hospitals must be encouraged to use population health planning data to anticipate future demand for equipment and services and plan its delivery more efficiently. Instead of looking at particular pieces of individual equipment therefore, they should begin by assessing future population needs. Hospitals tend to buy the equipment they have always bought, without planners calculating the best way to satisfy the medical needs in question. It may be better to have dialysis machines in patient's homes, for example, than in hospital. Hospitals will not have the capacity to address the growing needs of Australia's ageing population by traditional means, and a more rational, holistic and imaginative approach is required.

The process should start with patient needs, rather than purchaser specifications, and proceed in the knowledge that services and processes designed for today will have to evolve in the future. Health and social departments have considerable data on the size and demographics of their client populations and their likely health needs in terms of diabetes, mental health, Alzheimer's and other issues. Such data could offer solutions,

principles or processes to encourage integrated procurement across primary and acute care, and NSW is already trialing integrated models of this kind.

Just as individual tenders should not be seen in isolation, so health procurement is only one part of health provision overall. Health services should base their procurement on an evaluation of the future needs of the population overall, rather than the current demands of individual institutions. Individual clinicians will always argue for expensive purchases in support for their particular specialty, rather than look at the overall picture, but only a rational and comprehensive assessment of population and medical trends can properly assess future health needs and allocate resources accordingly. A full range of medical services – including home and primary care – should be mobilised to deal with them efficiently, and hospitals should not be allowed to dominate the debate.

However, while long-term planning and preventative health measures can rationalise provision and improve the population's quality of life, such measures only defer spending as the population ages and falls prey to a sequence of medical problems. Costs will inevitably increase as the population ages, therefore the delivery of health services will have to embrace a holistic approach to procurement, acquisition and operating expenditures.

Encouraging Innovation

Current purchasing frameworks do not encourage innovation sufficiently enough.⁶ Companies offering smart new solutions struggle to sell them as hospitals favor the same old machines. New companies do not know how to manage the complex tendering and purchase process as well as established, although less innovative, firms. Purchasers should look at companies which can offer better ways to deliver desired outputs, rather than always buying the same inputs.

The current system resists the adoption of the disruptive technology it urgently needs. The system should allow for innovative planning and processes as well as purchases. Public health bodies should partner with companies to design and deliver holistic solutions, rather than atomised widgets.

More education is needed to encourage decision makers in state and federal health departments to support innovation in procurement. Decision makers still focus on issuing tenders for widgets and any company not compliant with the specific criteria will be dropped from the process. The Australian Government is reviewing how general

⁶ Although there are conditional awards where innovation can be offered (HPV).

practitioners are reimbursed for primary health care⁷, but it is unclear which decision makers should be engaged with in departments to change their thinking about technology and procurement.

It is the responsibility of purchasers, such as governments and private hospitals, to articulate the outcomes they want and they should leave it to suppliers to come up with innovative solutions backed by strong evidence proving their clinical and cost effectiveness.

Emphasising Transparency of Information

Despite calls for greater and closer collaboration between public health purchasers and private equipment providers, the need for transparency, accountability and fairness in any purchasing decisions made with public funds should be underlined, not least to give new companies an equal chance of competing. However, transparency should extend beyond the elimination of corruption to empower efficiency. Information is the key to the successful operation of any market, and transparent comparisons of how much various entities paid for the same equipment, for example, would encourage lower prices overall.

Private health insurers and private hospitals argue they pay more for some prosthetics than public hospitals, for example, and would be better off buying such devices from public hospitals, rather than their suppliers. On the other hand, public authorities often pay more for supplies than private firms. People are more willing to negotiate lower prices, or make do with cheaper alternatives, if they are paying with their own money, rather than the public purse.

While there is more explicit financial pressure to reduce costs and increase efficiency in the private sector, many of the apparent disparities result from the ability of private health providers to 'cherry pick' their patients. Private health tends to favour patients and problems which are easier and more predictable to treat while a private pathology network can produce clear outcomes more easily than a public hospital through a definable and limited set of technology. Most private hospitals deal with a limited set of profitable procedures, while public hospitals have a much wider range of clinical and training responsibilities and cannot control their clientele. Private health providers can structure themselves to maximise efficiency while passing on more complicated problems to the government to solve. When a massive, unexpected accident occurs, for example, it is public hospitals which must shoulder the burden.

⁷ Primary Health Care Advisory Group Terms of Reference, Australian Government, 2015; www.health.gov.au/internet/main/publishing.nsf/content/primaryhealthcareadvisorygroup-1

Many clinicians also want to involve themselves in purchasing decisions, but do not take account of their part in an overall budget and tend to over-order for themselves because they do not know, or do not care, how much things cost. That said, cost comparison in regards to medical equipment supplied to the public sector is not entirely straightforward, as it ignores the training costs which no public hospital could afford.

benchmarking of prices would facilitate comparisons and drive better procurement and better information flows would improve clinical decision making. However, the difficulty of obtaining such information cannot be underestimated, as terms and prices can be withheld as matters of commercial confidence. Nevertheless, governments which advocate the importance of transparency for others should also be clear about their own transactions.

Relatively inexpensive software can be used to map the medical equipment industry. The NSW transport and energy sectors were mapped by this method, producing circular charts showing all the companies providing services and their interrelationships. The dissemination and use of such information by public purchasers could highlight vendors which should be bidding for tenders and lead to examination of the reasons why they are not.

Improving Evidence and Accountability

Procurement in health care is ultimately driven by individual clinicians making individual decisions; however, they are aggregated through different vehicles, such as HPV. Clinicians have different needs, and all companies market their wares as the best option, and so in the past it was difficult for purchasing bodies to quantify and compare their claims. Not only was it difficult to assess the value of innovation against established practices, but, whatever their views, individual decision makers were rarely empowered to pursue innovative and cost-saving solutions. In response, the government recognised that a company's claim that their product will reduce hospital stays, readmissions or infections must be validated by empirical evidence to be credible, just as the effectiveness of pharmaceuticals must be established by independent clinical trials.

Private insurers fund private hospitals with a level of financial accountability built into the relationship, although it remains far from ideal. There is no similar accountability in government funding of technology for public hospitals, and for many years there has been little post-funding investigation of an investment's effectiveness. Evidence from around the world regarding the effectiveness of a particular piece of technology can be cited in terms of reducing hospitals infections or stays, leading to that technology and the required training being bought and implemented, but the lack of post-investment analysis meant that initial claims, and their impact in this new environment, were seldom

tested. Similarly, once transfers of government money are made in many other areas, their effectiveness is not followed up.

The assessment of the costs and benefits of new technology has been improved in recent years through the efforts of HealthPACT⁸ in ‘scanning the horizon’ for new and emerging technologies. HealthPACT is a sub-committee of the Australian Health Ministers Advisory Council, with representation from all State and Territory health departments, the Federal Department of Health and their equivalents in New Zealand. It assesses innovation in technology and examines the cost and benefits associated with implementing new technology with a great deal of rigor. The success of this approach can be further built on, but demonstrates that attempts to improve rigour and cost effectiveness can be taken and prove effective, given sufficient political will. Individuals contrast and compare the merits of different goods and services every day, and employees should not be allowed to cite rules and regulations as an excuse to deliver poor service to their customers.

Overcoming a Defensive Health Service Culture

Every health minister wants to save money and extract better value from every tax dollar. However, the long history of failed health reform in Australia and abroad shows that merely advocating reform to generate better value is no guarantee of success. The more difficult part is changing the culture of the public service to accept a greater level of risk or show that what is apparently greater risk is not actually a danger. Governments and institutions alike over-specify their tenders because of their risk-averse approach. Although the current system does not really reduce risk, but reduces the appearance of risk, people do not get fired for making conservative decisions, even when those decisions go wrong. However, picking a new process or system or company which failed would lose the purchaser their job. A new approach which produces better outcomes and better value can only be sold by ameliorating the risk issue which really drives purchasing decisions. It must be sold as safe for the decision maker, as well as effective for the health service. Government should be convinced of the case, and then it is their responsibility to change the risk-averse purchasing culture.

Just as clinicians shy from reforms which might damage their interests, so the innately conservative nature of public health administration is a major impediment to procurement reform. Evidence of medical effectiveness does not drive the immediate adoption of new techniques any more than evidence regarding the benefits of reform ensures its acceptance or adoption. It can take up to two years to gain approval for medical devices through the Therapeutic Goods Administration (TGA) and almost a decade to obtain a new item code through the Medical Services Advisory Committee

⁸ <https://www.health.qld.gov.au/healthpact/>

(MSAC). The media storm which accompanies any adverse reactions or unforeseen consequences of early adoption is feared far more than the silent loss of lives and quality of life which the tardy acceptance of new techniques is responsible for.

The clinical and patient needs which will drive demand for equipment in the future must be understood alongside the lifecycles and total costs of pivotal machines, but it should be remembered that each clinician trained in the use of specific machines will naturally tend to request their support and resupply without regard to the overall health picture. Just as changes in hospital procedures create disruptions which can affect the institution elsewhere, so an unwillingness of trained personnel to give up the equipment on which they depend for income and status can stymie reform and innovation throughout the health system.

All too often purchasing needs are still driven by the immediate demands of individual clinicians rather than rational, evidence-based long-term population health planning. However well-intentioned it may be, or may appear, clinician demand is motivated by self-interest and parochial concerns as well as patient needs. Indeed, clinicians may know a particular test or procedure is pointless, but will still carry it out to earn income for themselves. A number of inefficiencies have been identified by HealthPACT, but this disinvestment has to be implemented in a collective way with clearly presented empirical evidence. The cost of maintaining legacy systems should also be considered, as it is extremely difficult to end an existing programme, no matter how ineffective, to funding the launch a new one, no matter how productive it may be. However, doctors must be consulted in the decision making process, because of, rather than despite, these realities. The range of incentives and pressures which drive their decision making must be understood and taken into account, given their independence and power in the public health system. Reviews which seek to remove an irrelevant procedure must compensate the institution with replacement activities to ensure their support. This can be achieved within a closed system through overall assessment of 'winners and losers' and a transfer to balance the overall effect at the end.

Moves from invasive surgical procedures to minimally invasive to non-invasive procedures change who does the work in a hospital, for example. There has been substantial investment in minimally and non-invasive technology, given the proven cost and medical effectiveness of such techniques, but very little disinvestment of invasive surgical techniques. Reform should unlock the cost and clinical benefits of less invasive techniques, while opening opportunities for additional invasive surgical procedures where medically appropriate in other areas of care.

Similarly, while a state's patients would benefit from better procurement processes, its public officials fear criticism if innovative approaches fail and so cleave to traditional practices which minimise risk to their careers, however cumbersome their outcomes. Health officials tend to defend their current approaches, rather than seek continuous improvement. While it is a commonplace to call for the broad adoption of best practice,

no-one wants to admit that someone else is doing a similar task better, and so many officials would rather defend their own inefficient practices than adopt better procedures from elsewhere.

The abolition of certain procedures is the most often suggested cost saving solution, but is the least likely to be accepted and succeed in practice. Owners of the system have to therefore decide how they will manage these changes in activity and forgive the institution its net loss for a definable period. An acceptance of shared responsibility for delivering overall outcomes is required from all stakeholders, but clinical and institutional support is unlikely to be secured without some degree of financial recompense or other activities in compensation.

CURRENT REFORMS

Health Purchasing Victoria

HPV exemplifies the progress which reform and rationalisation of health purchasing can achieve. HPV is taking a fresh approach to health procurement, beginning the process with open discussions with stakeholders to ensure that acquisitions will be fit for purpose. HPV focuses on the total cost of ownership over an asset's lifespan, rather than merely the initial cost of purchase. It acknowledges the importance of an efficient tendering process which minimises repetitive requests for the same information.

Framework agreements currently being implemented recognise the importance of building and sustaining strategic relationships with suppliers to support more sophisticated and expensive equipment throughout its lifespan, in contrast to the disposables which are bought, used up and thrown away. A productive relationship with equipment suppliers should be established as part of the overall category management process, as the public sector tendering process offers limited scope of interaction due to reasons of transparency and fairness.

Instead of attempting to maximise value by minimising the costs of a single transaction, HPV is open to the idea of involving suppliers in planning to produce more effective, appropriate and sustainable long-term solutions. Planning should be based on future population needs, rather than individual hospitals purchasing specific pieces of equipment in an uncoordinated way.

Wasteful duplication of effort in submitting duplicate information in multiple tenders for both purchases and suppliers can also be eliminated through the nurturing of long-term understandings and relationships. This approach mirrors that taken in Europe where mutually beneficial relationships between suppliers and purchasers are maintained.

Rather than focusing on creating and addressing overly specific functional and technical specifications, problems should be shared with suppliers to allow more holistic and innovative solutions to be created as part of the category management process.

HPV is looking at the technology which suppliers are developing and is shaping their thinking and requirements accordingly. Demand for health equipment is still overly reactive, and better data gathering and analysis of population trends should allow for more efficient planning of clinical needs and equipment requirements for the future.

Patient needs should be at the centre of health care and the purchasing decisions, including those to promote home care, which support it. There is a great deal of discussion of this topic, but empirical evidence and verifiable data must drive the

decision-making process. The efficacy of equipment, for example, must be assessed in its impact on hospital stays, readmission rates and clinical outcomes.

An increased focus on the purchase of medical equipment in the last quarter of 2015 saw value increase by \$40 million, driven by improvements in four sub-categories – pathology equipment and reagents (\$6 million), leasing arrangements (\$12 million), service and maintenance (\$20 million) and ventilators (\$2 million) – and HPV will continue to work closely with the state’s health services to align equipment purchases with health needs in 2016. The introduction of sub-category management targets for each sourcing event will reinforce HPV’s strategy to identify and drive new sources of value, particularly in more established categories.⁹

HPV has released \$69.2 million to the public health sector by avoiding or reducing costs in its \$745 million under contract, and further action is planned in 2016.¹⁰ Activities will include the scoping of a supply chain pilot project involving HPV and Melbourne Health, while the introduction of health purchasing policies across Victorian Health will see HPV work closely with health services to ensure compliance and probity.

HPV¹¹ seeks evidence-based information of product performance where effects on patient care can be measured, just as pharmaceutical companies are required to produce data from trials on the effects of their drugs. Purchasers must encourage all suppliers to offer evidence that their products are fit for purpose.

⁹ HPV Newsletter January/February 2016

¹⁰ Ibid.

¹¹ Hospitals have product evaluation committees; however, it is individual evaluation as opposed to a single process across the state (HPV).

CASE STUDY

Analysis of Melbourne Health's 2012 CT Scan Tender

The Taskforce examined Melbourne Health's 2012 CT Scan tender to highlight successes and failures of a specific procurement process. Before reform is contemplated to change the system, reformers have to understand the current system in place. The discussion stressed the following issues, elaborating on general topics discussed in earlier meetings.

Disconnect Between Stakeholders and Outcomes

While the CT Scan tender appears rational at first glance to a layman, it reveals fundamental disconnections between stakeholders, aims and outcomes. It was issued at a time when every purchase over \$150,000 in Victoria had to go to tender, but ongoing procurement reforms in the state have shifted the focus towards category management, meaning the market will be assessed and understood before purchases are made.

Quality Assessment and Long-Term Perspectives

Health vendors are inconvenienced by the paperwork involved in submitting a tender, but are ultimately more concerned by the process by which its quality is judged. A CT scanner is not an 'off-the-shelf' product with a twelve-month warranty, but involves a 7-10 year support commitment by the supplier. The transaction should therefore not be seen as a single purchase, but as a strategic relationship over the following decade. However, this vital element is largely ignored by current purchasing processes.

HPV is addressing this by looking to work with major suppliers at another level. Health purchasers across Australia have relationships with large suppliers which have developed in a de facto fashion over many years, but are afraid to send documents which acknowledge this reality lest it imply favouritism.

Over-Specification and Duplication of Effort

While the work in applying for this, or any particular, tender, may not be unduly arduous, the effort and repetition required to meet marginally different requirements of different health purchasers and the 'never-ending cycle' of negotiations of terms and conditions they required saps the will and ability of vendors to compete. The structure of the tender itself is not the problem, but the need to continually rework it for each new circumstance.

Reforms in Victoria have simplified the process to some degree, but tenders still tend to be overly technical and prescriptive in nature. The CT Scan tender incorporates very specific questions about the machine's capabilities, for example, which would serve to predefine its use. It also predefines commercial relationships between purchaser and vendor without taking the context of desired patient outcomes and clinical challenges into account. This gives vendors limited opportunities to collaborate to improve these outcomes by offering fresh solutions.

Unrealistic Expectations and Non-Compliant Bids

The current tender process is fair in that all competitors respond to the same criteria and can be scored by quality, but if the outcomes the health authority sought to achieve by the CT Scan purchase were disclosed, there could be greater collaboration to achieve them more effectively.

Most tenders claim to allow the acceptance of non-compliant bids, but in practice this very rarely occurs. Suppliers do not provide non-compliant bids as their only offer, as they would inevitably be rejected, but do on occasion offer a non-compliant bid in addition to a compliant one to demonstrate how the objectives sought for the purchase could be achieved more effectively. However, accepting a non-compliant bid creates a significant extra work for the purchaser, as they must then justify its acceptance to other bidders and their superiors. The highly technical nature of tenders is therefore understandable, but misses the opportunity to collaborate to find new solutions to achieve better outcomes. Purchasers should therefore be encouraged to consider non-compliant bids if the same vendor lodges a compliant bid as well, as non-compliant bids always have the potential to offer new insights or approaches to the purchaser.

Many tenders are unrealistic in their expectations, with their technical specifications cherry-picked from the highest standards gathered from a range of potential suppliers during an initial RFI process, but ignoring the trade-offs which inevitably accompany them. No company can hope to meet the composite tender, and so inevitably bids are made which fudge or obscure the criteria that company cannot meet in an effort to win the bid, with the company gambling that they can quibble about the details later under the guise that they were misunderstood at the time.

The demand for an impossible mix of elements means that even theoretically compliant tenders are inevitably non-compliant in reality. They meet the required standards where they can, and hide where they do not, in an effort to secure the business. The RFI process is flawed because it does not identify or assess the best solution any particular manufacturer can supply, but creates an impossibly ambitious product specification for them all.

A Service Approach Versus Equipment Purchasing

Melbourne Health's CT Scan tender begs the question of whether an equipment purchase is necessary to achieve the health outcomes sought by the health purchaser. If a choice can be made between buying standalone equipment and an ongoing service, the purchaser should consider whether a service approach should be adopted before a tender for equipment is sought. Equipment could be leased, rather than bought, for example, with payments for use substituted for outright purchase. A 'power by the hour' system has operated successfully on Australia's electrified rail network for a decade and reduced energy costs significantly.

Performance Guarantees

Melbourne Health's CT Scan tender incorporates a substantial performance guarantee, but such measures run the risk of limiting the vendor market, as some potential suppliers might not bid if they view the risk as unsustainable. Due diligence should therefore see a determination of the effects of such requirements on the potential market before their incorporation into tenders. One Taskforce member viewed Melbourne Health's self-proclaimed right to unilaterally change the tended prices as 'extraordinary' and warned that companies would inevitably pad their initial bids to protect themselves from such action.

The Australian Government's Innovation Agenda

The Prime Minister has stressed the need for Australia to innovate in a fast changing global economy, and the recent release of the National Innovation and Science Agenda¹² should spur the adoption of more innovative public purchasing strategies. However, while the Government should procure goods and services in ways which encourage innovative and more effective solutions, the traditional definition of successful procurement as one which avoids escalation remains. The public sector protects itself from escalation by being highly prescriptive in its tenders, but this inevitably means it buys today's technology to meet tomorrow's workload. There is no scope for imagination in its dialogue with vendors, let alone in what it ultimately buys. Such purchases make no provision for technological development or obsolescence or the age of infrastructure which will serve the population as the equipment serves out its service life.

Deeper partnerships in technology such as CT scanners could see government contracting industry partners to deliver agreed standards of throughput, performance and capacity in whatever way the companies involved found most effective. This would

¹² Australian Government (2015) National Innovation & Science Agenda "Welcome to the Ideas Boom", <http://innovation.gov.au/page/national-innovation-and-science-agenda-report>

allow and encourage continuing innovation and modernisation to improve quality and reduce costs. Such a radical rethink of the tendering process would achieve far more than incremental tinkering with the fundamentally flawed approach of today.

The criteria State and Territory governments use in assessing the impact of health contracts on the regional economy is important, but should not dominate their considerations, as it would limit purchases to local companies and exclude larger or more innovative firms based elsewhere. A shift towards outcome-based procurement would increase the sophistication of the economy by encouraging innovation and modern solutions.

Opportunities for Improvements in Service Delivery and Value for Money

Trivial variations in terms and conditions between different purchasers demand wasteful duplication of effort for vendors, but all tenders are so technical in nature that their terms cannot be challenged by anyone other than technical experts. Technicians on both the purchasing and vending side of the equation will inevitably tend to favour and generate highly technical specifications to ensure they dominate the debate. A broader tender for items such as CT scanners, based on achieving agreed outcomes rather than specifying particular characteristics of a specific machine, could improve quality, reduce costs and encourage ongoing improvement. A broader concept and discussion of value for money would allow greater value for money to be achieved.

Tenders for Complex Projects

If a public contract calls for a commoditised product, then a specification outlining its properties is appropriate. However, tenders for elements of more complex projects which demand particular specifications at the best cost are flawed because they ignore the wealth of knowledge and alternative approaches which more experienced or innovative vendors could bring to the table. Unfortunately, the current tender process for items such as medical scanners explicitly rejects opportunities for engagement with knowledgeable parties to maintain the appearance of probity and avoid accusations of favouritism or collusion.

The process presupposes that all wisdom rests with the health purchasers who then go to vendors to source the specifications they have ‘cherry picked’ at the best price when, as previously noted, no such amalgamated ideal may exist or be possible to produce. There should be an informed conversation about such trade-offs, but there is nothing in the tender process to facilitate it. The civil service is focused on risk mitigation and avoidance, rather than maximising outcomes for the public which funds it. A tender should therefore call for the best solution to fulfil the role the CT scanner, in this example, rather than specifying the particular parameters of a standalone machine.

Health Procurement and Patient Care

Health provision, such as CT scanning, is often analysed in terms of separate episodes of care. An isolated tender for a body scanner ignores the entirety of the episode of care of which the body scan is but a part. The challenge for the health provider is to understand the role that equipment plays in the entirety of the patient experience and outcome. Buying a 'like for like' replacement for an old machine inevitably ignores the possibility that a better or more holistic solution may now exist. A mechanism to allow such discussions, perhaps ring-fenced from the actual tender process for the solution or service it recommends, could allow for innovation while still maintaining standards of independence and probity.

Evidence-Based Solutions and Pre-Sourcing

Discussions with vendors regarding innovative solutions must still be evidence-based and cannot be swayed by unsubstantiated and self-interested claims from providers that their service would offer more value without convincing data to support them. Health purchasers could learn from other industries, such as car manufacturing, where concepts such as pre-sourcing allow business partners to meet required criteria in a variety of ways.

Procurement in a Wider Political Context

Public purchasing decisions for expensive and high-profile items such as CT scanners are often driven by a wider range of political and media factors. They can be influenced by the desire to support local providers and the regional economy, meaning innovative foreign companies may still lose out to traditional suppliers based in the same state. A state government stands or falls by the strength of its regional economy, and purchases from a multinational may offer no additional employment or value to that state.

Similarly, it would be unfair to exclude SMEs from a procurement process for a particular product if they were deemed incapable of providing a total service solution offered by a major multinational. A move towards such holistic end-to-end solutions would effectively exclude smaller Australia-based firms from government contracts in many areas. Just as long-term patient outcomes and holistic population planning should be incorporated into health purchase design, so health purchases must be seen in the context of wider government policy and public benefit.

Service Agreements and Statements of Objectives

Non-health technology companies also feel that opportunities for better service delivery are missed when purchasers tender for particular combinations of equipment, rather than seek collaborative solutions to achieve the outcomes required. The adoption of service models can encourage the regular updating of equipment, rather

than force users into retaining obsolete technology far beyond its abandonment in industry or the consumer market. Computers, for example, may be obsolete within three years, and the agreement of long-term service, rather than equipment purchase contracts, allows their replacement on a regular basis to improve productivity. Service agreements also afford the vendor the opportunity to innovate within that ten-year cycle to meet their customer's growing needs. The acknowledgement that equipment purchases are a possible means to an end, rather than an end in themselves would, as previously outlined, unlock a much wider range of more innovative solutions. A statement of the objective the purchaser wishes to achieve through equipment such as a CT scanner, rather than a prescriptive specification for the equipment they believe necessary to achieve, could therefore offer the best way to find a collaborative and more efficient solution.

Risk Mitigation

However, if long-term service agreements for equipment such as CT scanners are to be agreed, health purchasers would naturally expect firm guarantees that these outcomes would be achieved and maintained as providers move to cut costs over time. The requirement of such guarantees might then dissuade smaller companies – or consortiums of smaller companies – from assuming the risks and potentially significant extra expenses involved. A requirement that vendors cover the full cost of failed knee replacements – including surgical costs and recovery expenses, rather than merely the provision of a new prosthesis – would inevitably dissuade many companies from bidding for the work and inflate the fees demanded by those that do. Only major firms would have the resources to absorb these risks into their balance sheets without undue concern, but even such firms might prefer to seek contracts elsewhere without the risk of future penalties. This could be balanced by some dispensation for smaller, local firms. Although the concept of 'non-natural' relationships in which SMEs are afforded additional leeway or benefits has been somewhat discredited in Australia, it remains mainstream policy in the USA.

Efficiency Gains through Holistic Planning

Every well managed business looks to maximise collaboration between its own departments and functions to help processes flow and become more efficient. However, the traditional health tender process prohibits collaboration between supplier and customer to remove bottlenecks or devise more efficient ways to deliver the service in question. More holistic planning and investment is therefore required to enable efficiency gains over the whole healthcare network, rather than merely at the level of individual hospitals or general practices.

As long as value propositions are constructed as separate entities, they will not maximise overall efficiency, no matter how rational they appear in themselves. A systemic adoption of barcodes for consumable supplies used in health care to empower

automatic tracking and reordering would deliver the same supply chain benefits long enjoyed by a host of retailers and industries. The investment and planning required to apply such a system across a state or federal health care network can only be achieved through consistent public policy, rather than any particular contract with a commercial company.

Supply Chains in Other Sectors

Principles which are widely adopted to streamline supply chains in other sectors should be researched and adopted in health procurement where appropriate. Such principles, and the public investment required to support them, should facilitate improved efficiency across the whole system, rather than be restricted to individual instances in the hope that incremental savings can be achieved.

Analysis of Melbourne Health's CT Scan tender merely underscored the need for a more fundamental discussion among all stakeholders about the problems they are seeking to solve, as mutually beneficial solutions cannot be found until the problem itself is agreed upon. Health is twenty years behind many other sectors in its processes and supply chain optimisation. There is no need to 'reinvent the wheel', but merely to adapt and adopt well-known practices which have long proven their value elsewhere.

Electronic Data Interchange (EDI) is a widely used solution in many industries, for example, and has been employed by Coles and Woolworths for a decade. The approach could be applied to health, although vendors which use EDI themselves would obviously be more in favour of its adoption than those which do not. Similarly, some hospitals would be unable to use it without significant investment if they lack the necessary ICT infrastructure. Some parts of any health area will have state-of-the-art technology, while others will be saddled with obsolete kit. Whatever the enthusiasm of the latter group to embrace new approaches, they would be stymied by their lack of the resources required.

The adoption of IT infrastructure and software as a service would help reduce such barriers; HPV no longer buys its own servers, for example, but uses software as a service for its computing needs.

Moving Beyond Specifications

The fundamental flaw in health purchasing is not the bureaucracy involved in lodging a single tender, but the fact that the process is driven by specifications. Even when specifications are drawn up with an eye to the future, they miss the point that specifications themselves are the problem, rather than the solution. Discussing opportunities for innovation should bring vendors and purchasers to the same table for a constructive dialogue; however, collaboration to find improved solutions to complex

problems must not devolve into a competition between rival salesmen to tailor the tender to fit whatever product or service they happen to supply.

Although purchasers should be mindful of entire episodes of care, different elements may inevitably be provided by multiple suppliers. Health purchasers should therefore distinguish between commoditised and non-commoditised items in such episodes, allowing the former to be sourced through a traditional tender process somewhat streamlined for efficiency, while the latter will require a more sophisticated approach.

The Need for Radical Reform

While the analysis of a single tender process proved effective, the Taskforce stressed the need for a more radical, system-wide approach to reform. Every issue outlined above is a barrier to stakeholders delivering health care and adversely affects patient outcomes, but each is a symptom of wider problems which must be tackled at their root. Reforms suggested by those inside the health system benefit from their experience, but are limited by their concentration on their own particular problems, rather than offering an overview of the deficiencies of the system as a whole. Rather than seek to improve a tender for CT scanning in a handful of Melbourne hospitals, better public procurement should see public authorities working with commercial providers to provide holistic solutions for the state as a whole. Rather than concentrate on the technical specifications for one particular piece of equipment, the overall health problem in which it plays a part should be defined and the extent of required provision predicted to allow a greater range of perhaps more appropriate, effective and cheaper solutions to be developed.

An agile methodology of co-design, as used in the computing industry, could be applied to many health issues. Instead of the current concentration of CT scanners in a few metropolitan hospitals, for example, a larger number of CT scanners spread across the region might prove to be more effective, as might the creation of a single center handling every patient in the state. The calculation of whether a centralised or boutique model might be the best way to satisfy patient needs and minimise costs should also encompass the real costs of patient transportation and organisation, as well as the price of the machines and the staff required to support them.

State government action to improve health purchasing must also be supported at the federal level. The UK instituted a cabinet committee for managing procurement, and a similar approach could be adopted in Australia. Reform must be an ongoing process, just as procurement should not be carried out on a year-by-year basis. Neither should it be seen as a way to merely save money as history proves the health budgets are almost impossible to cut effectively. Given this historical and political reality, savings should be therefore be explicitly reinvested in the institutions making them, otherwise they have no incentive to support reform and improve efficiency.

KEY FINDINGS

<i>Issues</i>	<i>Solutions</i>
I. The complexity, cost and inefficiencies of the current tendering processes	
Lack of coordination: Most public healthcare procurement is undertaken by the states, but differences in agency structures and local practices increase costs for both purchasers and suppliers.	<ul style="list-style-type: none"> Establishment of a central body which would coordinate state procurement in the interests of efficiency and quality.
Scope for savings: There is scope for significant savings through modernised procurement practices and improved standards of equipment, service provision and quality of care.	<ul style="list-style-type: none"> The opportunities to cut costs, improve efficiency and maximise patient health outcomes must be identified and implemented - a taskforce on health system efficiencies could be established to build on the findings of the Productivity Commission 2015 review
Stakeholder engagement: Public service administrators and industry stakeholders acknowledge major opportunities to improve costs and efficiency.	<ul style="list-style-type: none"> A working group /workshop could be organised to examine the tendering and purchasing process of a recent set of equipment and propose how it might have been improved. A case study/template for reform can then be produced and tested with one jurisdiction through a practical pilot A wider inquiry through the 'Second Track' process into government procurement with the Productivity Commission and other stakeholders should be considered. A cabinet committee for managing procurement, similar to the UK, could also be proposed

<p>Barriers to more efficient procurement - over specification and risk aversion: Efforts to maximise value remain hampered by transactional issues, tendering costs, arbitrary funding cycles and overly restrictive specifications designed to minimise risk and 'future-proof' purchasing decisions.</p>	<ul style="list-style-type: none"> Highly detailed input specifications for public tenders should be replaced by a more output-focused approach. Tenders for equipment could be developed in two phases – defining a problem and inviting output-based solutions from suppliers.
	<ul style="list-style-type: none"> Any proposed changes to the procurement process need to show they would generate better value. The more difficult part is changing the culture of the public service to accept a greater level of risk.
	<ul style="list-style-type: none"> The Taskforce could design a new process for health procurement which all stakeholders could contribute to and benefit from.
	<ul style="list-style-type: none"> Health Purchasing Victoria offers a fresh approach to health procurement, focusing on building long-term partnerships with suppliers, evidence of product performance and efficacy, and the total cost of ownership over an asset's lifespan, rather than the initial cost of purchase.
	<ul style="list-style-type: none"> A pilot project with a hospital or jurisdiction could be designed around their procurement process and how to make it more efficient. The Taskforce could look at a region, assess its population needs, create a business case to address them and take the proposal to the purchasing authorities.
<p>Wasteful duplication of effort in multiple tenders</p>	<ul style="list-style-type: none"> This waste can also be eliminated through the nurturing of long-term understandings and relationships (See HPV approach)
<p>The need for transparency, accountability and fairness in any purchasing decisions made with public funds was underlined, not least to give new companies an equal chance of competing.</p>	<ul style="list-style-type: none"> Benchmarking prices would facilitate price comparison while better information flow would improve clinical decision making; Mapping of the medical equipment industry could produce circular charts showing all the providers and their interrelationships.

<p>Lack of innovation: Current purchasing frameworks do not encourage innovation.</p>	<ul style="list-style-type: none"> • The system should allow for innovative planning and processes, as well as purchases. • Tenders for equipment should be developed in two phases – defining a problem and inviting output-based solutions from suppliers. • Suppliers should be involved in the procurement process at a much earlier stage to help design and deliver more effective and holistic solutions. • An agile methodology of co-design, as used in the computing industry, could be applied to health. • More education is needed to encourage decision makers in state and federal health departments to support more innovative and holistic solutions • Purchasers (governments and private hospitals) should articulate the outcomes they want and leave it to suppliers to offer innovative solutions backed by strong evidence proving their clinical and cost effectiveness.
<p>The need for a more holistic approach: Current procurement pathways are overly prescriptive, focus on individual ‘widgets’, and do not take other cost factors such as labour offsets into account</p>	<ul style="list-style-type: none"> • The delivery of health services will have to embrace a holistic approach to procurement, acquisition and operating costs. High-cost widgets can use less labour than lower-cost ones, reducing overall costs, and procurement processes should factor these savings into account. • Patient outcomes, other costs to the system and opportunity costs should be taken into account in purchasing decisions.
<p>Learning from private sector procurement — Long-term planning: There is more pressure in the private sector, rather than the public, to plan for the long term to improve efficiency.</p>	<ul style="list-style-type: none"> • A taskforce comparing the costs of private and public health care may be created to highlight the differences. • Engage the private sector in designing a better process

2. The ageing of public health infrastructure and resulting clinical risks

Current procurement processes have impact on the age and reliability of medical equipment, waste in the system, service levels, innovation, competition, and quality and safety of care.

CAPEX vs OPEX: Public buyers are hamstrung by their inability to move capital expenditure into operating expenditure to secure a more efficient outcome.

Long-term planning: In the current purchasing system, equipment is bought with a 7-10 year lifespan, by which time they become obsolete.

Private sector procurement allows more flexibility (cascading, moving, upgrading, swapping and changing systems on a more regular basis to stay up to date and match capacity with needs) and can perhaps offer some solutions.

Reusing older equipment in smaller hospitals: Public hospitals are unable to efficiently manage their fleet of equipment across their network. It is difficult to cascade or trade equipment down through the system to address different needs and make the most of older assets.

- The supply chain must operate as a system to maximise delivery to patients, rather than merely meet individual input specifications.
- The delivery of health services will have to embrace a holistic approach to procurement, acquisition and operating costs.
- Procurement must become evidence-based, with registries offering good sources of reliable and patient data to ensure fairness and transparency.
- Asset management should be improved; the treatment of CAPEX and OPEX should be more flexible.
- A more agile process which anticipates change would be more effective.
- Fleet optimisation of large multinationals should be applied to the public sphere.
- A greater ability to trade such assets should be developed, to maximise their use and think creatively about moving technology around a broader network.

3. The drivers and metrics shaping procurement and investment decisions.	
<p>The ageing population: Costs will inevitably increase as the population ages.</p>	<ul style="list-style-type: none"> Population health planning data should be used to anticipate future demand for equipment and services and plan its delivery more efficiently.
<p>Understanding of patient and clinical needs</p>	<ul style="list-style-type: none"> The procurement process should start with patient needs, rather than producer specifications. The efficacy of equipment must be assessed in its impact on hospital stays, readmission rates and clinical outcomes. The building of an evidence base will allow the correlation and comparison of such claims.
<p>Proactive use of new technology: Demand for health equipment is still overly reactive.</p>	<ul style="list-style-type: none"> New technology should shape government's thinking and requirements. Better data gathering and analysis of population trends should allow for more efficient planning of clinical needs and equipment requirements for the future.
<p>Over ordering by doctors: Doctors want to be involved in purchasing decisions, but do not know the budget and so tend to over order.</p>	<ul style="list-style-type: none"> The whole medical team should be involved in the entire process to make them realise the costs. The lifecycles and total costs of equipment should be better understood. Incentives and pressures that drive doctors' decision making should be taken into account.
<p>Invasive versus non-invasive surgery: Moves from invasive surgical procedures to minimally invasive to noninvasive procedures change who does the work in a hospital. There has been substantial investment in minimally and non-invasive technology but very little disinvestment of invasive surgical techniques.</p>	<ul style="list-style-type: none"> Reform should unlock the cost and clinical benefits of less invasive techniques, while opening opportunities for additional invasive surgical procedures where medically appropriate in other areas of care.

<p>Lack of post-investment analysis and follow-up assessment of outcomes: There is no post-funding investigation of an investment’s effectiveness. Once money is allocated, there is no follow-up to assess how that spending affected outcomes.</p>	<ul style="list-style-type: none"> • The outcomes in health procurement should be properly calculated, reported and compared.
<p>4. The global context of domestic health procurement and the need to support Australia’s SMEs as well as multinationals.</p>	
<p>Supporting local providers and the regional economy may result in innovative foreign companies losing out to traditional suppliers based in the same state</p> <p>Smaller Australian firms are unable to compete with major multinational firms offering a total end-to-end service solution</p>	<ul style="list-style-type: none"> • Health purchases must have a long-term view and be seen in the context of wider government policy and public benefit

CONCLUSION

The success of Health Purchasing Victoria demonstrates that improvements can be made and significant cost savings achieved by more modern approaches. Procurement must continue to expand beyond a narrow focus on specifications and price to consider the entire value system and offer scope for vendor innovation. Although they remain the focus of most public, media and political attention, Australia's public hospitals account for only 40% of total Commonwealth spending on health.¹³ Purchasing pathways throughout the health system are the greater problem, as they remain prescriptive, focus on individual 'widgets', and do not take other cost factors into their calculations. Labour offsets are rarely taken into account, although high-cost widgets can use less labour than lower-cost ones, significantly reducing overall costs. Any number of purchasing silos focus on capital or infrastructure or consumables or devices or drugs, but rarely take a more holistic view.

Most industries develop close long-term strategic relationships between suppliers and purchasers, allowing the joint design and development of solutions. Health is an outlier in that its business is almost entirely transactional, with no formal long-term partnerships to improve customer experience. Early vendor engagement and a focus on outcomes would give companies greater opportunities to develop more imaginative and efficient solutions. Service models should be based on ends, rather than means, with vendors left free to meet their responsibilities in flexible ways to drive down their costs. The discussions between vendors and purchasers which agree a set of outcomes and approaches should be separated from the tender process, by which individual companies compete for the contract.

Most importantly, guiding principles to frame strategic relationships between public purchasers and private suppliers must be developed, to maintain standards of transparency and fairness of the process for all concerned.

The strategies discussed by the Taskforce, from blurring the boundaries between capital and operating expenditure to allow more innovative and holistic service-based solutions, better asset management through the entire health system, and a shift from overly specific tenders to a more output-focused approach have proven their worth in many other industries. Despite the claims of certain interest groups endeavouring to protect themselves from competition or scrutiny, health is not so different from other sectors that similar approaches cannot succeed in it. Federal and state treasuries already permit outcome-based tendering, and the acceptance of non-compliant bids, while the

¹³ Reform of the Federation White Paper. Appendix B: Health Funding Arrangements; <https://federation.dpmc.gov.au/appendix-b>

replacement of equipment purchases with service agreements is not only allowed, but widely encouraged.

The devolution of Commonwealth and State responsibility to individual entities in the system may have impeded the realisation that such flexibilities are now available. They would not be suitable for all circumstances, and so should not be imposed unilaterally or generally required, but where appropriate their adoption is entirely plausible. The Defence department, for example, has collaborated successfully with equipment suppliers to plan for future needs, although the execution of these plans still falls short of the ideal in terms of cost and performance.

The standardisation and simplification of tendering requirements across and within states, the use of online tools to lodge tenders with prepopulated information where appropriate, and more appropriate specifications and insurance requirements in the short term should be supported by better planning, cooperation and governance in the medium term to maximise patient access and outcomes, reduce bureaucratic burdens and constrain growth in health expenditure.

Such reforms should open the market to more vendors, increasing competition and diversity while spurring innovation and driving down costs. By reducing bureaucratic barriers to potential vendors, standardised tendering processes would also allow for greater flexibility and responsiveness to unforeseen needs, while better population planning would help rationalise purchasing decisions and provision over the long term. Simpler tendering procedures would also increase transparency, and clearer decision making rationales would allow failed vendors to improve their bids in the future.

Rather than issue specific tenders for particular pieces of equipment, health purchasing bodies should define and specify the outcomes they wish to obtain, be they reducing readmissions, increasing theatre efficiency or cutting labour requirements, and allow suppliers to produce innovative solutions. The value assigned to such outcomes must be specified to allow rational planning to take place. Though institutions will always try to spend the budget they are allocated, as they otherwise risk their budgets being cut, savings can be reinvested in the health system to increase overall service provision which will in turn increase public support for health reform.

As well as encouraging cooperation between purchasers and vendors, there must be better alignment between procurement and funding branches within the sphere of government, and there should be greater coordination between state and federal authorities in funding episodes of health care. Every State and Territory runs its procurement regime in a different way, and the Federal Government could offer incentives for the states to adopt more effective processes. The Commonwealth influences state spending decisions through diagnosis-related group environments, for example, which see hospitals paid a certain fee for a procedure, such as open heart surgery, which allows them to retain any surplus if cost savings on the procedure can be

found. The States and Territories have growing unmet health needs, so finding more effective ways to treat problems would increase service provision and reduce their exposure to any future funding shortfalls.

Next steps

The Taskforce discussed the possibility of continuing discussions with appropriate financial support. It was hoped phase two of the Taskforce could be announced in early 2017. This second phase could involve broader membership from vendors and health purchasers from NSW and Queensland as well as Victoria.

The proposed second stage could develop an alternative procurement model and test the model through a state pilot. Such a project could define specific business problems and reduce them to 'small manageable chunks' amenable to measurable improvement. This case study could then be offered to state health providers as a template for reform to improve health outcomes and budget efficiency. Geographically limited but demonstrable success would be effective in encouraging other entities to adopt these strategies more widely.

The Taskforce might look at a region, perhaps in regional Queensland, assess its population needs, create a business case to address them and take the proposal to the purchasing authorities. Alternatively, it might examine the most efficient way to deliver a particular service in a particular region or state.

The second phase could also discuss the need for consistent specs with members of the Medical Technology Association of Australia, a group which represents the interests of the medical supply industry. The involvement of the MTAA would engage a larger number of industry stakeholders and add weight to any recommendations taken to high-level public decision makers and procurement bodies.

An important part of the second phase will be the development of guiding principles on how to frame strategic relationships in a government context whilst maintaining the standards of transparency and fairness for all concerned.

ATTACHMENTS

Consult Australia Response to the NSW Procurement Review

On 19 February 2016, Consult Australia submitted its response to the NSW Government Inquiry into the Procurement of Government Infrastructure. Their report “*Delivering Better Value: Government as a ‘model client’*”¹⁴ has a number of broad recommendations for public sector procurement which align with those of the GAP Taskforce:

- **Recommendation 6:** Public and private sector clients share knowledge and work collaboratively to achieve better procurement outcomes.
- **Recommendation 7:** Additional investment in developing a quality project brief and early engagement with industry will yield improved outcomes.
- **Recommendation 14:** An industry reference group could assist dialogue between government and industry and provide a forum through which regular feedback could be provided with a view to improving the efficiency of the process.
- **Recommendation 17:** Bid selection should focus on maximising value rather than minimising cost, and should do so taking whole of life considerations into account.
- **Recommendation 18:** Governments should consider issuing guidelines allowing for non-conforming bids to be considered, where they identify errors in the scope, challenge assumptions, or provide an innovative solution to the problem at hand
- **Recommendation 22:** Consultants and other stakeholders should be included in workshops at an early stage, to help the client determine the most appropriate delivery model.

¹⁴ <http://www.consultaustralia.com.au/docs/default-source/nsw/consult-australia-submission-to-nsw-parliamentary-inquiry-into-procurement---20160219-w-attachments.pdf?Status=Temp&sfvrsn=2>

MELBOURNE HEALTH
REQUEST FOR TENDER (RFT)
FOR THE
PROVISION, INSTALLATION AND MAINTENANCE OF A
HIGH END CT SCANNER FOR RMH EMERGENCY
DEPARTMENT
TENDER TSER0212MH

April 2012

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1. INTRODUCTION TO THE TENDER DOCUMENT.

This Tender document comprises of the following documents.

Attachment #	Document Name	Format
-	Tender Document	pdf
1	Tender Declaration	doc
2	Statement of Improper Assistance	doc
3	Statement of Tender Compliance	doc
4	Cashiers Advice Form	xls
5	Specifications Response Table	xls
6	Draft Terms and Conditions	doc
7	NMW SCS Cabling Specification V 8	.pdf
8	Existing Floor Plan <i>(to be provided)</i>	.pdf

These documents are available from the Victorian Government Tenders website. Any interested party must create a login, access the tender and download the documentation.

Melbourne Health reserves the right to amend the documentation at any time during the tender response period. You will not be individually notified of any amendments. If you have downloaded the tender documents as per above, the Victorian Government Tenders website will notify you of any change.

<https://www.tenders.vic.gov.au/tenders/home.do>

2. INTRODUCTION TO THE TENDER.

2.1 Organisational Background.

Melbourne Health is Victoria's second largest health service, providing comprehensive acute, sub-acute and community based health care programs to more than one million people living in North-Western metropolitan Melbourne, as well as general and specialist services to regional and rural Victorians.

The Royal Melbourne Hospital (RMH) – City Campus is a tertiary, teaching referral hospital providing specialist and general medical and surgical services, including cardiac, neuroscience and oncology as well as providing a major trauma service and Victoria's Infectious Diseases Service.

The Royal Melbourne Hospital plays a significant role in catering for severely injured patients from around Victoria, many of whom arrive by helicopter. The hospital treats approximately 200 trauma patients a month (35% of the Victorian total), with about 30% classified as major trauma.

The Radiology Department annually completes more than 170,000 diagnostic examinations and continues to experience growth in productivity and demand.

2.2 Tender Background.

Melbourne Health will be replacing a one high end CT system under a project that will be facilitated by two (2) different RFT's.

1. **High-End CT Scanner equipment replacement.** – TSER0212MH: The provision, installation and maintenance of a high end CT Scanner for ED is detailed in this document and related Attachments. This RFT is managed by Melbourne Health Contracts Unit. All queries should be directed in accordance with clause 3.8 of this document.
2. **High-End CT Scanner building works.** – This RFT is managed by Melbourne Health Capital Works Department in conjunction with a separate team of external consultants. This team is responsible for building works including any architectural, services or structural requirements. The consultant team will tender the building works and appoint a contractor to undertake the building works. All queries are to be directed to Leanne Chappell, Director Capital Works. leanne.chappell@mh.org.au

For the purposes of this RFT **High-End CT Scanner equipment replacement** - TSER0212MH, your tendered price should be based on having access to a purpose built room as per attached plans. Once an equipment vendor is appointed the consultant team will liaise with the vendor to confirm exact details for all services and building works.

2.3 Tender Requirements Summary.

This Tender (TSER0212MH) is for the supply, installation and maintenance of one high end CT system that is capable of performing high quality imaging, including brain perfusion, trauma, triple rule out studies and Coronary CTA imaging.

The anticipated installation month is October 2012 and the unit will be located in a new CT suite that is to be built within the ED Radiology Department at The Royal Melbourne Hospital (RMH) Campus on the Ground Floor.

A trade in price is also requested for the existing CT equipment currently located in ED:

- Siemens Sensation 16 Slice CT scanner installed in April 2005 with serial number 51656

Preference may be given to a system that can easily be upgraded with regard to both hardware and software to maintain the system's performance and to match changing clinical and technological needs and development.

All options and accessories must be described and specified. It must be made clear whether equipment is offered as part of the overall quotation or whether it is offered at additional cost.

Ergonomic design and radiation safety features will be an important consideration when evaluating the submissions. The unit should be easy for users to operate and easily learnt by new operators. All selectable controls, displayed information and modes of operation should be clearly marked and explicit.

Melbourne Health has an enterprise wide Fuji Synapse PACS system as well as Fuji Computed Radiography (CR) system. Melbourne Health uses the Karisma Radiology Information System (RIS) which is supported by Kestral Computing. Vendor commitment to work collaboratively with Fuji Film Medical Systems and Kestral Computing is essential and it is expected that solutions offered be fully compatible with these existing systems.

Your organisation may wish to submit more than one system for Melbourne Health to consider. If this is the case, an ATTACHMENT 5 - Response to Specifications is required for EACH system you are offering.

2.4 Definitions and Abbreviations.

Agreement – refers to any resultant contract with the Successful Tenderer in regards to this RFT.

DR – means Direct Radiography

Equipment & Services – refers to the equipment tendered in this RTF as outlined in Tender Response Document - Specifications.

Health Service – refers to Melbourne Health or any of its entities.

Preferred Tenderer – refers to the party or panel of parties, which Melbourne Health selects to engage in contractual negotiations following tender evaluations

Successful Tenderer – refers to the party or panel of parties, which Melbourne Health (1) recognises as the winners of this RFT; and (2) has a legally binding agreement in place.

System – refers to the entire offering made by a Tenderer in response to the request for Tender. It may include, but is not limited to hardware, software, warranty and other support processes.

Tenderers – refers to all parties whom submit a tendered response to this RFT.

3. CONDITIONS OF TENDERING.

3.1 Tender Close Date & Time.

- 3.1.1 Tenders must be lodged [strictly] during the hours of 9:00am to 11:30am and 1:30pm and 3pm on the following date only.

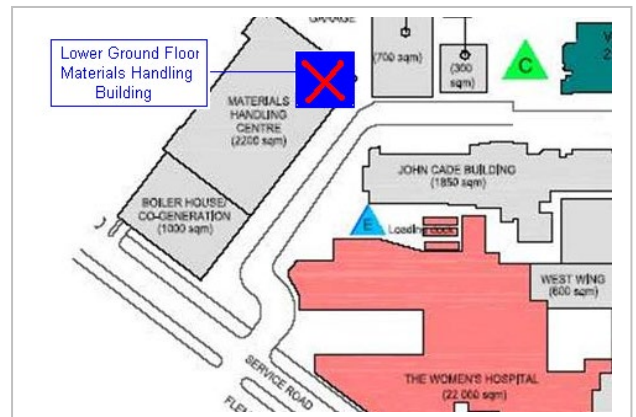
Thursday 10 May 2012

- 3.1.2 Failure to submit the tender within the specified timeframe will disqualify the tender from the evaluation process and the tender will be returned to the sender unopened. All times listed here and throughout the Tender, are Australian Eastern Standard Time (EST), unless otherwise stated.

3.2 Place of Closing.

- 3.2.1 The lodgement address for this RFT is:

Michelle Leone or Ben Black
Administration - Facilities Management
Materials Handling Building
Royal Melbourne Hospital – City Campus
Grattan Street
PARKVILLE VIC 3050



3.3 Delivery Method.

- 3.3.1 Tenders must be delivered by hand. Oral, postal, facsimile or E-mail responses will not be accepted.

3.4 Packaging of Tender Submissions.

- 3.4.1 Tenders and other supporting material must be submitted in a sealed envelope or other appropriate package endorsed on the outside with **Tender Number(s) and the name of the Company tendering**.
- 3.4.2 Tenderers must lodge 4 (four) hardcopy paper based Tender submissions. One must be marked ORIGINAL and the others marked COPY 1, COPY 2 etc.... In the event of any discrepancies between the ORIGINAL and COPIES, the version marked ORIGINAL shall prevail. **Please note: only the ORIGINAL copy needs to contain a hardcopy print out of ATTACHMENT 5.**
- 3.4.3 The Tenderer must also submit a complete CD Rom version of the Tender submission based on Microsoft Word (.doc) Adobe Reader (.pdf) and/or Microsoft Excel (.xls) file formats only.
- 3.4.4 The RFT must be lodged in accordance with Conditions of Tendering by the tender close date/time & place.

3.5 Extension of Tender Close Date & Time.

- 3.5.1 All requests for extensions to the deadline must be submitted in writing to the points of contact to ben.black@mh.org.au Any extension to the deadline is at the sole option of the Health Service.

3.6 Tender Lodgement Fee.

- 3.6.1 A fee of \$200.00 plus \$20.00 GST is applicable for this document. This fee is to partly cover the cost of producing this document and independent evaluation fees. The fee must be paid before any tender submission is made. Any tender submissions received where this fee has not been paid will not be considered and will be returned to the submitting party.
- 3.6.2 Payment can be made at the following locations and a Tax Invoice will be provided.
- **Tender Lodgement Office** – CASH & CHQ only. CHQ payable to 'Melbourne Health'
 - **Royal Melbourne Hospital Cashier** – CASH, CHQ, EFTPOS & Credit Card (*Mastercard & VISA only*).
 - Located in the main foyer of RMH Hospital, Grattan Street PARKVILLE.
 - Attachment 3 Cashiers Advice Form MUST be produced at the Cashier Office otherwise the payment cannot be processed. .

- A **Tax Invoice** provided by the Cashiers Office must be produced upon Tender lodgement otherwise the Tender cannot be accepted.
- Tenderers are advised to allow for at least 1 hour before close of Tender to make payment of Tender Documentation Fee at Cashiers Office and complete the Tender lodgement.
- Cheques are to be made out to Melbourne Health.

3.7 Site Visits & Tender Briefing.

- 3.7.1 An information session will be held for this Tender on the following date and time. Please arrive well before hand, as the session will commence on time. Bring everything you may need including pens, paper, measuring tape (if required).

Tuesday 17 April 2012
3 pm – 3.30 pm
Level 1, Clinical Room 1
Main Radiology Department
The Royal Melbourne Hospital
Grattan Street, PARKVILLE VIC 3050

- 3.7.2 Member(s) of the Tender Evaluation Committee with technical expertise *may* conduct site visits of the two referee sites you will be asked to nominate in your tender response. All reasonable travel and accommodation costs will be borne by the Tenderer if the site is outside the Melbourne Metropolitan area.
- 3.7.3 Approaching campus staff without written permission from the Point of Contact outlined below, is strictly forbidden. Tenderers who contravene this condition *may* have their tender disqualified.

3.8 Point of Contact & Questions.

- 3.8.1 All enquires for information beyond that contained in this RFT are to be formally lodged by e-mail given the limited time available to respond to this RFT. All questions are to be addressed to:

Technical Equipment Enquiries

Mr Peter Nuttman (Operations Manager - Imaging)
e-mail: peter.nuttman@mh.org.au

Building Works Enquiries

Mr Shaun Williams (Project Manager – Capital Works)
e-mail: shaun.williams@mh.org.au

Tender Process / Non-technical Enquiries

Mr Ben Black (Tenders & Contracts Administrator)
e-mail: ben.black@mh.org.au

- 3.8.2 Enquiries relating to this tender MUST NOT be made directly to the Department or to clinical staff. Only the above points of contact are acceptable. Tenderers who contravene this condition will have their tender response disqualified.
- 3.8.3 Melbourne Health is not bound to provide the information requested. Any response or information will also be given to other Tenderers.
- 3.8.4 The final time for any tender questions is **3 pm Thursday 3 May 2012**, any questions and enquires placed after this time may not be answered in a timely manner.

3.9 Late Tenders.

- 3.9.1 Late tenders will be returned unopened to the submitting party. If the tender package is not labelled in accordance with 3.4 of this document, then the package will be opened purely to identify the tenderers return information.

3.10 Tenders Conditions.

- 3.10.1 The provisions set out in this Tender Document, Section 3 govern the tender process in relation to the request for tender for the supply of the Equipment and Services. By submitting a tender response, the Tenderer becomes bound by these Conditions of Tendering.

3.11 Successful Tenderer.

- 3.11.1 The Successful Tenderer can use sub-contractors to provide some of the Equipment and Services. Tenderers should note that where Equipment and/or Services are sub-contracted, the management of the service delivery is integral to, and provided by the Successful Tenderer.
- 3.11.2 Where sub-contractors are used, the Service Provider must ensure the suitability of any sub-contractor and that all work performed by sub-contractors meets the requirements of the Agreement.
- 3.11.3 The Successful Tenderer shall include in all sub-contracts all relevant conditions of resultant Agreement between itself and Melbourne Health, shall be responsible for all work performed by its sub-contractors, and shall indemnify Melbourne Health accordingly.

3.12 Duration of Agreement.

- 3.12.1 Melbourne Health intends to enter into an Agreement with any successful tenderer for the duration of the service period that budget allows.

3.13 Tenderers are to Inform Themselves.

- 3.13.1 Tenderers shall be deemed to have:
 - 3.13.1.1 Examined this RFT and any other documents referenced or referred to herein, and any other information made available in writing by Melbourne Health to Tenderers for the purpose of submitting a tender response. This includes periodically referring to the Victorian Government Purchasing Board website through out the Tender response period (if used);
 - 3.13.1.2 Examined all other information which is obtainable by the making of reasonable and timely inquiries relevant to the risks, contingencies and other circumstances having an effect on their tender response; and
 - 3.13.1.3 Satisfied themselves as to the correctness and sufficiency of their tender response, including quoted prices which shall be deemed to cover the cost of complying with all Conditions of Tender, the Agreement, and of all matters necessary for the due and proper performance and delivery of the Equipment and Services described in the specifications contained in this RFT ("the Specifications").
- 3.13.2 It is the responsibility of Tenderers to obtain all information necessary for their tender response.
- 3.13.3 The activities detailed in the Specifications are based on current and historical requirements. However, the activity requirements as expressed in the Specifications may differ from such current and historical requirements. Tenderers must make their own independent assessments of actual workload requirements under any resultant Agreement and any tendered price will be deemed to have been based upon such an independent assessment. Such tendered prices must as a consequence also accommodate, the necessary flexibility of variances/fluctuations in service demand, i.e., demand peaks/troughs experienced in a public health facility of the nature, size and type of the Melbourne Health sites concerned.
- 3.13.4 Any significant variation to the scope or nature of Equipment or Services required under the Agreement due to planned or unforeseen activities will be the subject of appropriate Agreement variation provisions. In situations where a requirement arises for a new service not covered under the Agreement, Melbourne Health may, at its sole discretion, request a quotation from the successful tenderer to perform the new service.

3.14 Freedom of Information.

- 3.14.1 The attention of Tenderers is drawn to the Freedom of Information Act (1982) which gives members of the public right of access to documents in possession of the Victorian Government and its agencies (which include Melbourne Health). The Act extends as far as possible the right of the Victorian community to access information (generally documents) in the possession of Melbourne Health, limited only by exceptions and exemptions necessary for the protection of essential public interests and the private business affairs of persons in respect of whom information is collected and held by departments and public authorities. Tenderers should obtain their own advice on the impact of this legislation, on their participation in this process.

4. MAKING THE SUBMISSION.

4.1 Cost of preparing & submitting the RFT

- 4.1.1 Melbourne Health will not be responsible for any costs incurred by the Tenderer in preparing a tender or associated expense even if this RFT is withdrawn and the Tender process ended.

4.2 Ownership of Tender documents

- 4.2.1 All Tender documents become the property of Melbourne Health upon submission. The Health Service may make copies of the Tender documents for any purpose related to this RFT.

4.3 Tender validity period

- 4.3.1 It is a condition of this RFT, that the tender response's offer remains valid for acceptance for a period of no less than 90 days from close of Tenders. The Tenderer shall state any longer period for which its offer remains valid.

4.4 Conflict of Interest

- 4.4.1 Where a Tenderer identifies that a conflict of interest might arise in the provision of Equipment and Services, it must detail that potential conflict of interest in its Tender. If at any time prior to entering into an Agreement for the provision of the Equipment and Services, an actual or potential conflict of interest arises for a Tenderer, that Tenderer must immediately notify Melbourne Health in writing. If any conflict of interest is identified at any time before entering into an Agreement for the provision of the Equipment and Services, Melbourne Health may, in its absolute discretion:
- 4.4.1.1 Enter into discussions to seek to resolve such conflict of interest; or
 - 4.4.1.2 Disregard the tender submitted by such a Tenderer; or
 - 4.4.1.3 Take any other action, as Melbourne Health considers appropriate.

4.5 Language of Tenders

- 4.5.1 The Tender, including all attachments and supporting data, is to be written in English. Unless otherwise specified, all units of measurement are to be expressed in metric units and are to be consistent throughout the Tender and supporting data and documentation.

4.6 Quoted Prices

- 4.6.1 The prices quoted are to be expressed in Australian dollars, and shall be deemed to apply to the products and services, as described in the Tender documentation, and to the unit quantity and/or for the duration as stated.

4.7 Non-complying Tender

- 4.7.1 Any Tender submission that does not comply with all of the Tender Conditions in this RFT may be considered to be a non-complying tender and may be rejected at Melbourne Health's discretion.
- 4.7.2 Melbourne Health, however, reserves the right to accept non-complying Tenders.

4.8 Statement of Work

- 4.8.1 Melbourne Health in conjunction with the successful tenderer will develop a statement of work, which will form part of the Agreement (the Statement of Work). The Statement of Work will incorporate the following documents/information (amended where applicable to reflect the outcomes of the contract negotiation process):
- 4.8.1.1 The Specifications
 - 4.8.1.2 The successful Tenderer's Tender response; and
 - 4.8.1.3 Key Performance Indicators (KPI's)
- 4.8.2 The intention of the Statement of Work is to develop a succinct document, which reflects the Tenderers solution in line with service delivery and performance requirements agreed to by both parties during contract negotiations. The Statement of Work will act as the base document, which can be used by both Melbourne Health and Tenderer representative for the implementation, execution and management of the service delivery, and shall appear within the Agreement.

4.9 Agreement Project Plans

- 4.9.1 The successful Tenderer shall be required to convert elements of its tender response into project plans, which shall form part of the Agreement (the Plans). Prior to incorporation into the Agreement, the successful

Tenderer shall submit the Plans to Melbourne Health for review and final approval. Details of the required Plans are as follows:

4.9.1.1 Management plan – How the successful tenderer will manage delivery of the Equipments and Services; and

4.9.1.2 Quality plan – How the successful tenderer will ensure the quality of the Equipment and Services.

4.10 Alterations, Deletions & Illegibility

4.10.1 Tenders containing alterations or deletions, and in which prices or other information are not clearly and legibly stated, may be excluded from consideration. The Tenderer must initial any alteration made to a Tender.

4.10.2 In the event of a discrepancy between the paper and any electronic version of a Tender, the paper version will prevail.

4.10.3 Alterations, additions or amendments may be made to the tender only if it can be shown, to the satisfaction of Melbourne Health, that a clerical/keyboard error has been made.

4.11 Tenders discrepancies, errors or omissions

4.11.1 Should a Tenderer find or reasonably believe it has found any discrepancy, error, ambiguity, inconsistency or omission in the Tender documents or any other information given or made available by Melbourne Health, the Tenderer shall notify Melbourne Health in writing thereof on or before the required time and date for submissions as per 3.1 Tender Closing Time.

4.11.2 All particulars and information required in this RFT are to be provided. Failure to do so may render a Tender liable to rejection at Melbourne Health's sole discretion.

4.12 Performance Guarantee

4.12.1 The successful Tenderer **must** lodge with Melbourne Health a bank guarantee from a recognised financial institution as security for due performance of the proposed Agreement. The sum is to be determined by Melbourne Health and will not exceed 10% of the total Agreement value (excluding transition and set up costs). A Guarantee from the Tenderers parent company (where applicable) may also be required.

4.13 Clarification

4.13.1 Melbourne Health may seek oral or written clarification from the Tenderer in relation to the terms of its tender. Any clarification provided by the Tenderer in response to a request for clarification is not to contain any new material additional to that included in the Tenderers tender. Failure to supply clarification to the satisfaction of Melbourne Health may render the tender liable to rejection at Melbourne Health's sole discretion.

4.14 Prerequisites to Acceptance

4.14.1 Notwithstanding any other requirements of the Tender documents, Melbourne Health may require a Tenderer to submit additional information, to allow further consideration of its Tender before any Tender is accepted.

4.14.2 Should the Tenderer fail to submit any of the information required by the date and time stipulated by Melbourne Health, the Tender may be treated as non-conforming and may be rejected at Melbourne Health's sole discretion.

4.15 No contract or undertaking

4.15.1 The Conditions of Tendering do not and shall not be construed as making any representation, undertaking or commitment by Melbourne Health whether express or implied that:

4.15.1.1 The project will proceed to any stage beyond the lodgement of the Tender;

4.15.1.2 The project will actually be undertaken, whether in the form described in these Conditions of Tendering or otherwise: or

4.15.1.3 Melbourne Health will enter into any legally binding contract with any person to undertake the project.

4.16 Post Tender Negotiations

4.16.1 Melbourne Health reserves the right to conduct negotiations with any or all of the Tenderers after the Tender closing date. In these post-Tender negotiations Melbourne Health may seek variations to an offer within the original tendered price or may seek supplementary offers in respect of any changes to the originally stated requirements. Melbourne Health reserves the right to enter into such discussions and negotiations at its absolute discretion (which includes treating with any Tenderer as it deems fit without the need to correspond with other Tenderers during this post Tender period.)

4.17 Acceptance of Quotations

- 4.17.1 Acceptance of the preferred Tender will be subject to the execution of the Agreement between Melbourne Health and the successful Tenderer.

4.18 Disclosure of Information

- 4.18.1 No Tenderer shall make any public announcement concerning the acceptance of any tender or any other matter concerning this RFT or the subsequent Agreement without the prior written approval of Melbourne Health.

4.19 General Conditions

- 4.19.1 All periods of time specified by the Conditions of Tendering are expressly for the convenience of Melbourne Health and may be varied or extended, at any time and for such period, as Melbourne Health in its discretion considers appropriate.
- 4.19.2 Melbourne Health may, in its discretion at any time, vary the nature or specification of the project, the selection and engagement process at any stage of it, or terminate that selection and engagement process or any negotiations being conducted at that time with any person.
- 4.19.3 Participation in the Tender or any subsequent stage in relation to the selection and engagement process shall be at the Tenderer's risk, cost and expense in all things. Consequently, Melbourne Health shall not be liable to any Tenderer on the basis of any promissory estoppel, quantum meruit or on any other contractual or restitutionary grounds whatsoever as a consequence of any matter or thing relating to or incidental to that Tenderers participation in the selection and engagement process including without limitation the following:
- 4.19.3.1 The Tenderer is not engaged to undertake the project
 - 4.19.3.2 Melbourne Health varies or terminates the selection and engagement process and any negotiations with the Tenderer; or
 - 4.19.3.3 Melbourne Health decides not to proceed with the project.
- 4.19.4 Tenderers shall observe all relevant statutory and other regulatory authority requirements in the formulation of tenders and shall not:
- 4.19.4.1 Accept or provide secret commissions;
 - 4.19.4.2 Collude with other Tenderers;
 - 4.19.4.3 Enter into any improper and commercial arrangements with any other Tenderer;
 - 4.19.4.4 Seek to influence decisions by improper means;
 - 4.19.4.5 Accept incentives to provide services to their agents or contractors, which could financially disadvantage Melbourne Health.

5. TENDER EVALUATION.

5.1 Evaluation Process

- 5.1.1 Participation in the Tender or any subsequent stage in relation to the Tenders will be evaluated to identify the option that represents best value for money. The merit of each Tender will be determined based upon the assessed performance of the option against the evaluation criteria in balance with the risks Melbourne Health perceive it may potentially become exposed to, in accepting the Tender.
- 5.1.2 Melbourne Health may at any time and at its absolute discretion, withdraw this RFT from all Tenderers and end the Tender process.
- 5.1.3 Melbourne Health will not necessarily accept the lowest priced Tender, nor any Tender. Melbourne Health unconditionally reserves the right to accept or reject any Tender regardless of compliance or non-compliance with the Conditions of Tender. Acceptance of the preferred Tender will be subject to the execution of an Agreement between Melbourne Health and the successful Tenderer.
- 5.1.4 In determining best value for money, Melbourne Health is obliged to satisfy itself that prices offered are reasonable. The Tenderer agrees to provide access to such information as determined by Melbourne Health as necessary in order to evaluate the reasonableness of their Tendered prices. Any information obtained will be treated by Melbourne Health as strictly confidential.
- 5.1.5 Where no conforming Tenders are received or where Tenderers are assessed as not having the capacity or infrastructure or required expertise to provide the Equipment and Services, Melbourne Health may release itself from further consideration of the Tenders and either reject all Tenders or negotiate with any one or more Tenderers.

5.2 Evaluation Criteria

- 5.2.1 In assessing Tenders, Melbourne Health **may** use the following criteria, which are not listed in any order of importance or weight:
- 5.2.2 Level of compliance with the Melbourne Health requirements
- 5.2.3 Ability to deliver the Equipment and Services in accordance with the requirements of the Specifications contained in Attachment 5 & 6 of this RFT.
- 5.2.4 Price & Value for Money.
- 5.2.5 Financial and resource capacity of the Tenderer to undertake the Agreement
- 5.2.6 Ability to implement the full Agreement requirements within a timely period
- 5.2.7 Viability, effectiveness and functionality of the proposed provision of the Equipment and Services
- 5.2.8 Effectiveness of proposed strategies, systems and procedures, covering:
 - 5.2.8.1 Risk management
 - 5.2.8.2 Quality management, including the successful tenderer's willingness to participate in accreditation processes, as well as cooperating with accreditations to which Melbourne Health is subject to.
 - 5.2.8.3 Industrial relations
 - 5.2.8.4 Occupational Health and Safety
- 5.2.9 Nature of research support and/or collaboration offered
- 5.2.10 Level of contractual security offered to Melbourne Health through the Tenderers proposals on:
 - 5.2.10.1 Acceptance of draft Agreement
 - 5.2.10.2 Price variation
 - 5.2.10.3 Insurance and indemnity
- 5.2.11 Experience of the Tenderer in operation and management of activities of similar nature, range and size
- 5.2.12 Nature of any legal proceedings and/or judgements entered against the Tenderer during the past 3 years
- 5.2.13 Opinions of referees.

5.3 Tendered Prices

- 5.3.1 The assessment of Tendered prices may take into account the following:
 - 5.3.1.1 Whether the tendered price is fixed for the term of the Agreement or variable
 - 5.3.1.2 The tendered rates for each of the required products
 - 5.3.1.3 Pricing flexibility
 - 5.3.1.4 Administration and management costs
 - 5.3.1.5 Corporate overheads
 - 5.3.1.6 Transition costs
 - 5.3.1.7 Settlement discounts (if any)
 - 5.3.1.8 Any other costs or discounts which form part of the Tenderers offer
 - 5.3.1.9 Any offered trade in, decommissioning and removal of the existing equipment.
- 5.3.2 In the evaluation process, Melbourne Health may at its absolute discretion, make certain adjustments to the tendered prices to account for the following matters, which may need balancing in order to establish a common basis for the comparison of Tenderers:
 - 5.3.3 Transition costs, which are all costs incurred by Melbourne Health in moving from the current arrangements to a new Provider
 - 5.3.4 Other costs or financial impacts on Melbourne Health that may arise from appointing a particular Tenderer.

5.4 Tender Presentations

- 5.4.1 As part of the evaluation process, Tenderers *may* be required to give a presentation of their submissions to the Tender Evaluation Committee (TEC), at Melbourne Health's sole discretion. Should the TEC decide they wish to exercise this option, it is expected, that its format will include verbal explanation and written data supporting any proposal or quotation. Should the TEC decide they wish to exercise this option, Tenderers will be given further details at that time.

5.5 Acceptance of Tender

- 5.5.1 Melbourne Health is not under any obligation to:
- 5.5.1.1 Enter into discussions with Tenderers in relation to the rejection of any Tender submission; or
 - 5.5.1.2 Give reasons for not accepting any of the Tenders.

5.6 Appointment of Preferred Tenderer

- 5.6.1 Melbourne Health may select a preferred Tenderer by notice in writing. That does not mean that Melbourne Health has accepted any tender. The successful tenderer is entitled to negotiate with Melbourne Health and that in the course of such negotiations the terms of the Agreement may change.
- 5.6.2 Melbourne Health may request further information from the preferred Tenderer.
- 5.6.3 Melbourne Health may subsequently appoint a preferred tenderer as the successful tenderer, however, it is not obligated to do so.

5.7 Agreement to be final

- 5.7.1 The Agreement executed by Melbourne Health and the successful Tenderer will exclusively govern the relationship between the parties for the term of the Agreement.

5.8 Failure to execute Agreement

- 5.8.1 Without prejudice to any of its other rights, if the Tenderer fails to execute the resultant Agreement within 2 weeks of the date the Tenderer receives notification that it was the successful Tenderer, Melbourne Health may, at its sole discretion, cancel its award of the tender to the Tenderer and recover from the Tenderer any losses Melbourne Health has sustained as a consequence of the Tenderer's failure to fulfil its obligations.

6. INFORMATION TO BE PROVIDED BY TENDERERS.

6.1 ATTACHMENT 1 Tender Declaration

- 6.1.1 All Tenderers (including details of any sub-contractors it is intended to use in the delivery of the Equipment and/or Services) shall duly complete the 'Tender Declaration Form' enclosed in Attachment 1 of this package. This must be included and bound to any response to this tender.

6.2 ATTACHMENT 2 Statutory Declaration Improper Assistance

- 6.2.1 Melbourne Health shall exclude from further consideration Tenders that have been compiled with improper assistance of employees or ex-employees of Melbourne Health, or which have been compiled using information unlawfully obtained from Melbourne Health.
- 6.2.2 Tenderers are to the 'Statutory Declaration' enclosed in Attachment 2 of this package. This must be included and bound to any response to this tender.
- 6.2.3 Please note that this Statutory Declaration must be witnessed by A Current Practitioner within the meaning of the Legal Practice Act 1996, i.e. Justice of the Peace, Solicitor, Police Constable etc.

6.3 ATTACHMENT 3 Statement of Compliance

- 6.3.1 This Statement of Compliance is to be signed and completed ONLY by the person duly authorised to sign tenders and submit quotations on behalf of the tendering organisation.
- 6.3.2 It is important that Tendering organisations indicate they have read each section of the RFT documentation and indicate their willingness to comply or otherwise.
- 6.3.3 Tenderers are to use **ONLY** the two following statements:
- "Read and understood, we will comply"
- or
- "Read and understood, we will not comply for the following reasons.....".

6.4 ATTACHMENT 4 Cashiers Advice Form

- 6.4.1 Use this form to pay the lodgement fee. Refer to [Section 3.6](#) of this document for information on the submission of your Tender response.

6.5 ATTACHMENT 5 Specifications Response Table

- 6.5.1 This document contains equipment technical specifications and space for you to provide your response to specifications in an Microsoft Excel spreadsheet.

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- 6.5.2 You must complete this spreadsheet for each CT Type your organisation is offering to Melbourne Health. I.e.: 2 offerings means you will be providing 2 different copies of this spreadsheet.
 - 6.5.3 **DO NOT insert columns or merge/unmerge cells.** You may adjust cell width and height.
 - 6.5.4 Tenderers MUST use the space provided to answer the questions in FULL. Tenderers whom fail to answer the questions in FULL in the space provided and instead rely on Melbourne Health ONLY to follow referenced attachments or supporting documentation, risk tender evaluation committee members not finding key information regarding your submission.
 - 6.5.5 You only need to provide 1 hardcopy of this large document and it must be provided in the Tender submission marked ORIGINAL.

6.6 ATTACHMENT 6 Draft Terms and Conditions

- 6.1.1 Attachment 6 contains a copy of the agreement relating to this RFT. Tenderers are not required to sign the agreement at this stage. If however, you are selected to be Preferred Tenderer you will be required to sign two copies of this agreement [which may include relevant attachments and minor amendments as determined by Melbourne Health]. It is important that Melbourne Health understands your organisations willingness to sign such a document.
- 6.1.2. Acceptance of the terms and conditions within the agreement are a component of the assessment criteria for this RFT. Questions, clarifications or requests for amendment will only be considered if (1) submitted by the date and time stipulated in item 3.8.4; and (2) in accordance with 3.8.1 of this RFT document. Melbourne Health will only consider clarifications, requests and/or amendments if in its sole discretion they are considered as being of a material nature. Melbourne Health shall advise regarding same in accordance with item 3.8.3.
- 6.1.3 Tenderers **must** review this document and confirm they understand and accept the terms and conditions without variation or amendment as part of their tender.