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Building Australia's Future: Why We Need Alliancing for Hospital Infrastructure

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Australia doesn't need to be sold on the idea of alliance contracting. We invented much of it. Since the Wandoo and East Spar oil and gas projects introduced project alliancing to this country in 1994, the model has become a mainstay of Australian infrastructure delivery — particularly in the sectors that build the things we drive on, ride on, and drink from. Between 2004 and 2009 alone, alliance projects in the road, rail and water sectors across New South Wales, Victoria, Queensland and Western Australia were worth \$32 billion, representing 29% of the total \$110 billion infrastructure spend in those sectors nationally. More broadly, alliancing has been used on more than 200 complex infrastructure projects in Australia, from the AU\$1.95 billion Ipswich Motorway upgrade to major brownfield rail packages underpinning Melbourne's Metro Tunnel and Perth's METRONET program. Victoria, in particular, has kept the model close at hand for its rail sector, where alliancing is still seen as the most appropriate delivery method for large, complex, live-network projects.

In other words, when it comes to horizontal infrastructure — tunnels, tracks, pipelines, motorway interchanges — Australia has spent three decades building the expertise, contract templates, and institutional comfort to do alliancing well. So here's the obvious question we don't ask often enough: if alliancing is good enough for our most complex roads, railways and water networks, why do we still build most of our hospitals — arguably the most complex, bespoke vertical construction projects governments ever commission — under conventional design-and-construct or public-private-partnership (PPP) contracts instead?

Adelaide's New Women's and Children's Hospital show what can go wrong when we don't ask that question — and, remarkably, South Australia's own biggest-ever road project shows what can go right, using the very alliance delivery model this article is arguing for. British Columbia's new Cowichan District Hospital Replacement project, and Western Australia's newest hospital builds, suggest what might happen if the rest of the country's hospitals followed suit.

Adelaide's blowout: the cost of treating a hospital like a standard build

Look no further than Adelaide, where the New Royal Adelaide Hospital, using a PPP delivery model, is widely considered as one of Australia's most controversial and expensive infrastructure projects. Originally budgeted at \$1.7 billion, the project suffered extensive structural issues and massive cost blowouts, ultimately reaching approximately \$2.3 billion amidst ongoing legal battles between SA government and the construction builders.

Adelaide's new Women's and Children's Hospital (nWCH) has become a more recent case study in how badly a major hospital build can go under conventional procurement. First costed at \$1.95 billion, the project was reported to be running in excess of \$2 billion within months, then rose again to a confirmed \$3 to \$3.2 billion, with rumours of further blowouts — and its opening date has slipped from a promised 2027 to 2030-31. Health Minister, Chris Picton, has pointed to “a range of complexities on site” as part of the explanation. The project involved demolishing a heritage-listed police barracks, co-locating an entirely new intensive care unit alongside an existing tertiary hospital, integrating a helipad and specialist paediatric and maternity infrastructure, and hitting sustainability



targets as SA's first fully electric public hospital — all on a constrained inner-city site. Every one of those elements is a source of design and construction risk that is genuinely difficult to price accurately at the outset, because no two hospitals — and no two sites — are the same.

Under a conventional contract, that uncertainty tends to surface as a dispute: the builder claims a variation, the owner pushes back, and the resolution shows up months or years later as a headline cost blowout or a schedule slip. That is essentially the story of the nWCH — cost estimates that moved from \$1.95 billion, to a confirmed \$3-3.2 billion and counting, alongside a three-year-plus delay to the opening date. This is exactly the kind of outcome alliance contracting was developed to prevent on horizontal infrastructure — and there's a reasonable case that hospitals need that protection even more, given how much more bespoke and clinically specific a hospital build is than a standardised stretch of motorway.

The irony sitting a few kilometres away: SA's own alliance-delivered motorway is on budget

Here's what makes the nWCH story so pointed: South Australia doesn't have to look interstate or overseas to see the alternative in action. At the very same time its hospital budget has been climbing, the state has been delivering its biggest-ever infrastructure project — the \$15.4 billion River Torrens to Darlington (T2D) Project, the final 10.5km missing link in Adelaide's North-South Corridor — through exactly the delivery model this article is arguing hospitals should adopt.

T2D was procured as a Project Alliance from the outset, with the SA Government selecting a consortium of John Holland, Bouygues Construction, Arcadis Australia, Jacobs and Ventia as preferred alliance partner in 2024. Crucially, the government's own framing of the deal has been about cost certainty, not just speed: the Minister for Infrastructure and Transport said the consortium has confirmed that it can deliver the T2D Project on budget, delivering significant travel, economic and community benefits for South Australians. Since then, the project has kept hitting its construction milestones — three tunnel boring machines assembled and craned into place, more than 1,000 precast tunnel-lining segments manufactured, and full-scale tunnelling now underway on schedule in 2026, with an additional third TBM giving planners a reasonable expectation the project could finish even earlier than its stated 2031 deadline.

That's the contrast in one state, side by side: a \$15.4 billion tunnelling megaproject — arguably as complex, uncertain and technically demanding as any hospital build — delivered through an alliance and tracking on time and on budget; and a \$3.2 billion hospital, delivered through more conventional procurement, that has already blown its budget by roughly two-thirds and slipped its opening by more than three years. Same state government, same era, same exposure to labour shortages and construction inflation — very different delivery model, very different outcome.

What is an alliance model, and why does it suit complex, one-off projects?

Traditional hospital procurement in Australia typically relies on design-and-construct or public-private partnership (PPP) contracts, where risk is transferred (at least on paper) to a single head contractor, and the owner and builder often end up on opposite sides of a negotiating table the moment something goes wrong — a site condition, a supply chain shock, a design clash. Disputes get litigated or negotiated after the fact, and schedules and budgets absorb the damage.



An alliance model works differently. The project owner and the private-sector participants — head contractor, architect, engineers, and sometimes major trade partners — enter into a single alliance agreement and operate as one integrated team. Decisions are made on a "best-for-project" basis rather than by each party protecting its own commercial position. Risk and reward are shared across the alliance rather than allocated to one party, and because everyone's commercial outcome is tied to the project's overall success, the incentive structure pushes toward collaborative problem-solving instead of adversarial claims management.

That's precisely why Australian road, rail and water agencies have reached for it repeatedly on their hardest jobs — T2D being the freshest and largest example. And it's precisely the mechanism missing from a project like Adelaide's Royal Adelaide Hospital: because the owner and delivery team share risk and make decisions jointly under a single agreement, unexpected site conditions or design complexities get solved collaboratively and priced transparently as they arise, rather than becoming adversarial claims that fester until the next public cost update. The bespoke, one-off nature of hospitals — the very thing that makes them expensive to get wrong — is also the reason an integrated, best-for-project delivery structure should suit them just as well as it has suited our biggest tunnels and rail packages.

Cowichan, British Columbia: proof the model translates to hospitals

If Australia has the horizontal track record, British Columbia is now supplying the vertical proof point — and it's a compelling one. PCI Group supported the Infrastructure BC to establish the Cowichan District Hospital Replacement Project Alliance — recently renamed **Quw'utsun Valley Hospital / Quw'utsun Hilitun-ew't-hw**. This was the first vertical infrastructure project in Canada to adopt an alliance project delivery model, bringing together Island Health, EllisDon, Parkin Architects, BC Infrastructure Benefits, and Infrastructure BC as a single integrated team.

The numbers are compelling. The new fully electric facility will be 56,448 gross square metres in size, more than three times larger than the current facility, with capacity for 204 beds, expanding the emergency department from 17 to 45 treatment spaces and increasing operating rooms from four to seven. As of May 2026, the project had reached 90% construction completion, with the BC Minister of Infrastructure confirming it remains on track to open to patients in mid-2027. It has also picked up external recognition along the way, being named the Gold Level winner of the 2026 Touchstone Award from the Center for Health Design for its evidence-based design.

Just as importantly for anyone assessing the model's credibility, this wasn't a sole-sourced arrangement. The project was awarded after a competitive twin-TOC (target outturn cost) process in which multiple proponents submitted bid pricing and designs— meaning BC tested the market to ensure price competition.

The strongest signal: BC didn't stop at one

A single successful project could be a fluke of good management or a favourable site. What makes Cowichan a genuinely strong case study is that British Columbia's infrastructure agency has continued rolling the model out. Infrastructure BC, with PCI support, has since applied an alliance-style "Single TOC" (target outturn cost) procurement approach on four separate projects on the BC Highway Reinstatement Program, as well as on the Burnaby Hospital Phase 2 and BC Cancer Centre project, the Richmond Hospital Redevelopment Project (Phase 2 & 3), and the University Hospital of



Northern BC Acute Care Tower Project to accelerate procurement and delivery of these critical projects.

That's a government repeatedly choosing the same collaborative procurement structure for its next generation of hospital builds, after watching how the first one performed on site. In infrastructure delivery, repeat business from the owner is the clearest endorsement there is.

Western Australia is already asking the same question

Australia doesn't need to look only overseas for evidence — WA has just placed the same bet, extending a delivery model it already trusts on roads and rail into hospital buildings. In January 2026, the WA Government announced that preferred alliance partners had been identified for both a new building at Royal Perth Hospital and a new hospital for the Mandurah and Peel region. Both are being funded through the Cook Government's \$1.5 billion Building Hospitals Fund, part of a broader \$4.9 billion health infrastructure program.

WA's own Health Infrastructure Minister, John Carey, has been explicit about why: "The alliance contracting model streamlines procurement and ultimately, will support quicker delivery times", describing the milestone as part of a broader effort to review how to speed up major hospital projects. Construction on the Royal Perth Hospital emergency department expansion — delivered through what Lendlease has branded the "Perth Pulse Alliance" — began in June 2026, with the project bringing together government and industry to collaboratively manage complex projects and support more efficient delivery.

Two major public hospital projects, one state government, one clear procurement choice — made by a state that already knows how to run an alliance from decades of road and rail work. If Cowichan is the proof point from abroad, Royal Perth and Mandurah suggest Australia's own health infrastructure planners are starting to point that same institutional capability at vertical builds, even if the rest of the country hasn't caught up yet.

Why this should matter to the rest of Australia

Put these threads together and a pattern emerges that's hard to ignore:

- **Australia already has thirty years of alliancing experience on exactly the kind of complex, high-uncertainty projects hospitals resemble** — we've simply pointed that capability at horizontal infrastructure almost exclusively, while our hospitals keep going through the same conventional contracts that keep blowing out.
- **South Australia is proving the point in real time, on two projects running side by side.** Its alliance-delivered T2D motorway — the state's biggest-ever infrastructure project — is tracking on budget and potentially ahead of schedule, while its conventionally procured nWCH hospital has blown out by roughly two-thirds and lost more than three years.
- **BC bet on alliance for its hardest, most technically demanding vertical health project**, and it delivered a three-times-larger, seismically resilient, fully electric hospital that is 90% built and tracking to its stated completion window and budget — the kind of performance that has become rare for major hospital builds anywhere.



- **The same owner then re-used the model** across highway reinstatement, a cancer centre, and multiple hospital redevelopments — a far more meaningful vote of confidence than any single project's outcome.
- **A state as experienced in alliance procurement as Western Australia has now extended the model to two major hospital projects**, explicitly citing faster delivery as the rationale.

For state health departments and treasuries watching cost overruns and schedule blowouts on traditional D&C and PPP hospital contracts — Adelaide's nWCH being the most vivid recent example, and its own T2D motorway the most vivid counter-example — that combination of evidence is about as strong a signal as procurement policy ever gets. The alliance model won't suit every project; it demands a genuinely collaborative owner, sophisticated commercial structuring, and a market willing to bid competitively into that structure. But that's precisely the discipline Australia has already built for roads, rail and water. The gap isn't capability — it's application.

Cowichan shows what "on time and on budget" can look like when the incentives are aligned rather than opposed, even for a jurisdiction building this model from scratch. Royal Perth and Mandurah suggest Australia is starting to point its own well-established alliancing expertise at hospitals rather than just motorways and railways. Australia has been alliancing its way through complex horizontal infrastructure for three decades — isn't it about time we did the same for our hospitals?

This article reflects publicly reported project status as of July 2026. Readers should verify current project timelines and figures with Island Health, Infrastructure BC, and the Western Australian Government before citing specific figures in this article.