

Chapter 3

Section 3.03

Brampton Civic Hospital Public-private Partnership Project

Background

William Osler Health Centre (WOHC) is one of Ontario's largest hospital corporations, serving Etobicoke, Brampton, and surrounding areas. In the late 1990s, the Health Services Restructuring Commission recognized the need for a new hospital in this region. In September 2000, an external consulting firm provided a capital-cost estimate to WOHC for a 1.275-million-square-foot, 716-bed hospital of approximately \$357 million (excluding the cost of equipment). This was the estimate if WOHC was to be responsible for the hospital's design and construction.

In May 2001, the then Minister of Finance announced that public-private partnerships (P3s) would have to be seriously considered before the government of Ontario would commit any funding to new hospitals. Generally, P3s are contractual agreements between government and the private sector by which private-sector businesses provide assets and deliver services, and the various partners share the responsibilities and business risks. In the case of a hospital agreement, the private-sector partners would typically be responsible for the design costs, the construction costs, and the financing (and possibly the ongoing facility capital maintenance costs as well). The hospital would

then repay the partners through a series of payments over the long term. Governments enter into P3s because they provide an opportunity to transfer risks to the private sector, allow both sectors to focus on what they do best, and accelerate investment to help bridge the gap between the need for public infrastructure and the government's financial capacity.

In November 2001, the government approved the development of two new hospitals in Brampton and Ottawa using the P3 approach. In August 2003, following a request for proposal (RFP) selection process, WOHC reached an agreement with The Healthcare Infrastructure Company of Canada (THICC), a consortium of the two private-sector companies Ellis Don (construction contractor) and Carillion Canada Inc. (non-clinical-service contractor), and the Ontario Municipal Employees Retirement System (OMERS). Under the agreement, THICC would design, build, and finance a new 608-bed Brampton Civic Hospital. It would also provide certain non-clinical services (including laundry; housekeeping; transporting patients within the hospital; food; security; and maintaining and servicing the facility) over a 25-year period. Under the project agreement with the private-sector consortium, WOHC agreed to pay the consortium a monthly payment over the 25-year service period, beginning on the completion date of the hospital.

WOHC also had plans to redevelop an existing hospital under its administration, Peel Memorial Hospital, to provide an additional 112-bed capacity. Together, the two hospitals were expected to meet the projected health-care needs of the community.

In October 2007, WOHC opened the new 608-bed hospital with 479 beds in service. It plans to increase this number to 527 beds in the 2009/10 fiscal year, 570 beds in 2010/11, and 608 beds by 2011/12. According to the Ministry of Health and Long-Term Care, the reason for following this plan is that there was not enough initial demand for health services to require immediately operating the hospital at full capacity. In addition, the hospital lacked the staffing complement on opening day to operate at full capacity.

No clinical services are currently being provided at Peel Memorial Hospital. At the time of our audit, the hospital remained open, with only security and engineering staff on hand to secure and maintain the building and equipment. The Ministry, in conjunction with WOHC and its Local Health Integration Network, is to determine the future plan for the project.

Audit Objective and Scope

The objective of our audit with respect to procurement and financing for the Brampton Civic Hospital Project (Project) was to assess whether adequate systems and processes were in place to ensure that:

- the decision to use the P3 model was suitably supported by a competent analysis of alternatives;
- all significant risks and issues were considered and addressed appropriately in the final agreement; and
- public expenditures were incurred with due regard for economy.

Our audit focused on reviewing the Project's P3 arrangement. An assessment of the clinical services

planned or provided by the new hospital was not part of the scope of this audit.

Our audit followed the professional standards of the Canadian Institute of Chartered Accountants for assessing value for money and compliance. We set an objective for what we wanted to achieve in the audit, and developed audit criteria that covered the key systems, policies, and procedures that should be in place and operating effectively. We discussed these criteria with senior management at the Ministry of Health and Long-Term Care (Ministry) and WOHC. Finally, we designed and conducted tests and procedures to address our audit objective and criteria.

Our audit work included interviews with staff and technical and financial advisers engaged by the Ministry and WOHC; review and analysis of pertinent information; and research into the reports and practices of public-private partnerships in other jurisdictions, including other Canadian provinces, the United Kingdom, United States, Australia, and New Zealand. We engaged the service of an independent financial expert to assist in certain aspects of our audit. In addition, during the audit, we received and took into consideration information from certain concerned stakeholder groups. Our audit was conducted primarily at the head office of WOHC in Brampton.

Toward the completion of our audit fieldwork we visited and interviewed staff, contractors, and advisers to the new Peterborough Regional Health Centre. This hospital, which was built about the same time as the Brampton Civic Hospital, followed the traditional model of procurement and not P3. We also held discussions with management of Infrastructure Ontario, a Crown agency established in November 2005 with the mandate to oversee delivery of Ontario's AFP projects. The objective of our visits to these two organizations was to compare delivery approaches and practices.

On this audit, we co-ordinated our work with that of two audit teams of the internal audit division of the province. The two teams conducted work on the province's current processes for

managing AFP projects at the Ministry and through Infrastructure Ontario. Their work made observations that, in some cases, corroborated our findings.

Summary

We noted that WOHC had invested much time and effort in planning and delivering the new hospital project. However, WOHC did not have the option of choosing which procurement approach to follow. Rather, it was the government of the day that decided to follow the public-private partnership (P3) approach. We noted that, before this decision was made, the costs and benefits of alternative procurement approaches, including traditional procurement, were not adequately assessed. This, along with a number of other issues we had with respect to this first P3 project at WOHC, led us to conclude that the all-in cost could well have been lower had the hospital and the related non-clinical services been procured under the traditional approach, rather than the P3 approach implemented in this case.

However, as with any new process, there are inevitably lessons to be learned. In responding to our recommendations for future P3 projects (see Appendix), Infrastructure Ontario, the Crown agency now responsible for managing most government infrastructure projects, and its ministry partners indicated that most of the issues we raised are now being handled differently to better ensure the cost-effectiveness of current P3 projects.

After the Ministry directed WOHC to follow the P3 approach for the Brampton Civic Hospital project, it then directed WOHC to compare the estimated cost if WOHC itself—that is, the public sector—had undertaken the project with the bids it received from the private sector. In other words, WOHC was to compare the estimated costs under traditional versus P3 procurement. We noted, however, that the assessment was not based on a full analysis of all relevant factors and was done too late

to allow any significant changes or improvements to be made to the procurement process. Our more specific significant concerns with the process were as follows:

- A consulting firm engaged by WOHC estimated in September 2000 that the cost for the government to design and build a new hospital would be approximately \$357 million (updated to \$381 million in October 2001). Using a similar approach in January 2003, a second consulting firm estimated that the cost would be \$507 million (updated in November 2004 to \$525 million). While there had been increases in labour and material costs during the period, those increases and inflation alone would not account for the large difference in the two estimates. WOHC had not investigated the reasons for the significant difference between the two independent estimates.
- WOHC added to the estimates for the government to design and build a new hospital an estimated \$67 million in risks transferred to the private sector. This is equivalent to expecting a 13% cost overrun if the traditional construction method was used. As well, there are a limited number of companies in the province that are willing or able to undertake a project of this size, and therefore the same companies would be bidding for and doing the work regardless of which procurement approach was chosen. We questioned why the estimates for the government design-and-build approach assumed that the risk of overruns would be so significantly greater and would need to be handled differently than under the P3 approach. WOHC should have more carefully evaluated the extent to which a properly structured contract under a traditional procurement agreement could have mitigated the risk of any such cost overruns.
- We found that the cost estimates for the government to do the project were overstated by a net amount of \$634 million (\$289 million in 2003 dollars). Specifically, certain design and

construction costs were overstated, and there were costs for non-clinical services that should not have been included in the estimates when comparing to the costs under the P3 arrangement. For example, a depreciation charge was inappropriately included as a non-clinical service cost in the government estimate. As well, the costs for utilities and property insurance that WOHC would be responsible for regardless of who provides non-clinical services was counted as a cost only under the estimate for government provision of non-clinical services, but not in the bid for the P3 arrangement. WOHC had also estimated that it could transfer the risks of price fluctuations to the private sector. However, the project agreement contained provisions allowing for re-pricing of these services after the first four years of the agreement.

- The province's 5.45% cost of borrowing at the time the agreement was executed was cheaper than the weighted average cost of capital charged by the private-sector consortium. Had the province financed the design and construction costs at its lower rate, the savings would be approximately \$200 million over the term of the project's P3 arrangement (\$107 million in 2004 dollars). However, WOHC had not considered the impact of these savings in its comparison of the traditional procurement approach with the P3 project.
- WOHC and the Ministry engaged approximately 60 legal, technical, financial, and other consultants at a total cost of approximately \$34 million. About \$28 million of these costs related to the work associated with the new P3 approach, yet they were not included in the P3 cost. While acknowledging that additional professional services will be required given the newness of the P3 process, we still believe a significant portion of the professional costs relating to the P3 arrangement should have been included in the cost comparison.

On the other hand, it was evident to us that WOHC staff and management carried out extensive research and invested significant time and effort throughout the development of the Brampton Civic Hospital Project. As well, with respect to the selection of the private-sector partner, WOHC followed a competitive selection process and took appropriate steps to ensure that the process was designed and conducted in a manner that was fair to all potential, successful, and unsuccessful respondents. However, a competitive selection process was not followed consistently in the engagement of advisers. Over 40% of the advisers in our sample were single sourced. In addition, many consulting assignments were open-ended, without pre-established budgets or a ceiling price. We acknowledge that this was in part due to the arrangement being a pilot and to the uncertainty regarding the exact requirements of the various aspects of the project.

Over the approximately three-year construction period, the total cost came to \$614 million, comprising \$467 million in design and construction costs for the hospital, which was built on a reduced scale; \$63 million primarily for modifications to the facilities to accommodate installation of equipment; and \$84 million in financing charges. We noted that a portion of the \$63 million cost to modify the facilities for installation of equipment could have been avoided with better planning.

We have prepared a table of recommendations (see Appendix) for consideration in future infrastructure procurement projects. We shared these recommendations with management of WOHC, Infrastructure Ontario, the Ministry of Energy and Infrastructure, and the Ministry of Health and Long-Term Care. As the responses in the Appendix indicate, management of these organizations believe that their current P3 processes address most of the issues we raised with respect to this first P3 project at WOHC.

OVERALL RESPONSE FROM WOHC

WOHC's mission and mandate is to provide hospital facilities and services for the communities that it serves. As noted by the Auditor General, the need for more hospital capacity in the Brampton area was well documented. Moreover, existing facilities varied in age from 30 to 80 years and had suffered a number of age-related infrastructure problems.

In entering into an agreement with the Ministry of Health and Long-Term Care, WOHC recognized that the project would serve as a "pilot" project to test and refine the P3 model for possible future use for hospital capital in Ontario. The agreement was premised on the potential benefits of P3. As noted in the Auditor General's report: "Governments enter into P3s or AFPs because they provide an opportunity to transfer risks to the private sector, allow both sectors to focus on what they do best, and accelerate investment..."

Given the magnitude of the new hospital project, the P3 arrangement did enable the hospital and government to leverage private capital and investment in the new hospital facilities, thereby improving the quality of health-care services to the community sooner than would have otherwise been possible, in light of annual hospital capital allocations.

Another key benefit of the P3 approach is that facilities' maintenance and life-cycle replacement costs are built into the transaction. Under the traditional approach, capital and operating funding decisions are often made independent of one another. The P3 approach requires an analysis of combined operating and capital funding and introduces analytical rigour around life-cycle costs that in some cases did not previously exist. It is important not to underestimate the risk that operating pressures might lead to constraints on maintenance and life-cycle expenditures resulting in higher costs in the long term.

The inclusion of non-clinical services in the Project's P3 arrangement will also likely result in a higher level of such services being available than would otherwise be the case. This approach to paying for the hospital and obtaining services represents a significant benefit to the community (and by contrast, the inability to follow such an approach would represent a significant, even if difficult to quantify, cost).

WOHC acknowledges that the value-for-money assessment prepared by WOHC and its professional advisors was based on the information available at the time. Detailed data on previous Ontario hospital capital projects would have enhanced the confidence level of risk estimates related to our design and construction costs, but this information was not available and anecdotal evidence is not necessarily reliable. We would recommend that the province develop a framework and start collecting this information for use in future projects.

In addition, the sheer magnitude of the project meant that the existing policy and decision-making frameworks were challenged in new ways, particularly with respect to:

- determination and approval of equipment and IT budgets and procurement;
- determination and communication of final local share requirements; and
- determination and disposition of replaced facilities.

In the end, WOHC believes these challenges have been overcome by working in partnership, on one hand, with the Ministry and the provincial government, and on the other hand, with the private sector consortium. Perhaps one of the most important lessons learned from the project, especially given its scale, is the need for a detailed readiness assessment that would identify risks to successful delivery and appropriate mitigation strategies. This should include the need for an experienced and dedicated project delivery team; comprehensive project

governance structure and process, including government decision processes; and a comprehensive and integrated commissioning and transition plan to mitigate risks and ensure a timely and safe transition of services to new facilities.

WOHC believes that existence of the Infrastructure Ontario organization with experienced and dedicated resources aimed at optimizing the current P3 process and assisting the hospital sector to successfully deliver the benefits of the approach is of great value, as is establishment of a standard project governance structure to manage project governance, key project approvals, and decision-making.

Overall, WOHC believes that, for the most part, WOHC's goal of improving the delivery of health-care services to the residents it serves has been achieved with lessons learned.

Detailed Observations

OVERVIEW

Although P3s have become more common in recent years, the Canadian P3 market was in the early stages of development when the government directed WOHC to use P3 as the model to follow in procuring and financing a new hospital. According to WOHC, the Brampton Civic Hospital Project was meant to be a pilot project, as it was among the first in Ontario to follow the P3 approach. WOHC indicated to us that it therefore carried out extensive research and was guided by P3 practices used in the United Kingdom.

The province has since released *Building a Better Tomorrow*, a framework for public infrastructure development that includes guidelines for private-sector involvement in such development—known in Ontario as Alternative Financing and Procurement (AFP). This framework, established in 2004, stipulates five fundamental principles for infrastructure

development: protection of the public interest; value for money; appropriate public control/ownership; accountability; and fair, transparent, and efficient processes. The framework also has principles specifically for procurement, as follows:

- Procurement processes must be fair, open, and transparent.
- Infrastructure procurement opportunities must be tendered publicly, using competitive processes.
- Procurement processes should ensure the efficient and cost-effective participation of bidders.
- Procurement decisions must be based on value-for-money assessments, with the protection of the public interest being paramount.
- Risks should be allocated to the party that is best able to manage them.

In November 2005, a Crown agency—Infrastructure Ontario—was established with the mandate to oversee delivery of all AFP projects in the province. This followed the province's announcement in May 2005 of *ReNew Ontario*, a five-year plan to invest more than \$30 billion in public infrastructure by the year 2010. The plan included approximately \$5 billion for health-care projects; a significant number of these are to be financed and built using AFP arrangements. All AFP projects are to undergo a value-for-money analysis by independent consultants to ensure that they offer potential cost savings when compared to a traditional procurement approach. At the time of our audit, Infrastructure Ontario was managing about 35 health-related AFP projects in various stages of completion.

We acknowledge that the province's framework for infrastructure procurement was introduced after the Brampton Civic Hospital P3 arrangement had been finalized. In reviewing this project, we compared it to best practices in other jurisdictions as well as the principles in the *Building a Better Tomorrow* framework.

NEED FOR A NEW HOSPITAL IN BRAMPTON AND DECISION TO ADOPT THE P3 PROCESS

The need for additional hospital capacity in Brampton was first recognized in the late 1990s by the Health Services Restructuring Commission, an independent body established in 1996 by the Ontario government to make decisions on restructuring Ontario's public hospitals and to advise the Minister of Health on other aspects of Ontario's health services system. Specifically, WOHC had projected that from 2000 to 2008 the population of the Brampton area would grow by 15,000 to 20,000 residents annually. According to Statistics Canada data, the actual population growth in the Brampton area between 2001 and 2006 has been about 22,000 residents each year.

We noted that the need for more hospital capacity in the Brampton area was well demonstrated and that WOHC had invested much time and effort in planning and delivering the new hospital project. However, WOHC did not have the option of choosing which procurement approach to follow. In a letter to WOHC dated February 2002, the Ministry of Health and Long-Term Care directed that the P3 model must be the one used for the development of the new hospital, and that other options or deviations from this model could not be considered. At the time, WOHC had already incurred about \$6 million in fees for technical advice primarily relating to cost consulting and architectural design, in preparation for the design and construction of the new hospital under the traditional design-build procurement approach.

With a contract of this size, best practices call for a business case to assess the costs and benefits of a range of alternative procurement models, to allow the option that offers the best value for money to be chosen. One approach is a value-for-money assessment that captures the total estimated cost of the traditional public-sector delivery of an infrastructure project through a design-build approach and compares that to the estimated delivery cost of

the same project using a P3 model. This assessment should be carried out early in the process, as recommended, for example, in a 2004 value-for-money P3 assessment guide published by the UK Treasury. The guide says that "it is important that value-for-money assessments take place at the earliest practical stage of any decision-making process and that departments retain the flexibility to pursue alternative procurement routes if at any stage P3 does not offer the best value for money."

In the case of the Brampton Civic Hospital Project, we noted that the Ministry did direct WOHC to commission a value-for-money assessment of the P3 arrangement, but only after the decision to follow the P3 approach had been made. In fact, the assessment was not completed until about the time the initial RFP was issued in November 2002. There was little opportunity by the time WOHC commissioned the assessment to make any meaningful improvements to the arrangement, and prospective bidders would have already made significant investments preparing their submissions.

The WOHC assessment only provided a reference point against which it and the Ministry assessed the reasonableness of the bids received. There was no formal assessment based on a business-case analysis of criteria to help determine which procurement option offered the best value for money. Specifically:

- There was no formal analysis of whether the market had sufficient capacity and was competitive enough to support a P3 arrangement for the project. Our review of available information suggested that only a limited number of construction contractors in the province are able or willing to undertake a project of this size. The same construction companies would be involved in the bidding and work regardless of whether WOHC followed the traditional procurement or P3 approach.

At the direction of the Ministry, WOHC was also asked to engage the private sector not only to design and build the new hospital, but also to provide maintenance and non-

clinical services for it. As most private-sector companies specialize in providing either capital construction or operational support services, the mingling of the two further limited the number of companies qualified to deliver the P3 arrangement.

- There was no formal analysis of the likelihood and potential value of the risks—such as cost overruns—that traditional procurement might have incurred. When such risks are known to be significant, transferring them to the private sector is a key benefit of the P3 approach. A proper business-case analysis would have required much clearer evidence that significant cost overruns were likely if WOHC managed a traditional design-and-build approach. Only then would a P3 arrangement to help mitigate such risks have been thoroughly justified.
- A prior assessment of all of the costs of the Project’s P3 arrangement was not carried out. We were advised that adopting P3 was the only way that WOHC could receive funding for a new hospital. Nevertheless, a significant component of cost under either arrangement is the cost to finance the construction of the hospital. In this regard, government could have secured a lower financing rate owing to its credit rating. However, we noted that the Ministry had not conducted a formal assessment of the cost differential between public and private financing, and whether the additional costs associated with private financing would be more than offset by the risks that could be transferred to the private sector.
- Another significant cost component that tends to be high for a P3 or AFP arrangement in comparison to traditional procurement is transaction costs, such as fees for technical, legal, and financial advisers. We noted that the potential impact of such costs had not been assessed.

As detailed in the remaining sections of this report, we identified a number of other issues

that demonstrate the importance of a thorough assessment of the costs and benefits of all available procurement alternatives, as well as better planning in future infrastructure development projects.

COMPARING THE COSTS OF TRADITIONAL PROCUREMENT TO P3

Overview

As indicated earlier, planning for a new Brampton hospital began in early 2000. Because few new hospitals had been built in recent years, information on the costs of building new hospitals was lacking. In 2000, in order to arrive at an estimate of what it would cost the government to build the new hospital under the “traditional procurement” system, WOHC engaged the services of a firm of cost consultants (quantity surveyors). The estimation process is fairly standardized. It involves the preparation of a functional program to provide a preliminary estimate of the area required for each hospital department and applies an estimate of the relevant cost per square foot to come up with a total amount. Other costs such as building shell, common areas, ancillary costs, and site development, as well as contingencies and allowances, are then factored in to arrive at an estimate of the total cost. On that basis, WOHC estimated in September 2000 that a new 716-bed, 1.275-million-square-foot hospital would cost the government approximately \$357 million. In October 2001, this amount was updated to \$381 million to reflect cost increases.

Despite the existence of this estimate, the Ministry directed WOHC in 2002 to provide a second estimate of what it would cost the government to build the hospital under the traditional procurement system—in other words, the cost for WOHC to undertake the project itself—to enable a comparison with the costs under a P3 arrangement. WOHC engaged a second cost consultant to come up with this estimate using an approach similar to that of the first estimate.

In January 2003, this second cost consultant estimated that it would cost the government

\$507 million under traditional procurement to design and build a new 608-bed, 1.2-million-square-foot hospital. With respect to non-clinical costs, such as laundry, housekeeping, food services, and so on, WOHC benchmarked the 2001 cost of having these services provided by WOHC itself and by 10 other hospitals to arrive at an estimate. These traditional procurement estimates formed the basis of the value-for-money assessment of the P3 arrangement by WOHC, which WOHC commissioned through a financial consultant. The Ministry of Health and Long-Term Care also hired its own consultants to review WOHC's assessment.

In addition to the traditional procurement estimates above, WOHC had by April 2003 received bids from the private sector for procuring the hospital under a P3 arrangement. The bids, for the proposed 28-year term of the arrangement (30 months for design and construction and a 25-year service period) included three main cost components: design and construction; non-clinical services; and financing costs comprising interest and dividends. Figure 1 shows the comparison between the January 2003 estimate under traditional procurement and the April 2003 preferred bid. Both the bid and the estimate were updated in November 2004, when the P3 agreement was finalized.

At November 2004, the updated cost estimate for design and construction was \$525 million. WOHC quantified and added to the \$525 million a total of \$67 million in design and construction

risks that it estimated could be transferred to the private sector under a P3 arrangement. WOHC considered this a reasonable "cost" to include to cover potential cost overruns that it felt were more likely if the government were responsible for design and construction. More specifically, WOHC identified 43 risks, including the risks of cost increases due to design errors and omissions, unknown site conditions, delays in obtaining site plan approvals and/or building permits, and labour wage increases and/or disputes. Thus, in total, WOHC estimated that building the new hospital would cost the government \$592 million (\$550 million in 2004 dollars).

In contrast, the capital cost portion of the new hospital in the final P3 agreement that WOHC reached with the private-sector consortium in November 2004 was approximately \$467 million (\$431 million in 2004 dollars).

Figure 2 compares WOHC's cost estimates of September 2000 and November 2004 for the government to design and build the hospital with the amount agreed to under the Project's P3 arrangement in 2004 for the private sector to design and build the hospital. At first glance, when comparing the November 2004 estimate to the amount agreed to under the P3 arrangement, the P3 approach clearly appeared much less costly.

However, as discussed below, we felt a number of adjustments were needed to the November 2004 cost estimate. We also questioned whether WOHC

Figure 1: WOHC's Comparison of Cost Between Traditional Procurement and P3 (\$ million)

Source of data: WOHC

	January 2003 Estimate Under Traditional Procurement		April 2003 P3 Preferred Bid	
	Nominal	2003 Dollars	Nominal	2003 Dollars
design and construction ¹	507	465	1,151 ²	513 ²
non-clinical services	1,745	687	1,440	612
transferred risk ³	172	96	n/a	n/a
Total	2,424	1,248	2,591	1,125

1. for a 608-bed, 1.2 million-square-foot hospital

2. includes financing

3. relating to design and construction (\$67 million), life cycle (\$2 million), and non-clinical services (\$103 million)

Figure 2: WOHC's Comparison of Design and Construction Costs (\$ million)

Source of data: WOHC

	WOHC's Sep 2000 Estimate for Government to Design and Build	WOHC's Nov 2004 Estimate for Government to Design and Build		WOHC's Nov 2004 Cost for P3 to Design and Build	
		Nominal	2004 Dollars	Nominal	2004 Dollars
design and construction	357	525	492	467	431
transferred risk	n/a	67	58	n/a	n/a
Total Before Financing Costs	357	592	550	467	431

Note: The September 2000 estimate was for a 716-bed, 1.274-million-square-foot hospital. The November 2004 estimates were for a 608-bed, 1.2-million-square-foot hospital.

had adequately considered all significant costs of the Project's P3 arrangement.

The cost to provide non-clinical services also seemed to be much lower under P3 than under the traditional procurement approach, as shown in Figure 3. However, our review indicated that the cost for the hospital rather than the P3 contractor to supply non-clinical services was overstated by \$582 million (\$245 million in 2003 dollars).

On the basis of this concern and the issues we identified (which are presented in detail in the following subsections), we question whether this first P3 pilot project actually did result in the Brampton hospital costing less than it would have under the traditional approach.

Design and Construction Cost Estimate

As can be seen in Figure 2, the November 2004 design and construction estimate of \$525 million (exclusive of transferred risk) exceeds the initial September 2000 estimate of \$357 million by \$168 million. While there had been increases in labour and material costs (such as steel prices) over the period, those costs and inflation alone could not account for the large difference in the two estimates.

We compared the functional programs prepared by the two cost consultants and noted that for the most part they were comparable. However, there were two areas where we questioned the large difference in the two estimates:

- *Cost of unassigned areas such as common areas, plant space, and building shell*—Representatives we interviewed at various cost consulting and architectural firms indicated that it is a common practice to apply 26.5% of the total area in square feet of the individual departments as a basis for estimating the square footage and cost for unassigned areas. This percentage was applied to both the November 2004 estimates and the September 2000 estimate. In the November 2004 estimates, however, an additional \$112 million was included for building shell, which is normally already included as part of the 26.5% gross-up for unassigned areas. As a result of this separate amount for building shell, the cost of the unassigned areas in the November 2004 estimates was \$530 per square foot, compared to \$200 per square foot in the September 2000 estimate. The impact of this difference in the area costs was about \$79 million.
- *Contingencies and allowances*—These are allowances for cost escalations during construction and for design, construction, and pricing unknowns. The cost consultant engaged by the Ministry had pointed out that one-third of the design and construction costs of \$525 million in the November 2004 estimate for government design-and-build was made up of allowances and contingencies. Specifically, the Ministry's consultant identified a potential net overstatement of

Figure 3: WOHC's Comparison of Non-clinical Service Costs (\$ million)

Source of data: WOHC

	WOHC's Nov 2004 Estimate for Government to Provide		WOHC's Nov 2004 Cost for P3 to Provide	
	Nominal	2004 Dollars	Nominal	2004 Dollars
non-clinical services*	1,997	791	1,536	647
transferred risk	108	43	n/a	n/a
Total	2,105	834	1,536	647

* includes life-cycle costs of \$107 million and \$99 million under traditional procurement and P3 respectively

approximately \$40 million in the November 2004 estimate for government design-and-build, but the Ministry did not follow up with WOHC on these findings. We also felt a one-third contingency allowance was unduly high, especially given that separate provisions totalling \$67 million had already been made for transferred risks relating to various contingencies.

Another concern we had was the \$67 million in transferred risks that was added to the November 2004 government design-and-build estimate. This amount was arrived at on the basis of the judgment and experience of management and consultants. Owing to the subjective nature of these estimates, it is virtually impossible to substantiate the validity and accuracy of the quantified amounts. We were concerned that the transferred risks for this project amounted to almost 13% of the November 2004 government design-and-build estimate of \$525 million. In comparison, actual cost overruns (a major component of risk transfer) in the design and construction of the Peterborough Regional Health Centre—a hospital built under the traditional procurement approach during the same period—were about 5% of the total contract value.

Also noteworthy in this regard is the limited number of contractors in Ontario's construction market that are capable of providing services to large capital projects such as the new Brampton hospital. The same architects and construction companies would be bidding on and doing the work regardless of which procurement approach was

chosen. We therefore questioned why the estimates for the government design-and-build approach assumed that the risk of overruns would justify an additional 13%, or \$67 million, being added to the cost estimate for the traditional approach. In quantifying and assigning transferable risks, WOHC should have more carefully evaluated and documented the extent to which a properly structured contract under a traditional procurement agreement could have mitigated the risk of any such cost overruns.

The cost consultant engaged by the Ministry to review WOHC's estimate indicated that, in total, there could be a net overstatement in the government design-and-build estimate of nearly \$44 million (in 2003 dollars). On the basis of the above analysis, we believe the potential overstatement may well be higher.

Non-clinical Services Cost Estimate

Under the Project's P3 arrangement, the private-sector consortium is responsible for providing non-clinical services including laundry, housekeeping, portering (transporting patients within the hospital), patient and non-patient food, materials management, security, and plant operations and maintenance. As with the design-and-construction cost comparison, the cost to provide these non-clinical services also seemed to be much lower under P3 than under the traditional procurement approach, as shown in Figure 3. However, our review indicated that the estimate for the hospital

to provide these services instead of outsourcing them as part of a P3 contract was overstated by \$582 million (\$245 million in 2003 dollars). We reviewed our work with an expert in business valuation, who agreed with our assessment.

We identified four items that should have been excluded from WOHC's analysis of the government-provision-of-services estimate and two others that should have been added. The Ministry's consultant also flagged several of these items; however, the consultant's concerns were not followed up with WOHC.

The inclusion of the following items in the estimate for government provision of services was inappropriate:

- *\$308 million (\$134 million in 2003 dollars) for depreciation of mechanical and electrical components*—Such a charge is already included in the cost estimate for design and construction and ongoing life-cycle renewal of major facility subsystems.
- *\$203 million (\$88 million in 2003 dollars) for utilities and property insurance*—Over the term of the agreement, WOHC is responsible for paying these costs directly, regardless of whether the WOHC or the private sector is responsible for operating the hospital. These costs should therefore not be included in the estimate for government provision of services.
- *\$83 million (\$36 million in 2003 dollars) for annual inflation from 2001 to 2007 at a rate of 3.6%*—WOHC used an annual inflation rate of 3.6% to derive the benchmarked data for expenditures made by the other hospitals, with which it arrived at the cost estimate for government provision of services. As these expenditures were mostly made up of salaries and wages, we reviewed the hospital's agreements with its unions and noted that a 2% inflation rate for the period would have been more appropriate. WOHC was not able to provide support for the higher rate used.
- *\$95 million (\$34 million in 2003 dollars) for the risks of price fluctuations resulting from*

estimation error and/or inflation—In its estimate for government provision of non-clinical services, WOHC estimated the risks of price fluctuations resulting from estimation error and/or inflation to be \$108 million (\$43 million in 2003 dollars) over the 25-year term of the project agreement. However, the project agreement contained benchmarking and market-testing provisions allowing for re-pricing of the support services after the first four years of the agreement. Therefore, the risk is being transferred only for this initial term of the agreement. Of the total value of \$108 million in transferred risks, \$95 million (\$34 million in 2003 dollars) was related to the years after the re-pricing provisions would take effect and should have been excluded from the estimate for government provision of services.

On the other hand, we did note the following two areas where costs should have been included in the estimate for government provision of services but were not:

- The volumes used to estimate the costs for the government to provide laundry services, transport patients within the hospital, and provide food services were lower than volumes in the executed agreement at financial close. If the actual volumes in the executed agreement had been used, the estimate for government provision of services would increase by \$89 million (\$39 million in 2003 dollars).
- The amount of \$18 million (\$8 million in 2003 dollars) in costs associated with providing food services and materials management services at WOHC's other hospital, Etobicoke General, was removed from the estimate for government provision of services. This cost should be added back because, under the executed agreement, the private-sector consortium is still providing this service at this hospital.

We believe that, in total, the estimate for the hospital to provide the non-clinical services directly (rather than outsourcing them as part of the P3 contract) was overstated by at least \$245 million (in 2003 dollars).

In addition to the above net overstatement, the cost estimate that WOHC had calculated for providing the non-clinical services itself (rather than part of P3) was higher than the average of 10 other hospitals that it had benchmarked. WOHC told us that this was because new hospitals are more costly to operate than established ones. However, the Ministry's consultant was unable to substantiate this explanation and indicated the cost of WOHC providing the non-clinical services itself would have been \$126 million (\$42 million in 2003 dollars) less if the average costs of the 10 hospitals had been used as the benchmark in the calculation.

Transaction Costs Not Considered in WOHC Assessment

WOHC and the Ministry engaged approximately 60 legal, technical, financial, and other consultants in the P3 arrangement at a total cost of approximately \$34 million, of which WOHC had already spent about \$6 million before the government directed it to adopt the P3 approach. The difference of \$28 million was not included in considering the costs of the P3 project approach.

Estimated Costs After Audit Adjustments

As indicated in Figure 1, WOHC's cost comparison clearly indicated that the P3 approach would cost much less than the traditional approach. However, if the above adjustments are made to reflect what we believe is a more representative cost estimate—as we have done in Figure 4—it can be seen that the traditional procurement approach may well have cost less.

Figure 4: Our Comparison of Total Costs After Audit Adjustments (\$ million, 2003 Dollars)

Prepared by the Office of the Auditor General of Ontario

	Traditional Procurement Estimate	P3 Cost
WOHC's assessment	1,248	1,125
adjustments based on our audit work ¹	(289)	28
Adjusted Total	959	1,153

1. Our adjustments to the traditional procurement estimate include the \$44-million overstatement for design and construction estimated by the Ministry's cost consultant and \$245 million relating to overstatements in the estimate for non-clinical services.

Timing and Methodology of the Cost Comparison

Timing

Both WOHC's estimates and the Ministry's review of them were completed only after critical stages of the Project's P3 procurement process had passed. They were therefore not very useful in suggesting possible improvements to the process. Moreover, since the decision to follow P3 had already been made, there was a risk that the estimates and reviews could be biased in favour of the P3 approach over the traditional approach.

The specifics of the timing were as follows. The first estimate of cost under the traditional approach from WOHC was produced in January 2003. By then, evaluation of the bidders who had responded to the initial phase of the RFP was well under way. As a result of delays in finalizing the project arrangement, WOHC then updated this estimate in November 2004, after the preferred bidder had been chosen and negotiations had concluded. Both the initial and updated estimates indicated that the P3 arrangement was more favourable than the traditional procurement approach.

The Ministry's initial review of WOHC's comparative analysis was not finalized until March 2003, when evaluation of bids for the initial phase of the RFP process had already been concluded.

An update of this review was completed in January 2005, two months after WOHC had already executed the agreement with the preferred bidder. In fact, WOHC management was not aware that the Ministry had produced an updated report when we brought it to their attention.

Methodology

In comparing the design and construction costs of the two options, WOHC assumed that there would be no financing if the government undertook the project itself, but that the arrangement would be financed over 25 years. It justified this assumption by noting that in the past, hospitals were required to have their share of project costs available before the Ministry would approve any projects.

Governments do have the capacity and the option of financing and typically obtain a lower debt interest rate than private-sector borrowers do. The province's 5.45% cost of borrowing at the time the agreement was executed was cheaper than the weighted average cost of capital charged by the private-sector consortium. Had the province financed the design and construction costs under the same terms as the private-sector partner but used its lower rate, we estimate that the savings in financing costs would be approximately \$200 million (\$107 million in 2004 dollars) over the term of the agreement. WOHC and the government entered into the P3 project arrangement recognizing that the arrangement's financing costs were higher than those of the traditional approach, but nevertheless assumed that the value of the risk transfer to the private-sector consortium, either alone or together with other offsetting advantages, would equal or exceed the higher cost and would compensate for it. However, as discussed earlier, we questioned the magnitude of the perceived benefits resulting from the transfer of cost overruns and other risks because many of the risks could be mitigated in a sound competitive and contractual process.

In response to our comments in this section, WOHC indicated to us the comparison was based

on the information available, and that no models or framework existed to guide its analysis at the time. It believes the current process has improved substantially, although there continues to be a need for more formal methods and comparable data to assess risks and measure the relative value of each procurement approach.

COST INCREASES SUBSEQUENT TO SELECTION OF PREFERRED BIDDER

In April 2003, when WOHC selected the preferred bidder, the amount attributed to design and construction of the new hospital was \$427 million. Minor changes to the scope of the project totalling \$8 million were agreed to afterward. As well, WOHC agreed to assume the \$32-million cost of constructing the parking structure, which the consortium had previously agreed to build, in return for the related parking revenue that the consortium would have received. The net revenue from parking over the term of the arrangement was expected to offset the additional construction cost. These changes increased the cost of design and construction by \$40 million, to \$467 million.

A change in government, actions taken by unions and a coalition of community organizations, and complications associated with finalizing the financial arrangements caused a nearly 20-month delay between the selection of the preferred bidder and the final execution of the agreement in November 2004. As a result, the consortium made an additional claim to WOHC for construction cost escalations. WOHC engaged the services of a cost consulting firm to review the consortium's claim, and the two parties settled on \$16 million to be realized by reducing the original scope of the project. Some of the more significant changes to the plan included eliminating the ambulatory care building (with services relocating to another part of the hospital) as well as a 32,000-square-foot administration building, and reducing the number of parking spaces by 130. The consortium also made claims for non-clinical services relating to

the timing of inflation adjustments, extra insurance premiums, and other matters. We reviewed the claims and felt that they were generally reasonable.

However, we noted that the planning for the installation of medical and IT equipment was not integrated with the construction process. As a result, over and above the cost of design and construction, WOHC paid \$63 million for mainly mechanical and electrical modifications within the new facility to accommodate the installation of medical equipment. While such modifications are not unexpected in hospital construction, the proportion of the total costs that they constitute is typically much lower, as we noted in our visit to the Peterborough Regional Health Centre. WOHC acknowledged a portion of this cost could have been avoided with better upfront planning.

The new hospital opened in July 2007. Over the approximately three-year construction period the total cost came to \$614 million, comprising \$467 million in design and construction costs for the hospital, which was built on a reduced scale, \$63 million primarily for modifications to the facilities to accommodate installation of equipment, and \$84 million in financing charges during the construction period.

THE TENDERING PROCESS

Selection of P3 Contractor

WOHC followed a four-stage competitive selection process:

- *Request for expression of interest (RFEI)*—The RFEI stage solicited the level of interest of companies or consortia in the P3 transaction. Twenty-three companies or consortia responded to the RFEI.
- *Request for qualifications (RFQ)*—The RFQ stage solicited statements of qualifications from interested companies or consortia to qualify for the next stage. Four parties responded to the RFQ, and all four proceeded to the subsequent stage of the process.

- *Stage 1 request for proposals (Stage 1 RFP)*—This stage of the process solicited detailed submissions, including bids, from the four parties that qualified in the RFQ stage. All four parties responded, and after WOHC's evaluation of the responses, the two highest scoring bidders proceeded to the subsequent stage.
- *Stage 2 request for proposals (Stage 2 RFP)*—In this stage the two remaining bidders were asked to resubmit their proposals incorporating some of the suggestions received in the stage 1 evaluation. Both bidders responded, and after an evaluation of the responses, one was selected as the preferred proponent and the other was selected as the reserve proponent.

As indicated above, 23 companies or consortia made the initial submission in response to the RFEI, but only four consortia were able to submit a proposal. WOHC explained that the P3 process was new to Ontario at the time and that the lack of market readiness limited the number of companies that were able to submit a bid. In this regard, we believe that the bundling of design and construction along with non-clinical services in the P3 arrangement might have further limited the number of companies that were able to bid on the entire P3 contract.

WOHC retained an accounting firm to monitor its process of selecting the P3 contractor and to assess whether the process was designed and conducted in a manner that was fair to all potential, successful, and unsuccessful respondents. The firm concluded that, despite some variances that it noted, overall the process was fair to all respondents.

Engagement of Advisers

Between 2000 and 2007, WOHC and the Ministry engaged nearly 60 legal, technical, financial, and other advisers at a cost of nearly \$34 million to assist with the Brampton Civic Hospital Project. The value of the individual assignments ranged from a few hundred dollars to nearly \$10 million. The

vast majority of these advisers were engaged by WOHC to aid in developing the project agreement, financial advice, or the building and service specifications of the new hospital, among other things. Figure 5 shows a breakdown of the amount spent on these advisers by type of adviser.

WOHC's procurement policy requires that a competitive procurement process be followed when the anticipated annual value of a product or service exceeds \$50,000. We noted that for many of the advisers used in the P3 project arrangement for the Brampton Civic Hospital, WOHC did not follow a competitive procurement process even though the value of the assignment exceeded this threshold. In other cases, where a competitive procurement process appeared to have been followed, WOHC was not able to provide the underlying documentation as evidence of the competitive process followed.

Specifically, our test of a sample of advisers indicated that over 40% of them had been single sourced by WOHC. Of the remaining 60%, in most cases there was no evidence of tendering. WOHC indicated to us that it had followed a competitive process in some cases but was unable to locate the supporting documentation.

Many of the consulting assignments were open-ended assignments without pre-established budgets or a ceiling price. WOHC informed us that the engagements were open ended because the P3 project arrangement for the Brampton hospital was a pilot and the hospital was uncertain of the exact

requirements of the various aspects of the project. Nevertheless, it is extremely difficult to monitor the work of advisers and assess the reasonableness of billings if assignments are not clearly defined with deliverables and estimated costs.

NON-CLINICAL SERVICES CONTRACT MANAGEMENT

Project Agreement and Performance Monitoring

Overall, we noted that the project agreement between WOHC and the private-sector partner contained remedy provisions to protect the hospital against risks such as delays in the construction of the hospital or significant disruptions in the provision of the non-clinical services at any time during the term of the agreement, resulting from a major failure or insolvency of the private-sector partner.

With respect to the provision of the non-clinical services, the project agreement specified comprehensive service standards to be maintained by the private-sector partner. To monitor these service standards, the private-sector partner is required to establish a hotline for WOHC staff, visitors, and patients; conduct periodic user satisfaction surveys; and self-monitor by tracking and reporting service failures to WOHC on a monthly basis. Service failures are events that have a material adverse effect on the ability of WOHC to provide clinical services at the new hospital or that cause the death or serious personal injury of any person, and, in general, include the failure to provide services in accordance with the service specifications. Under the terms of the agreement, WOHC can make deductions from the monthly payment in the event of service failures.

The project agreement allows WOHC to audit the private-sector partner's quality assurance and management systems, including all relevant service plans and any manuals and procedures used by the contractor at intervals of approximately three months. WOHC may also carry out other periodic

Figure 5: Advisers Used by WOHC and the Ministry

Prepared by the Office of the Auditor General of Ontario

Type of Adviser	# of Advisers	Total Amount Paid (\$ million)
legal	9	12.8
technical	12	12.7
financial	9	4.9
other	28	3.5
Total	58	33.9*

* Of this total, \$6 million was paid to two technical advisers prior to the decision to use the P3 approach.

monitoring and spot checks as it considers appropriate, and may carry out performance reviews of the private-sector partner.

At the time of our audit, the private-sector partner had established the hotline and had been submitting the monthly performance-monitoring reports. In addition, the contractor had conducted the first user satisfaction survey in February 2008. WOHC indicated that it was in the process of establishing procedures for the formal monitoring of the private-sector partner's performance.

Service Volumes

The project agreement contained benchmark service volumes for certain non-clinical services (linen and laundry services, patient food services, and materials management). The service contractor is to submit monthly invoices based on these benchmark volumes. Every quarter in which actual volumes are less than 95% or greater than 105% of the benchmark volumes, a unit rate is to be applied on the difference, to calculate adjustments to the service payments. We noted that no adjustments had been made in the first quarter of the hospital's operation. WOHC informed us that it planned to capture these adjustments at the hospital's fiscal year-end of March 31, 2008. According to the project agreement, WOHC can audit the volumes reported by the contractor; however, the hospital had not established any specific audit procedures.

Currently, portering (transporting patients within the hospital) is not subject to these quarterly adjustments. In the agreement, the price charged by the private-sector partner for portering is fixed, and no adjustment is permitted unless as a result of a variation to the contract. The contractor's bid, based on a volume of approximately 56,000 annual portering tasks that WOHC initially estimated in the RFP, was approximately \$9.3 million for the initial four-year term, after which the re-pricing provisions for non-clinical support services take effect (see the section Non-clinical Services Cost Estimate). At the time of our audit, WOHC and

the contractor were discussing an amendment to the project agreement regarding large differences between the actual number of portering tasks and those estimated in the RFP. In the amendment, the contractor proposed establishing benchmark volumes for portering that ranged from 194,000 projected moves—or about a 250% increase—in the 2007/08 fiscal year to 246,000 projected moves in 2011/12; if actual volumes exceeded the benchmark, it would be entitled to an additional payment. At the end of our fieldwork, WOHC and the private-sector partner were still in negotiations over this issue.

LOCAL SHARE OF THE CAPITAL COST

When the hospital opened in October 2007, there were concerns about WOHC's ability to come up with its local share of the total capital costs. In fact, there was a shortfall, and WOHC subsequently requested that the Ministry revise the local share. One of our recommendations in the Appendix is that, prior to hospital projects being approved, the Ministry ensure that hospitals have a realistic plan to raise the agreed-to local share.

According to the 2004 funding agreement with the province, WOHC's local share of a total capital cost of \$1.3 billion over 25 years was to be \$452 million, or about 30%. The Ministry granted WOHC a credit (value adjustment credit) equal to the difference between the estimated cost for government design-and-build and the preferred P3 bid, which came to approximately \$164 million, and other credits totalling nearly \$40 million, leaving the local share at \$248 million. At the time of our audit in 2008, WOHC was requesting that the Ministry revise the local share of the capital cost of the construction of the new hospital by another \$119 million, from \$248 million to \$129 million.

In addition to the capital cost of construction, WOHC had also incurred over \$240 million in equipment and equipment installation costs for the hospital. The Ministry had previously agreed to fund over \$175 million of the total equipment

and installation costs, leaving WOHC to fund the remaining \$65 million.

Near the end of our audit, WOHC informed us that it had now identified approximately \$175 million in funding from the following sources, leaving a shortfall—provided its request would be approved by the Ministry—of approximately \$19 million (\$129 million + \$65 million – \$175 million):

- Region of Peel—\$37 million;
- ancillary revenues (mainly from parking)—\$70 million;
- interest—\$34 million; and
- donations—\$35 million.

Under the most recent proposal by WOHC, and in accordance with the process of review and adjustment to funding contributions provided for in the funding agreement, the Ministry would now fund approximately 90% (all but \$129 million of \$1.3 billion over the 25-year term of the contract) of the total capital costs of the hospital. In addition, under an existing arrangement, the Ministry will fund approximately 70% (\$175 million of \$240 million) of the cost of the equipment.

TRANSPARENCY AND ACCOUNTABILITY

In P3 transactions such as the one entered into by WOHC and the province for Brampton Civic Hospital, a balance has to be struck between the taxpayer's right to know about the cost and other details of the transaction and the private-sector partner's desire to protect proprietary information. At the time WOHC entered into the P3 transaction, there was no standard policy on disclosure practices specific to these P3 arrangements. Certain stakeholders expressed concern with regard to the commercial secrecy surrounding the P3 arrangement, even though WOHC did disclose in its published financial statements some details of the transaction. These included the total obligation to the private-

sector partner under the P3 arrangement, the cost of design and construction, the interest rate on the financing, and the total costs of non-clinical services to be provided by the private-sector partner over the term of the agreement. WOHC also posted a summary of the project agreement on its website.

Nevertheless, other financial information and documents, such as some aspects of tender documents and value-for-money assessments, could also be made available to the public while at the same time protecting private proprietary information. Because the government has entered into a number of other P3 or AFP arrangements, the need to establish a standard policy on disclosure practices becomes even more important. A consistent approach to disclosure will not only help ensure transparency but also help provide some assurance to private-sector partners as to what can be disclosed and what is confidential and will not be disclosed. To this end we note that Partnerships BC, the agency responsible for managing public-private partnerships on behalf of the government of British Columbia, has on its website disclosure guidelines for public-private partnerships. Its guidelines, based on the principles of competition and transparency, list the recommended disclosures at all stages of a public-private procurement process. Infrastructure Ontario indicated that it has developed an internal policy on disclosure and, based on this policy, key documents related to major project milestones such as requests for proposals, project agreements, and value-for-money reports on individual projects are posted on its website. To further enhance disclosure practices, the agency should consider posting on its website the standards and disclosure criteria outlined in its policy. In addition, it should consider disclosing other relevant information for individual projects, such as progress reports and interim and final costs.

Appendix—Recommendations for Future P3 Infrastructure Development Projects

Issues Noted in Office of the Auditor General Review	Lessons Learned and Recommendations	Infrastructure Ontario/MEI ¹ /MOHLTC ² /WOHC Response and Current Practice
Decision to Adopt P3		
1. There was no formal assessment of the costs and benefits of all available procurement alternatives.	The costs and benefits of all feasible procurement alternatives should be evaluated. Consideration should be given to expanding the involvement and expertise of Infrastructure Ontario to all infrastructure projects.	<p>MEI/Infrastructure Ontario Response:</p> <p>The Ministry of Energy and Infrastructure recommends investments in particular projects through the infrastructure planning process, part of the annual Budget Planning process. Individual projects are evaluated against policy priorities and to ensure they are consistent with ReNew Ontario, the government's five-year, \$30-billion Infrastructure Plan. Investment decisions are made independently of the assessment of procurement alternatives. The Ministry of Energy and Infrastructure also conducts a preliminary assessment of projects to determine whether they may be suitable for alternative financing and procurement (AFP) and should be assigned to Infrastructure Ontario.</p> <p>When a project is assigned to Infrastructure Ontario, it conducts a full value-for-money (VFM) assessment that compares the costs and benefits of traditional procurement with an AFP approach. A VFM assessment is completed prior to issuing a request for proposal. In some instances, projects assigned as AFP have been reassigned as traditional projects in response to the VFM assessment.</p>
2. In Ontario only a limited number of contractors have the capacity to undertake large institutional projects. The bundling of capital and operational support services might have further limited competition and reduced value for money.	Before a decision is made to enter into an AFP arrangement, a comprehensive market assessment should be carried out.	<p>MEI/Infrastructure Ontario Response:</p> <p>Since the establishment of Infrastructure Ontario, the agency has routinely conducted market assessments and consultations to ensure that an appropriate level of market capacity is available. The portfolio staging plan is frequently reviewed and adjusted to take into consideration market capacity of contractors, subcontractors, lenders, investors, maintenance services, and so on.</p>

Issues Noted in Office of the Auditor General Review	Lessons Learned and Recommendations	Infrastructure Ontario/MEI ¹ /MOHLTC ² /WOHC Response and Current Practice
Value-for-money Assessment		
<p>3. The value-for-money assessment was not based on a full analysis of all relevant factors and criteria and was done too late to allow improvements to be made to the procurement process.</p>	<p>Value-for-money assessments should have relevant and clear criteria, and should be conducted at the earliest stage of the procurement process.</p>	<p>MEI/Infrastructure Ontario Response:</p> <p>In 2007, Infrastructure Ontario published its VFM methodology. The methodology lists all cost and risk items that are considered as part of the VFM calculation.</p> <p>All anticipated costs and risks are documented and reviewed by third-party advisers to ensure that an appropriate level of transparency is maintained during the process.</p> <p>Infrastructure Ontario conducts VFM analysis at three stages during the procurement process:</p> <ol style="list-style-type: none"> 1) before RFP release; 2) before awarding of contract (preferred proponent selection); and 3) after financial close.
<p>4. The value-for-money assessment could be perceived as biased, as the only way WOHC could receive funding for a new hospital was to follow the P3 approach.</p>	<p>Comparing costs under the traditional approach and the AFP approach should be an objective process to reduce the risk of any bias in comparison.</p>	<p>MEI/Infrastructure Ontario Response:</p> <p>Infrastructure Ontario has produced a publicly available VFM guide that standardizes the methodology for the analysis of all AFP projects and to minimize subjectivity that may arise. The methodology includes an assessment of all AFP costs. The methodology was recently reviewed by the Ministry of Finance's Ontario Internal Audit Division and found to be sound.</p>
<p>5. Despite having established an appropriate due-diligence process to review the work of WOHC's consultants, the Ministry had not followed up and acted on the findings of the reviewers.</p>	<p>Appropriate and timely action should be taken on issues raised during the due-diligence process.</p>	<p>MEI/Infrastructure Ontario Response:</p> <p>Infrastructure Ontario has established a robust due-diligence process, including a project-governance structure that manages and monitors key project approvals and the related decision-making process.</p> <p>Procedures are in place to review, document, and follow up on lessons learned from project to project.</p> <p>Further, management continuously monitors project-related issues through various working groups and project reporting to ensure the timely resolution of those issues.</p>

Issues Noted in Office of the Auditor General Review	Lessons Learned and Recommendations	Infrastructure Ontario/MEI ¹ /MOHLTC ² /WOHC Response and Current Practice
<p>6. In comparing the design and construction costs of the traditional procurement approach and the P3 approach, the hospital assumed that there would be no financing under the traditional approach but that the design and construction costs under the P3 would be financed.</p>	<p>To ensure that all options are adequately considered, the decision to build and the decision to finance should be evaluated separately.</p>	<p>MEI/Infrastructure Ontario Response:</p> <p>The Ministry of Energy and Infrastructure evaluates individual projects against policy priorities and to ensure that they are consistent with ReNew Ontario, the government's five-year, \$30-billion Infrastructure Plan. Investment decisions are made independently of the assessment of procurement alternatives.</p> <p>Infrastructure Ontario has developed and published a standard VFM methodology that considers financing costs under both models—AFP and traditional procurement.</p>
<p>7. Risk transfer:</p> <ul style="list-style-type: none"> ● The extent to which a properly structured traditional procurement contract could mitigate cost overruns should have been more carefully considered, given that the same contractors were involved regardless of the procurement models. ● \$95 million in risk transfer to the private sector was not realizable, as there are re-pricing provisions in the project agreement for non-clinical services. 	<p>In assigning transferable risks, all relevant factors, including those that mitigate the risks, should be considered. As well, actual experience from previous AFPs should be applied wherever possible.</p> <p>The transfer of risk should be supported by the terms of the project agreement.</p>	<p>MEI/Infrastructure Ontario Response:</p> <p>The AFP model used by Infrastructure Ontario quantifies the risks that would be retained by the public sector under the traditional procurement model using a risk-allocation matrix based on empirical data.</p> <p>Infrastructure Ontario ensures that project agreements are structured such that risks are assumed by the party best able to manage them. Infrastructure Ontario's project agreements have been standardized to include lessons learned on earlier projects to support continuous improvement.</p>
<p>8. Additional costs of following the P3 approach, including interest rate differentials between private-sector and government borrowing and other transaction costs, should have been included in the decision-making process.</p>	<p>All significant costs of AFP should be assessed in the decision-making process.</p>	<p>MEI/Infrastructure Ontario Response:</p> <p>As part of the assessment of procurement alternatives, all AFP costs are considered, including all transaction costs, financing costs, and contingencies.</p> <p>For example, typical AFP-related costs include private-sector financing, private-sector contingencies, bid costs, special-purpose-vehicle fees, and advisory fees.</p>

Issues Noted in Office of the Auditor General Review	Lessons Learned and Recommendations	Infrastructure Ontario/MEI ¹ /MOHLTC ² /WOHC Response and Current Practice
Advisers		
9. Many advisers retained by WOHC were single sourced, and the contracts were open ended and without ceiling prices.	To ensure that advisers are retained at the best possible price, a competitive selection process should be followed. The assignments should be defined with contracts that stipulate the exact deliverables. The work of the advisers should be monitored and a process put in place to ensure knowledge transfer.	<p>MEI/Infrastructure Ontario Response:</p> <p>Infrastructure Ontario has a rigorous internal procurement policy. All contracts are fixed-priced arrangements. Generally, any sole-sourced contracts have been for situations where previous competitive procurements have not been successful—for example, insurance advisory services—and account for less than 3% of all contracts over the past two years.</p> <p>Infrastructure Ontario’s project-governance structure includes procedures to review, document, and follow up on lessons learned from project to project. Further, management continuously monitors project-related issues through various working groups and project reporting to ensure the timely resolution of issues.</p> <p>As a result of Infrastructure Ontario’s commitment to continuous improvement and standardization, advisory related costs per project are trending lower.</p>
Contract Management		
10. WOHC has yet to establish procedures for monitoring the performance of its private-sector partner.	Hospitals should have adequate procedures in place to verify the performance of contractors. Any resulting adjustments to the unitary payment should be made on a timely basis.	<p>MEI/Infrastructure Ontario/WOHC Response:</p> <p>Infrastructure Ontario is currently developing a comprehensive user guide for hospitals on how to properly administer the project agreement.</p> <p>Further, Infrastructure Ontario is co-ordinating the establishment of a help-desk service that will allow hospitals to call in as issues arise and receive timely input as to available recourses.</p> <p>With respect to monitoring the performance of the Brampton Civic Hospital contractor, WOHC has established formal processes for management of all day-to-day operational issues, performance review, and joint strategic discussions.</p> <p>Further, WOHC is currently establishing a program for auditing the private-sector partner’s performance and its monitoring and quality-assurance program and is developing a user guide for administration of the project agreement.</p>

Issues Noted in Office of the Auditor General Review	Lessons Learned and Recommendations	Infrastructure Ontario/MEI ¹ /MOHLTC ² /WOHC Response and Current Practice
Local Share of the Capital Cost		
11. WOHC initially had a significant funding shortfall for its share of the cost of the hospital's design and construction and of the equipment. The government will have to cover the shortfall.	Before granting approval for a new hospital, the government should carry out a more comprehensive assessment of whether the hospital has a realistic plan for raising its agreed-to local share of the funding.	<p>MOHLTC Response:</p> <p>In assessing the local share plan, the Ministry of Health and Long-Term Care balances a number of considerations, including the need for the project, cost escalation, and the procurement process against the time it will take to raise the local share of funds, the likelihood that projected revenues will materialize, and potential risks due to cost escalation in the intervening period.</p> <p>The provincial local share policy has since been updated so that, in most cases, hospitals essentially pay 10% of construction and design and 100% of equipment costs.</p>
Accountability and Transparency		
12. There was no standard policy on disclosure practices specific to these P3 arrangements.	To ensure transparency, Infrastructure Ontario should establish and communicate a policy on disclosure of AFP information.	<p>MEI/Infrastructure Ontario Response:</p> <p>Infrastructure Ontario's commitment to transparency is based on the principles outlined in the government's <i>Building a Better Tomorrow</i> framework. Infrastructure Ontario has in place a disclosure policy that it follows consistently on all projects. Based on this policy, requests for qualifications are posted on MERX, and all requests for proposals, project agreements, and value-for-money reports are posted for public view on Infrastructure Ontario's website.</p>