Submission to the Ontario Auditor General on the William Osler Health Centre Brampton Public-Private Partnership (P3) Hospital Development

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The Ontario Health Coalition is a network of more than 400 grassroots community organizations representing virtually all areas of Ontario. Our primary goal is to empower the members of our constituent organizations to become actively engaged in the making of public policy on matters related to health care and healthy communities. To this end, we seek to provide to our member organizations and the broader public ongoing information about their health care system and its programs and services. Through public education and support for public debate, we contribute to the maintenance and extension of a system of checks and balances that is essential to good decision-making. We are an extremely collaborative organization, actively working with others to share resources and information. We are a non-partisan group committed to maintaining and enhancing our publicly-funded, publicly-administered health care system. We work to honour and strengthen the principles of the Canada Health Act.

We comprise the broadest public interest group on health care in the province, with more than 50 local health coalitions in communities across Ontario and more than 400 member organizations including health and social service agencies; seniors' organizations; unions; nurses; health professionals; doctors, interns and medical students who support public medicare; disability and human rights organizations; ethnic and cultural organizations; student groups; disease advocacy groups; progressive law firms; social workers' organizations and many others.

We are linked to the Canadian Health Coalition and provide provincial coordination of community-based health coalitions.

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Introduction

The decision of Ontario's provincial government to adopt the "Public Private Partnership" (P3) policy in the William Osler Health Centre (WOHC) hospital project was taken after almost a decade of experience with these projects in the United Kingdom. In January 2001, then Health Minister Tony Clement visited the U.K. and met with William Hague, conservative party leader. Among the U.K.-inspired "innovations" he introduced in Ontario upon his return was the P3 scheme at the William Osler Health Centre, announced in December that year.

But even by 2001, the policy of using P3s - or Private Finance Initiative (PFI) as it was known in Britain - was mired in controversy. High costs, significant service cuts and quality problems, serious design flaws and eroded public accountability had resulted in an avalanche of criticism from high-profile sources, including the professional societies for architects[1] and accountants[2], the British Medical Journal editors, and the U.K. Audit Office. Later, the International Monetary Fund[3] and even the British Conservative Party raised serious concerns on the public record about inflexibility, the off-book debt and extraordinary commitments of generation-long streams of public revenue to the P3 consortia.

The credibility and scope of the criticism in Britain was enough to warrant a skeptical approach to this policy change. Yet at no time is there any evidence that the Harris/Eves or McGuinty governments made any serious attempt to investigate the concerns that had been raised. Nor did they engage in appropriate public and legislative processes prior to adopting this policy themselves. At no time - neither under the Harris/Eves nor the McGuinty government - has there been any legislation, nor proper public hearings regarding this significantly different and controversial approach to infrastructure development. In fact, there has been no statutory framework laid, and

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[1] Even by 2001, England's Commission for Architecture and the Built Environment (Cabe) had criticized the first wave of PFI hospitals because building design was forged in answer to financiers as opposed to the public interest, describing them as "urban disasters". In 2001, chairperson Sir Stuart Lipton, noted: "There has been a general under-performance in terms of functionality, build quality and aesthetics." See: Mann, Will. "Accident or Design?" Contract Journal, May 2002. In following years, criticism of the subsequent projects by high-profile architects and architects' associations escalated. See further comments by Sir Stuart Lipton in "Property Beyond Profit: The Case of the Enlightened Developer" in Architect, 2004 pp. 9. See also "New Royal London Hospital Design 'a Failure'" by Matt Weaver, Guardian August 3, 2004 and BNet.com: "Royal London PFI goves back to drawing board" September 2004. See also the resignation of the deputy chair of Scotland's public architecture association over PPPs - "Fraser's resignation from A + DS could provoke PPP debate" Architecture Scotland 6 February 2008. This was followed by similar criticisms from N. Ireland's equivalent to Cabe in 2007/08. See also the case of PFI school design: "Half of new schools badly designed, says survey" by Matthew Taylor, The Guardian, July 4, 2006 and Cabe survey.

[2] Criticism of the financial models and regimes re. PFI/PPP was already significant and public in the UK by 2001. See footnote 6 for quotes and sources. For a history of UK Treasury Guidelines, covering critiques and responses for this time period, see: "Value for Money in PFI Proposals: A Commentary on the 2004 UK Treasury Guidelines for Public Sector Comparators" by Andrew Coulson, Institute of Local Government Studies, University of Birmingham.

[3] See "Brown warned: don't hide £100bn" Dan Atkinson, Mail on Sunday, 25 April 2004, http://www.thisismoney.com/20040425/nm77403.html

public consultation and debate have been shunned.

The decision to move forward with the WOHC Design-Finance-Build-Operate (DBFO) P3 scheme has been surrounded by significant and justifiable controversy in the community of Brampton and across Ontario, particularly where P3 hospital projects have now been introduced. In Brampton, residents have watched costs for the project increase dramatically, even as the size of the hospital was reduced. Residents have witnessed local health planning and democratic processes subverted as a consequence of an overly expensive infrastructure procurement arrangement and privatization.

Most recently, plans for 112 complex continuing care beds to be redeveloped in the Peel Memorial hospital (the site closed when the P3 hospital opened) have been postponed indefinitely[4]. The new redevelopment proposal is to build another hospital to house the services that were cut from the P3 hospital when costs ballooned. It now appears that the provincial government is paying almost double the originally projected capital costs for the P3 hospital *plus* an uncalculated sum for redeveloping the Peel Memorial site in order to obtain the hospital capacity projected for one hospital at the beginning of this process. Planned in-patient hospital bed capacity for the community has been cut significantly as a result of the higher-than-anticipated cost of the P3 scheme, though hospital bed plans were already inadequate for assessed community needs.

It is our hope that the scope of the audit is sufficient to capture the important issues and questions that have been repeatedly raised with respect to this project. In this brief, we have outlined several of the critical issues we urge you to address, including:

- The failure by two successive provincial governments to engage in appropriate public and legislative consultation processes, to investigate and fully consider public infrastructure development options, to consider the international evidence of errors and flaws in P3s, and to properly disclose their policy decision and its implications to the public and the legislature prior to their policy decision to embrace P3s.
- The high costs of the financing and commercial arrangements in the WOHC P3.
- The dramatic cost overruns - starting from the approved projected cost of the facility up to and including the construction period for the WOHC P3.
- The cuts to the capacity of the hospital resulting from the cost increases and the implications for access to care in Brampton.
- The decision to include in the scheme the for-profit privatization of the hospital support services, access to the lands and other commercial developments over the 25-year duration of the deal, and the implications for complexity, cost, governance, management, and public accountability.
- The unprecedented level of secrecy, lack of public access to information and erosion of public accountability as a result of the P3 agreement.
- The misalignment of this project with stated government health care policy.

[4] The Central-West Local Health Integration Network, on direction from the MOHLTC last autumn, created a Task Force to determine the future of the Peel Memorial hospital site. The Task Force recommendations delay until some undetermined date in the future the creation of the planned 112 complex continuing care beds which were based on assessed community needs. For the most recent needs assessment see "Regional Hospital Infrastructure Plan for Halton and Peel" prepared by the Halton-Peel District Health Council, January 27, 2003.

Particularly in light of the lack of public accountability demonstrated to date, we welcome the decision to audit the William Osler Health Centre Public-Private Partnership (P3) deal and appreciate the opportunity to provide you with this submission outlining our findings and concerns with the project. It is in the public interest that the final costs and consequences of this project finally receive a full analysis and public disclosure. It is our hope that the additional P3 hospital projects be audited as they are also the subject of significant public controversy over cost overruns, secrecy and clinical service impacts, including the Royal Ottawa Hospital P3, and the P3 projects now underway in North Bay, Sault Ste. Marie and Sarnia.

1. Public options not considered

As in the Special Audit of the Cancer Care Ontario private cancer treatment centre at Sunnybrook Hospital[5], it is our hope that the provincial Auditor General include in your investigation whether or not public/non-profit options were considered before moving forward with the P3 deal for the William Osler Health Centre.

We have been unable to find any evidence that public procurement options were considered prior to adopting the P3 policy for this project. In fact, in 2001 Finance Minister Jim Flaherty told the media:

> *"As I announced in this year's spring budget, the government is committed to a new framework for health care partnerships in the province. Public/private partnerships are an option that will have to be seriously considered before the Ontario government will commit to any type of funding," said Flaherty."* Brampton Guardian "Province wants partners for new hospital" Sabrina Divell 12/05/01

Thus, without appropriate debate, legislation, regulation or consultation, the Finance Minister announced that P3s had become the default and public procurement the exception. The policy was set prior to any Value for Money assessments being conducted. From that time on, hospital officials repeated that if they did not embrace the P3 privatization, Brampton would not get the needed new hospital. It is in this context that the WOHC negotiated and defended the deal that saw costs escalate dramatically while the planned size of the facility was reduced.

If improved procurement management at the provincial level, creation of specialized teams to assist hospitals with project management and procurement, improved design processes to reduce change orders, improved timelines for government approvals or any other possibilities for improvements in governance and management of large project procurement under the traditional public funding model were considered as an alternative strategy to the P3 privatization, we have not been able to find any evidence of these. Despite our requests to Tony Clement for grounds that the P3 deal would live up to government claims that it would be "faster, better and cheaper", no such evidence was provided.

Indeed, prior to the decision to adopt the P3 policy for the Brampton hospital, there was more than sufficient information available to warrant a skeptical approach to this financing and procurement policy. We repeatedly raised this evidence with both governments that held office during the WOHC P3 procurement. The experience from the United Kingdom - from which the model was adopted - was that the privately financed hospitals in the UK were significantly more expensive, the financial and accounting regimes were mired in controversy, the UK auditor had made public his criticisms of the schemes, and the British Medical Association Journal had published an editorial that was severely critical of the bed and staff cuts that resulted from the high cost of the projects. Criticisms of high costs in hospital P3s were also publicly disclosed by the Australian New South Wales State Auditor-General[6]. Similarly, P3 school projects in Nova Scotia and New Brunswick had

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[5]Special Audit, December 2001.

[6] See British Medical Journal Editorial which found "Financed under the private finance initiative this programme is associated with reductions in acute bed provision of around 30% and staff numbers of up to 25%."

been criticized by their provincial auditors for high costs and inappropriate technology contracts.[7] However, the government never responded to repeated requests for evidence to counter the problems that had occurred in these projects in hospitals in the UK and Australia and schools in Canada.

A similar lack of appropriate process and consultation occurred under the new government. After the Conservative government lost the election in 2003, we asked repeatedly to meet with the appropriate people in the Ministry of Health under the McGuinty government to share our research and raise our concerns. Instead, the government moved forward exceptionally quickly with the deal after the October 2003 election. By November 13, 2003, the Assistant Deputy Minister's correspondence with the WOHC shows that the decision had already been made - within a month of the election - to move ahead with the deal based on the Project Agreement that had been in negotiation with the Conservative government.[8] If there was an opportunity to avoid moving forward with the P3 deal at that time, we have not found any evidence that it was investigated. We have not found any evidence that options other than P3 privatization were considered. Requests for meetings by groups that had raised concerns about the scheme were

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BMJ 2000; 320:461-462 (19 February). See also: Gaffney, Declan et al. "NHS capital expenditure and the private finance initiative - expansion or contraction?" British Medical Journal, Vol. 319, 3 July 1999. Also, "The politics of the private finance initiative and the new NHS", same volume. Also, "PFI in the NHS - is there an economic case?", same volume, Pollock, Allyson et al. "Planning the new NHS: downsizing for the 21st century", BMJ, Vol. 319, 17 July 1999.

By the early 2000s, criticism of P3 financing was growing in the U.K. On the public record, the following serious criticisms had already been raised by credible sources:

The BMA in Scotland called for a moratorium on P3s after a leaked document indicated that the Edinburgh Royal Infirmary had been reduced in size due to costs in the P3 project. See British Medical Journal: News "Scottish doctors call for a moratorium on PFI" 1999;319:275 (31 July)

Jeremy Colman, deputy controller and auditor-general of the National Audit Office, described value-for-money exercises involving the PFI as 'pseudo-scientific mumbo-jumbo where the financial modelling takes over from thinking…It becomes so complicated that no one, not even the experts, really understands what is going on.' He criticized the public sector comparators, stating that "many suffer from "spurious precision". Some, he said, were "utter rubbish", and were reworked so late in the deal that the comparator had ceased to represent a realistic alternative. That, he said, made them "utterly irrelevant". He went on to state that the comparators contained "scope to manipulate the figures". (See Financial Times, National News, "Warning of 'spurious' figures on value of PFI" by Nicholas Timmins, Public Policy Editor, June 5, 2002)

In the summer of 2001, the Institute for Public Policy Research (IPPR) Commission's report Building Better Partnerships contained a surprising amount of criticism of PFI. It said: the evidence suggests a "lack of convincing value-for-money" gains in PFI schools and hospitals.

The New South Wales Auditor-General in Australia found that the Port Macquarie P3 hospital was unduly expensive, noting that the taxpayers were paying for the hospital twice over (1996 Report).

[7] See Provincial Auditors' reports on Evergreen & Wacknut Leases (New Brunswick,1998), and O'Connell Drive Elementary School Lease (Nova Scotia, 1998)

[8] Documents filed in court: Vol VI - 28 - Letter from ADM to WOHC enclosing amendments to Project Agreement, on the CD we provided. See also Section 4c for analysis of changes to the Project Agreement and government claims regarding these.

refused. We were able to meet with the Ministry only after the decision to move forward with the deal was made.

Though it appears that the Liberal government has undertaken several measures to improve publicly-funded procurement for other projects, there is no evidence that either the Conservative nor the Liberal governments involved considered public procurement options for this project.

It should further be noted that the Brampton and Royal Ottawa P3 projects were initially described as "pilot projects". However, the P3 policy has now been adopted for a host of new infrastructure projects including more than 30 hospitals and several court houses, and the ReNew Ontario plan foresees the use of P3s in schools, water systems, transportation and other sectors over the next several years[9]. The only consultation prior to the wholesale policy change under the McGuinty government took the form of invitation-only workshops with the Ministry of Public Infrastructure Renewal. In these, participants were placed into groups dominated by the P3 industry representatives who comprised the overwhelming majority of invitees, and in which participants were asked to answer a set of questions about *how* not *whether* P3s would be implemented. Neither at this time, nor at any other, is there is any publicly-available evidence that the government has properly assessed its two "pilot projects" prior to embracing the P3 policy across the board.

[9] There are more than 30 hospital P3 projects approved. See Infrastructure Ontario website for current listing and status at http://www.infrastructureontario.ca/en/projects/index.asp
For the full plan see "ReNew Ontario" - the government's 5 year $30 billion infrastructure plan at http://www.pir.gov.on.ca/english/infrastructure/renew.htm

2. Unnecessary Costs

There is sufficient evidence to conclude that the WOHC P3 deal subjects Ontarians to unnecessary costs and complexity and dramatic cost increases - in contradiction to government claims - without explanation or accountability. We have provided you with several analyses of the costs of the WOHC P3 arrangement, including review of the Value for Money Benchmark[10] by Lewis Auerbach, former Director in the Auditor General's Office of Canada, several reports by economist Hugh Mackenzie, and an Ontario Health Coalition report tracking the cost increases and size reductions over the course of the P3 development[11]. The information that was publicly disclosed in the Project Agreement (PA) in March 2004 included financial information in Schedule 28 (see Box 1) which revealed that the P3 financing arrangement resulted in significantly higher costs than if the government had borrowed the money and built the hospital using traditional financing. It shows that the hospital is committed to streams of payments for 25 years to cover the service privatization, which are unnecessary but for the P3. In addition to these costs, after Financial Close, the MOHLTC issued several press releases announcing additional capital funds above and beyond what was agreed in the publicly-disclosed PA. We have expanded on the risks of this bundling-in of service contracts in Section 4. The financial data available raises several serious concerns about unnecessarily high costs as follows:

- The sum of the annual payments, defined in the Project Agreement as the "Unitary Charge", yields a total cost of more than $2.6 billion in public funds (before the equipment deal was added). This is an extraordinary commitment of streams of public funds and long term service privatization in order to get a hospital built that was originally valued and approved at a cost of $350 million.

- The "coupon rate"or borrowing rate for the senior debt of $455,840,000 is 6.73%. In 2003/2004 the rate for similar term government bonds was at least a full percentage point below this. For example, as of August 4, 2004,the borrowing rate for Government of Ontario bonds that matured in 27 years was 5.65%, in July 2004 the rate for Ontario bonds maturing in 2029 was 5.23% and in February 2004 the borrowing rate for an Ontario bond with a 21-year yield as 5.56%. Therefore, the decision to finance this project through the P3 meant that the borrowing costs were at least 100 basis points and possibly 150 basis points higher. Depending on the discount rate used, the cost consequences vary, but are almost certainly in the range of $100 million or more over the life of the project.

- In addition to the costs outlined in Schedule 28 of the project agreement, there have been additional announcements of capital funding (excluding equipment) for the project after the Project Agreement was signed and Financial Close was announced. An internal document from a May 17, 2004 WOHC Board meeting was leaked to the press revealing that the consortium required an additional $21.8 million to begin construction. Subsequently another $24 million in capital funding was announced by the provincial government. Then, during construction in 2007, another $100 million was announced by the

[10] See Auerbach, Lewis "Commentary on the William Osler Health Centre Value for Money Benchmark and Letters of Assurance" May 9, 2007

[11] See Ontario Health Coalition "When Public Relations Trump Public Accountability: The Evolution of Cost Overruns, Service Cuts and Cover-Up in the Brampton Hospital P3" January 7, 2008

government. (See sources and details of cost overruns in Section 2a.) Thus, it appears that capital costs continued to increase after Financial Close. Our calculations show that the total for capital costs -excluding equipment - that have been publicly revealed now sits at more than $650 million ($536 million disclosed in March 2004 Project Agreement Schedule 28 + $24 million + $100 million = $660 million).

- The review of the VFM, by Deloitte and Touche, revealed that the service privatization relied on an implausible reduction in service costs, projecting that they could be provided for 70% of the VFMB. Thus, it appears that the financial case for the hospital rests on the controversial bundling-in of generation-long service contracts and a dubious assumption that hospital operating costs can be reduced beyond reasonable levels in order to offset the unnecessarily high cost of design and construction.

- Lewis Auerbach reports that the Deloitte and Touche review of the VFM found that the WOHC overstated the VFMB by at least $300 million and perhaps as much as $400 million.

- The same review showed that the equity investors will be receiving $240 million in dividends on an equity investment of $60 million in addition to their return on equity and Project Co. will be receiving dividends of $59 million on their investment of $22 million in addition to their return on equity. The consortium will also receive management fees of $38 million. Lewis Auerbach calculates the total of extra interest, above government of Ontario borrowing costs to be $94 million. Thus, the total cost of dividends, management fees and extra interest are $430 million, which will be paid to the P3 consortium. The government has never accounted for why it would be necessary to commit $430 million in profits, management fees and extra interest to get the hospital built that was estimated to cost $350 million in total at the outset of negotiations with the private consortium.

- In addition, the Project Agreement shows high costs for consultants - unlikely to include all of the hospital's consulting costs - incurred because of the undue complexity of the scheme.

Box 1.

William Osler Health Centre
Project Agreement
Schedule 28
Hospital & Parking Structure

Bid - revision time 2:03 pm Revision Date - 02 Dec 03

				31,394	42,682
Program	Date				
Financial Close	15 Oct 03		Funding	$000	Yrs
Senior debt funding date	15 Dec 03		Senior debt		
End of construction	30 June 06		Facility	455,840	
Start of operations	1 Jul 06		Drawn	455,840	
End of operations	30 June 31		Term		25.8
			Average life		17.0
Pre-Operating	Yrs 2.7		Equity		
Operating	Yrs 25		Facility	80,442	
			Drawn	80,442	
Key Rates	%		Term		27.8
Annual CPI	2.00%				
MMEX inflat factor	2.00%		Sources & Uses of Funds	$000	%
Deposit rate construct	3.87%		Uses		
Deposit rate operations	2.00%		Design-build contract	447,506	83.4
Deposit rate DSRA	3.87%		Pre Operating costs	13,185	2.5
Senior date coupon rate	6.73%		Rent (DS) Reserve Acct	19,551	3.6
			Senior Debt Interest	56,040	10.4
Construction Period Cost	($000)		Total Uses	536,283	100.0
Transaction cost paid at closing	9,159				
Construction period admin costs	4,026		Sources		
Total	13,185		Senior debt	455,840	85.0
			Equity	80,442	15.0
Unitary Charge	$000	$000	Total sources	536,283	100.0
Base unitary charge	93,890				
Financial yr.	1 (9 mos)	2 (12 mos)	Cover Ratios	DSCR	LLCR	C LLCR
	70,418	94,798	Min	1.19	1.40	1.45
Operating Costs			Max	1.77	2.37	13.65
included in unitary charge			Aug	1.37	1.51	2.06
- non market-tested serv's	7,632	10,360				
- market-tested serv's	23,761	32,321				

2 a. Cost overruns

Table 1. Publicly-disclosed cost increases in the Brampton P3 hospital occurred during the following stages of procurement (capital costs only):	
From final approved proposal to the end of the RFP stage	Costs increased from $350 million[12] prior to tendering to $430 million[13] by the time the finalist bidder was selected.
From beginning of the Project Agreement negotiations with the finalist bidder to Financial Close	Costs increased from $430 million when the finalist bidder was selected to $536 million[14] when the Project Agreement was initially made public.
After Financial Close until Substantial Completion of the construction	Costs increased from $536 million at Financial Close to more than $550 million[15], then to at least $650 million[16] by the time construction was at Substantial Completion.
Total cost increases	From the publicly disclosed figures, the final approved cost estimate prior to tendering was $350 million and the final known cost at Substantial Completion is $650 million; a $300 million increase on a hospital project that was initially estimated at $350 million.

[12] Publicly disclosed figure repeatedly used by Health Minister, WOHC CEO and WOHC VP. See Brampton Guardian "Contenders to build new hospital narrowed to four" Sabrina Divell 10/25/02: "Rosalie Penny, vice president of public affairs for WOHC said the final budget is estimated at $350 million plus $100 million estimation for equipment and commissioning budgets." See MOH press release July 2, 2002, Tony Clement announced the hospital is estimated to cost $350 million for 608 beds to be opened by 2005.

[13] See Canadian Press "Ont. government remakes hospital deals, private firms will still build them" Keith Leslie 11/21/03: "Bob Bell, president and CEO of the William Osler facility, estimated building the new 608 bed facility at $430 million just 'for the bricks and mortar'". See also Toronto Star "Brampton to get its public hospital" Mike Funston 11/22/03: "Construction of Brampton's $420million, 600-bed hospital will proceed on schedule, and will open in 2006 as a publicly owned and operated facility, Ontario Health Minister George Smitherman says."

[14] Schedule 28 of the Project Agreement released March 2004.

[15] After the final Project Agreement was signed, the consortium required another $21.8 million before they would start construction. This resulted in a stalemate between the MOHLTC and the consortium which delayed construction. Ultimately the MOHLTC announced another $24 million in capital costs, raising the total capital cost (publicly disclosed) from the previously disclosed total of $536 million to over $550 million. See "$22M causing more delays to hospital" by Sabrina Divell, Brampton Guardian, 06/11/04. See Hansard for Minister George Smitherman's comments in the legislature - June 8, 2004. Also see Toronto Star "Mayor fights for hospital; Promised Brampton centre still in limbo while costs soar" Morgan Campbell 07/21/04. On December 22,2006 the government issued a press release announcing another $24 million in capital funding as follows: "the McGuinty government is investing $34 million to help the William Osler health Centre to finish building its new 608-bed Brampton Civic Hospital site, Health and Long-Term Care Minister George Smitherman announced today....The funding announced by the government today includes: - $24 million in capital funding for the William Osler Health Centre to provide equipment and related accommodation, such as electrical fixtures and building structures....- $10 million in operational funding to assist the hospital with costs related to transitioning to the new hospital site." MOHLTC press release on CNW.

[16] See News Release Ministry of Health and Long Term Care "Brampton Civic On-Time Opening Ensured by New $114 Million Investment from McGuinty Government" 3/30/07: "Smitherman announced today the government is....investing an additional $101 million in capital and $13 million in one-time operating funds...."

From the publicly-available figures, large cost increases occurred in the capital costs and in the equipment contract. Unlike the increases in publicly-procured projects in Thunder Bay and Peterborough which were associated with increases in the size of the planned hospitals, the cost increases in the Brampton P3 led to cuts to the size of the hospital, reducing clinical care capacity. There has never been any public explanation for the cost increases.

- The total capital cost increase is approximately $300 million from the approved estimated cost prior to tendering to the publicly disclosed costs at Substantial Completion (see Table 1).
- The cost increase for equipment is more than $100 million from the publicly-released estimated cost to the publicly-announced final cost (see Table 2).
- This has also had implications for the local community share of funding which increased from a publicly-disclosed estimate of $60 - $100 million to the final publicly-disclosed total at $270 million (see Table 3).
- We cannot assess how the projections and final contract price measures against actual costs for the service contracts which cover all support services as no data is publicly available.

Table 2. Equipment cost increases

2002 - Estimated cost for equipment announced to be $100 million	"Rosalie Penny, vice president of public affairs for WOHC said the final budget for the new hospital is estimated at $350 million plus a $100 million estimation for equipment and commissioning budgets." Brampton Guardian "Contenders to build hospital narrowed to four" Sabrina Divell 10/25/02
2006 - Equipment cost announced to be $250 million	"The price tag for bricks and mortar at the site has been pegged at $550 million, and it will cost an additional $250 million for equipment, furniture and technology for the hospital....said [hospital CEO Bob] Richards." Brampton Guardian "Hospital needs help from residents" Heather Ennis 06/11/06

Table 3. Local Fundraising Share cost increases

2003 - Reported local fundraising share $60 - $100 million	Brampton Guardian "Builder selected for new hospital" Sabrina Divell 05/14/03
2006 - Reported local fundraising share $240 million	Metroland - Brampton Division "Hospital needs help from residents; Community needed" Heather Ennis 06/11/03
2007- Reported local fundraising share $270 million	Metroland - Brampton Division "Hospital pricetag rises to $900-M; Community fundraising more than doubled" Peter Criscione 05/25/07

2 b. Cost comparison between WOHC P3 and PRHC traditional procurement, same timelines

A comparison of the costs of procurement for the Brampton P3 hospital to the Peterborough Hospital (PRHC) procured without use of private financing, raises serious questions about the costs of the P3 model. Both hospitals have been procured at the same time. The Peterborough Hospital project was the last public project to be approved before the P3 program was introduced by Tony Clement and Jim Flaherty. The Brampton P3 hospital was the first P3 hospital announced under the new policy.

Table 4. Comparison of Traditionally (Public) Financed Peterborough Hospital with Brampton P3

Hospital Type	**Peterborough Hospital (traditional/public procurement)**	**Brampton Hospital (P3 financing & procurement)**
Time Period	June 20, 2000 initial announcement of approval to June 8, 2008 patients moving in	November 30, 2001 initial announcement of approval to October 2007 patients moved in
Bed Capacity	494 beds	608 beds
Total Cost (capital only - exclu. equipment)	$197 million	$650 million
Total Cost (including equipment, all other approved contracts)	$276 million[17] including equipment	Approx. $900 million including equipment[18], >$3 billion with service contracts

Table 4 shows the comparison of cost, size and timelines between the two hospital projects. The new Peterborough Hospital with its traditional (public/non-profit) procurement is significantly less expensive in capital and equipment costs, even taking into account its smaller bed capacity. In addition to the savings in capital costs, the Peterborough project entails no additional risky 25 year service privatization, bifurcated management, overly complex Project Agreement, land deals, etc. Among the questions raised by this comparison:

- why would the government commit >$3 billion in payment streams to the private consortium to get the WOHC P3 built, when a comparable project, publicly-procured, done over the same time period, could get a hospital built for considerably less money without the additional complexity and risk entailed in a 25 year Project Agreement that bundles all the support services, use of lands and facilities into the real estate deal?
- why can an approximately 500-bed hospital entail $200 million in capital costs and an approx. 600-bed hospital total $650 million in capital costs?

[17] Peterborough MPP Jeff Leal, in response to community question at All-Candidates' Meeting, September 2006: total cost is $276 million comprised of capital cost, equipment cost, all other allowable costs by MOHLTC.

[18] Metroland- Brampton Division "Hospital pricetag rises to $900-M; Community fundraising obligation more than doubled" Peter Criscione 05/25/07

2 c. A closer look at cost comparisons and risk transfer claims

The government has repeatedly used two examples of cost overruns in public procurement - in Sudbury and Thunder Bay - as justification for its P3 policy, asserting that P3s result in greater price certainty. But this claim does not withstand scrutiny. The experiences in Sudbury and Thunder Bay, instructive as they are, do not establish any causal relationship between cost increases and the type of financing (government or P3), do not speak to value for money or total cost, do not warrant a conclusion that all future projects must be financed by private sector consortia, and bear no relation at all to the policy decision to create generation-long service privatization contracts bundled into the capital financing deals for hospitals as is the case in the WOHC P3.

In fact, the use of these examples obscures the lack of substantive evaluation of P3 costs and risks by Ontario's government. There is no publicly-available evidence that the evaluation of the risk of cost overruns during hospital construction under different forms of procurement has been adequately assessed and is appropriate, that changes to this evaluation as a result of improved public procurement processes have been used in evaluating the WOHC P3 or any other P3 projects currently in process, nor that there has been appropriate consideration of the use of public procurement improvements in large hospital projects in Ontario. Finally, the experience of the WOHC project is that price certainty was not achieved using the P3 procurement method.

The evidence is that procurement processes are more important in achieving price certainty than type of financing and that price certainty does not equal better value for money:

- The experience of the WOHC P3 shows that price certainty was not achieved as a result of the use of the P3 procurement strategy. In the WOHC P3, costs not only escalated significantly during the tendering process, they also continued to escalate after the deal was signed during the construction period when risks were supposed to have been transferred to the private sector.
- There are a range of policy options available to improve price certainty in procurement without necessitating the use of expensive private finance and generation-long privatization deals[19].
- A comparison between the publicly-procured Peterborough hospital project and the WOHC P3 project indicates that costs are higher in the P3.
- The Thunder Bay hospital is significantly larger than originally designed, accounting for a significant portion of cost increases. In the WOHC P3, the size of the planned hospital was reduced as costs increased.
- To date in Ontario, cost overruns in the P3 projects are the same or greater than those in the two examples of public procurement that the government is using (see Table 5 & 6).[20] This

[19]The provincial government is aware of these options. In addition to the wealth of international research on this, the MOHLTC appointed Tom Closson as an investigator for the Thunder Bay Hospital. He produced a report with a list of recommended improvements to procurement processes and accountability that would operate under a traditional -or public - financing regime without P3s. See http://www.canhealth.com/News087.html "Report on Thunder Bay hospital cost overruns" Canadian Healthcare Technology for a summary.

[20] In addition, subsequent to the Sudbury and Thunder Bay projects the government has reported adopting improved oversight and project approvals processes to reduce the risk of cost overruns in publicly-procured projects. We applaud these initiatives in theory, though we are not privy to the details. We would like to see the evidence supporting the government's decision not to use improved public oversight as part of a public-procurement policy prior to adopting the P3 policy across more than 30 hospital projects, including the Brampton WOHC P3.

is in keeping with the findings of the British Association of Certified Chartered Accountants in their investigation of privately-financed hospitals, in which they concluded: "[c]onservatively estimated the trusts appear to be paying a risk premium of about 30% of the total construction costs just to get the hospitals built on time and in budget, a sum that considerably exceeds evidence of past cost overruns."[21]

Thus, the question of risk transfer and procurement process warrants a more substantive response by government than the simplistic use of the Thunder Bay and Sudbury hospital project costs as a rationale for a drastic policy change with far-reaching implications.

Since the risk of cost overruns in public procurement reduces with the adoption of improved procurement regimes, changes in procurement processes should alter the value of any public sector comparator that is used. Since the financial justification for P3s rests almost entirely upon the theory of risk transfer, this is not insignificant. In fact, in the UK, the evaluation of risk and public sector comparators has been the subject of robust debate and discussion, resulting in multiple re-assessments of Treasury Guidances and Green Book accounting guidelines. In Ontario, since at least 2003, the government reports that it has undertaken a number of measures to improve public procurement regimes and approvals processes which would impact the value of risk of cost overruns in public procurement. If there is any analysis or consideration of this -with respect to the WOHC P3 or any other projects underway in Ontario - there is no publicly-disclosed evidence of it. In a meeting with David Livingstone, CEO of Infrastructure Ontario, we asked if IO had an analysis of average cost overruns across recent publicly-procured projects. We were told that IO did not have such data. This raises the question of how Ontario has arrived at a value for "risks" to be transferred without this information.

It should be further noted that despite the considerable evidence of significant cost increases in the British P3 hospitals[22], one survey from the National Audit Office in the UK compared cost overruns in a limited sample of public and PFI hospitals and found improved price certainty in the PFI deals. This report has been used by Ontario government officials as justification for the P3 policy. But the UK Auditor cautioned against misuse of this survey, noting that it neither assessed the costs of private financing compared to public procurement, nor could it assess price certainty for the duration of the generation-long contracts. In addition the survey used questionable methodology which has been controversial in the UK and which significantly limits the usefulness of its findings:

i. It used two different timelines when comparing price certainty. In the publicly-procured projects it measured costs from the final projections prior to engaging in any construction contracts to the final building cost. In the PFI contracts it measured costs only from the end of the tendering process (the final negotiated price) to the final construction cost, excluding

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[21] Association of Certified Chartered Accountants "Evaluating PFI in Roads and Hospitals" Research Report No. 84 (2004).

[22] In one recent example the projected costs of the Paddington health campus P3 in west London increased from 360 million pounds to 1.1 billion pounds while the bed total fell from 1000 to 800. The British government cancelled the deal. (See The Guardian "Plan for super-hospital scrapped after eight years and 14m. Mark Gould, 15th June 2005). Similar huge cost increases led to bed decreases in the Royal Edinborough Infirmary P3. In Worcestershire, the hospital P3costs increased by 118% over the negotiations of the deal, leading to closures in neighbouring Kidderminster hospital. See Pollock et al. British Medical Association Journal "Private finance and 'value for money'in NHS hospitals: a policy in search of a rationale? Vol. 324 18 May 2002 and "Trampled Underfoot: The Government's passion for PFI is basically a tax that is set to bankrupt future generations" The Observer, Sunday March 28, 2004. In his research, George Monbiot found cost increases of more than 70% across the British PFIs, see Monbiot, G. "Captive State: the corporate takeover of Britain" Macmillan, London, 2000.

cost increases from the final approved projected cost to the end of the tendering process. If it had compared "apples to apples" and measured both the public and PFI contracts from the pre-tender final costs through to substantial completion of the construction, it would have likely found considerable cost increases in addition to the "risk premiums" charged by the PFI contractors (which exceed any evidence of past cost overruns in public projects, as the British Association of Chartered Accountants found in their report)[23].

ii. In addition to this, the survey relied almost exclusively on project managers who owed their employment to the private consortia involved in the deals.

It will not serve the public interest for an audit in Ontario to use similar methodology.

[23]Evaluating PFI in Roads and Hospitals 2004.

Table 5. Ontario P3 Hospitals Cost Increases (Capital Costs Excluding Equipment)			
Community	**Projected Costs (final publicly reported costs prior to tendering)**	**Final Reported Costs At Signing of Project Agreement**	**Cost Increase**
Brampton	$350 million (reported cost by WOHC and MOHLTC 2001 - 2003)	At least $650 million (2007) for a building that was substantially reduced in capacity from initial design	$300 million
North Bay	$218 million (2005- reported by hospital)	$551 million (2007 - disclosed by leaked document printed in local newspaper, confirmed by government)	$333 million
Royal Ottawa	The project was capped at $100 million (2001- reported by hospital) (announced twice more on September 9, 2003 and July 6, 2004 at cost of $100 million - by government releases reported in Ottawa Citizen.)	$146 million (2006- disclosed by hospital)	$46 million (note: this was the reported cost at the hospital opening. However, it has since been reported that the building is incomplete and has significant construction problems. It is not clear whether this is the final cost.)
Sarnia	$140 million (2005 - reported by hospital)	$214 million (2007 - disclosed by leaked document reported in newspaper, confirmed by MPP)	$74 million
Sault Ste. Marie	$200 million (2005 - reported by hospital)	$408 million (2007 - disclosed by hospital)	$208 million

Table 6. Examples of Publicly-Procured Hospitals Cost Increases (Capital Costs Excluding Equipment)			
Community	Final Projected Cost	Final Cost	Cost Increase
Sudbury	$132 million (1998)	$209 million (May 2001 bid received by hospital not including equipment - reported by hospital) $363 million (2002 including equipment - reported by hospital). Project stopped, incomplete.	At least $ 77 million. Project was never completed and final figures include undisclosed amount for equipment, so comparison is not possible from available data.
Thunder Bay	Redesigned building cost estimated at $179.68 million (source: report by Tom Closson, appointed by MOHLTC) (Original building approved at $ 98 million (April 2002), then project redesigned to increase size from 470,000 square feet to 686,000 square feet.)	$283.9 million (2004)	$104.1 million

3. Size Reductions

As the costs for the WOHC P3 project increased, the hospital CEO revealed that the size of the project had been reduced to contain costs. In a media interview - the only revelation of the cuts to the Brampton public that we have found - he downplayed the extent of the size reduction, stating that it did not affect clinical care capacity[24]. This is untrue. We have asked the hospital and the government for copies of the various iterations of the building design plans, but have been told that this is not publicly-available information. However, WOHC documents show that the building plans were significantly downsized and clinical capacity was cut to contain costs as follows:

- Design plans were reduced from three main buildings to two. The original design proposed three distinct clinical care buildings including an Inpatient Tower, a Diagnostic/Therapeutic Wing with an Emergency Department, and an Outpatient/Ambulatory Care Block. The scaled-down design contained two buildings - A North Building and a South Building. By the hospital CEO's admission the Ambulatory Care space was cut along with the administrative offices. (See Appendix 1.)
- Unannounced, the number of Operating Rooms was reduced from 20 to 18 and later to12. (Ibid.)
- The VFM documents show fewer Transition beds, reductions to the Medical/Surgical unit and the abandonment of pairing blocks of 37 - 38 beds which will require higher staffing costs (see Auerbach).

The consequences of this downsizing are additional costs and diminished hospital capacity in the community:

- The hospital continues to lease additional space off-site at an undisclosed cost for its Administrative Offices which no longer fit in the new hospital building
- The new redevelopment plan for the Peel Memorial Hospital (the old site of WOHC which was slated for redevelopment once the P3 was complete) has been changed to accommodate an Ambulatory Care Centre (cut from the P3 design) and Administration (also cut from the P3 design), as well as day-surgeries (possibly to replace the O/Rs cut from the P3 design). It appears then, that the government is planning to build another hospital at an uncalculated sum to contain the services that were originally planned to be located in the P3 before the costs escalated. Plans for 112 complex continuing care beds to go into the redevelopment at the Peel Memorial site have been delayed indefinitely, despite the fact that they were announced as approved once in 2001 by Tony Clement and again in 2005 by George Smitherman, and were based on the District Health Council's assessed health care needs for the community. Neither hospital nor government officials have answered yet where the complex continuing care patients are supposed to go.
- The total in-patient bed capacity for the community was planned to be 608 beds at the P3 hospital plus 112 beds at the redeveloped Peel Memorial site totalling 720 beds[25]. After the cost increases, the total community's planned capacity for inpatient beds is now 608, a bed capacity reduction of 15%. The current bed capacity in the WOHC P3 is 479.

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[24] "Some adjustments were made to the final design of the hospital, [hospital CEO Bob] Bell said, to help reduce some of the "financial pressures on this project." Brampton Guardian, "Hospital construction is going forward; 2007 is target date for new hospital" Sabrina Divell, October 24, 2004.

[25] These bed totals appear repeatedly in government announcements, and can be found in the WOHC Briefing Note dated October 31, 2003 on the CD which we provided to you. The table containing the bed plans is scanned and pasted in Appendix II.

4. Scope of the deal unnecessary, unjustified, and increases risks

We have raised our concerns with the high cost of borrowing and the premiums on equity contained in the WOHC P3 financing arrangement which we have addressed in Section 2. In addition to this we are deeply concerned about the consequences of the multifaceted nature and scope of the scheme. The duration and magnitude of the privatization in the WOHC P3 are unprecedented and involve complexity, inflexibility, new requirements and costs for the hospital board that are unforseen in the Public Hospitals Act and are without precedent in Ontario.

As economist Kim Jarvi at the Registered Nurses' Association of Ontario has warned, this P3 contract amounts to "a risk-creating machine" for public authorities. The project entails new risks, opportunity costs, bifurcation of management functions, and loss of control that are without rationale. Yet the government has consistently understated the size and implications of the scheme and there is a dearth of evidence that the Ministry of Health and the WOHC have adequately recognized or evaluated the risks and costs associated with their approach.

The WOHC P3 Project Agreement bundles into the private finance deal for the real estate an unprecedented 25 year service contract covering all support services in the hospital. It also introduces a range of ancillary commercial contracts and revenue-sharing arrangements, including those covering retail spaces, the parking lot, space rentals, and potential developments on the lands. Neither the William Osler Health Centre nor the government have ever provided explanation for the scope of the privatization in this contract, nor any evidence to support the risks entailed in bundling the services into the capital financing deal. In fact, the public statements of the Ministry continue to hold that the P3 model has no impact on "what goes on inside the hospital"[26]. This is a mischaracterization of the scope of the deal.

In fact, the multifaceted nature of this P3 raises serious concerns. No Ontario hospitals have heretofore bundled all their support services into one commercial contract, and then, in turn, bundled that contract into a capital financing deal. No Ontario hospitals have contracted out this range of support services for a 25 year contract that extends beyond the scope of the hospital's or government's ability to predict population need or technological changes. The management complexities and risks of such an approach are unnecessary and without precedent in this province. The regimes outlined in the Project Agreement for monitoring, evaluating, and asserting control over the services are complex, create an array of new legal and financial risks, and rest on an assumption of a balance of power that is unrealistic. In addition to the lack of rationale for the extent and duration of privatization in the WOHC P3, the government has never laid the statutory framework for this major change in hospital management and constraints on governance.

[26]See Hansard, Toronto Star. Hospital CEO Bob Richards in the Toronto Star, December 5,2007 "New Hospital Upsets Community": "There are absolutely no linkages between who finances a hospital and what goes on within its walls. It's absolute nonsense...."

4a. Service Deal Exceeds Reasonable Horizon of Predictability

In this P3 deal, the WOHC Health Centre and the government have contracted for services that they cannot predict, may not need, or may need in significantly different formulations. The pace of technological change in health care is rapid. Twenty-five years ago there were no MRIs and no PET scanners. In 2002 Ontario had approximately 20,000 less hospital beds than in 1990[27]. Care modalities have changed, not only with the movement of patients out of hospital to other settings, but also through distance-care information technology innovations such as telehealth, video-conferencing for specialists, at-home wound care through virtual consults using electronic photographs. New advances in pharmaceuticals, and diagnostic technologies, new patient records systems, the advent of ambulatory care centres and nurse-led clinics are just a handful of innovations that point to a requirement for flexibility in the organization of hospital services, space, and technology.

Since the WOHC P3 bundles hospital space management and all support services into the 25-year contract, flexibility is reduced. Under the terms of the Project Agreement, the hospital needs to investigate unprecedented legal and cost implications as each change occurs and will have to negotiate these changes with the consortium through the myriad processes set out in the PA. The consequences of this inflexibility are becoming evident in the UK where the cost of PFI projects prohibits their closure and has reduced options in regional health planning for hospital beds. Because of PFI financial and contractual obligations, local health planning authorities have been forced to close down public/non-profit hospitals[28]. In other projects, increased utilization has meant that hospitals have faced "penalty clauses".

[27] Ontario Hospital Association, "Hospital Stability and Sustainability: Proposed Action Plan for the 2003 Budget" OHA Submission to the Ontario Standing Committee on Finance and Economic Affairs, Ottawa Hearing, February 6, 2003 - slide #63.

[28] See NHS "The Implications of Fixed Costs and PFI Schemes for Service Redesign in SE London" NHS 2007, and; "Bankrupt or sinking under debt the new hospitals too costly to for cuts" by Nigel Hawkes in The Times, May 11, 2007 - http://www.timesonline.co.uk/tol/news/uk/health/article1774372.ece

4 b. Loss of hospital governance and management control over vital hospital functions

The scope of the WOHC P3 contract limits the hospital's control over vital services in a number of ways.

- Management functions are bifurcated. The for-profit consortium runs all the support services that are vital for all clinical service functions of the hospital

  While the government holds that all "patient care" services remain under the hospital's non-profit management, this is not true. Under the WOHC PA, the management of the hospital is now bifurcated, with the consortium managing all of the support services. No hospital can operate without patient records, portering (transporting patients around the hospital), cleaning (including disinfection, vital for the control of hospital-borne infections), security, food services, and the host of additional services privatized for the duration of the P3 contract. Every clinical service relies upon a range of support services. Thus, the provision of all patient care in the WOHC now requires the cooperation of the consortium. This conflicts directly with government claims in the legislature and in the media[29].

  In the WOHC P3, hospital employees have described the changes that the bifurcated management and service privatization regimes mean for day-to-day operation of the hospital. Since the service staff are no longer employees of WOHC, but employees of Carillion, they have been informed by their management that they are not to aid nursing staff (who are employees of WOHC) in getting patients ready to be moved, nor in cleaning up incidental items upon request, for example. According to one employee:

  "We used to work as a team, but the team is now broken. If a patient isn't ready to be moved, we have been told by Carillion that we have to put them back into the system, we can't help get them ready and then take them. It isn't in our job description. I don't know how the hospital is going to afford the costs. Every time they go back into the system, the hospital gets billed for another patient. So we put the patient back into the system and we go to the next person on the list. We might go back two or three times, and the hospital gets billed each time, for the same work it took us one time to do before. The same is happening to the cleaners. If they are asked to pick something up or clean up something as they go by, they can't do it. It has to go through Carillion."

  These observations echo experiences in the UK P3s. A contract dispute in North Durham's University Hospital P3, for example, featured the private sector consortium claiming that the contract did not specify requirements for porters to move patients so ambulances had to be called to transport patients short distances within the hospital[30].

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[29] Ibid.

[30] "Crisis-hit hospital finds that private finance for NHS comes at a price" Guardian Unlimited, July 23, 2001. Also see front-line description of work in a P3 hospital by Catherine Blake "Choice is an empty word" The Guardian, July, 20, 2004.

In another example, a doctor describes her experience of the contracted-out support services and technology in one of the UK's P3 hospitals as follows:

"There were TV sets and telephones available in all the "old" NHS hospitals I trained in, but now, under the banner of better choice for patients, every bed in the hospital comes with an in-built TV, courtesy of PatientLine, the company that hit the headlines earlier this year after installing thousands of sets in hospitals without an off button. If my patients resist the PatientLine reps and decline to sign up for premium-rate television and phone services, they are treated to a repeated loop of adverts for the company on the screen. So much for tranquillity.

The changes happen silently and it's the things that would never occur to you - and clearly didn't occur to the policy makers - which have the most disturbing effects. For six years, I never really noticed when people who had died were removed from the ward. The porters who removed their bodies to the morgue were professional - they took care to be discreet so as to cause minimal upset to families and other patients, who don't like to be reminded that they might not make it. Since arriving at this hospital I have twice seen covered corpses being noisily negotiated past the lunch trolley at midday. It seems to me that when you sub-contract out vital staff, de-unionise them, literally de-value them - the porters have lost their holiday pay and now have to work a third more hours to make the same pay they did under the NHS - the result is a de-skilling and demotivation of the workforce, with consequences for patients.

Before I started working, I was vaguely aware of plans to introduce private investment into the health service, but it wasn't until I dealt with my first emergency that I realised the extent of the takeover. In my first week, I was asked to see a man who had become extremely short of breath. When I examined him I realised that his heart was failing and his lungs were filling with fluid as a result. I gave him some oxygen, ordered a chest x-ray and sent off my blood tests. When I went to look up the results, the computer was broken....I thought it would be easy enough to retrieve my urgent blood results. I rang the switchboard and was put through to the company: press one for portering services; two for cleaning services; three for catering services; four for laboratory services; five for maintenance services; six for IT services. I pressed six and got a recorded message. The patient lived, but it transpired the next day that the computer firm who owned and ran the hospital was not responsible for fixing the computer - this had been subcontracted out to another firm."

In addition to the management implications, there are a significant number of labour issues and cost issues that were not adequately assessed prior to signing the deal. In the WOHC P3, the impact on the costs of the service contracts are governed by a set of formulas in the Project Agreement and documentation that are not fully disclosed. We raise these issues in the hope that your office will look more deeply into the cost, management, labour, and service implications.

- The duration of the service contracts precludes returning them "in house" without prohibitive legal costs

  The WOHC PA contains unprecedented legal and cost implications for contracted-

out services. The usual practice for hospital contracting-out of services in Ontario has been 3-year contracts encompassing single services in which the hospital and the private company have the ability to give 6 months notice to terminate the contract, leaving the hospital in control with a strong incentive for the private contractor to perform. Even with this balance of incentives, there have been quality problems and cuts to service levels in these short-term contracts[31]. In comparison, the WOHC P3 deal encompasses all the services bundled into one 25 year contract, which is, in turn, bundled into the real estate deal. Under the PA, the hospital board has significantly constrained potential to terminate the contract and find a different provider or return the service "in house". As in all contracts, the private sector has a profit incentive in reducing costs that are usually accomplished through reducing the number of workers, creating strict time limits for performing tasks and constraining job descriptions, limiting the use of supplies and using cheaper supplies. This has been a significant problem in British P3 hospitals and has been most publicly evidenced in their extremely high rate of hospital-born infections. The result of the duration of the service contract, the number of services involved in the contract, and the complexity of leveraging control and terminating the contract in the WOHC P3, is a significant increase in risks borne by the hospital board and public authorities.

- The hospital board has limited ability to take action against the P3 companies because of the risk of costs and legal disputes

  The Project Agreement provides a complex array of monitoring, oversight and enforcement regimes to deal with service quality and additional business contracts arising over the course of the P3 scheme, thus creating a host of new legal risks for the hospital if disputes arise with the consortium - and any of the various companies involved in the deal. Such disputes are not infrequent in recent P3 experience (see Box 2 for examples of recent management breakdown in P3 projects[32]). The British Association of Certified Chartered Accountants recognized the difficulties in appraising, monitoring and enforcing the contracts, the power imbalances and additional costs for monitoring and oversight required as a consequence of these deals[33]. In his commentary on the VFM, Lewis Auerbach raised the question of the viability of assurance maintenance is done towards the end of the contract. In fact, the Cambridge Economic Policy Associates 2005 study found that 30% of the clients found hard facilities management did not meet expectations, even in the

[31] Note: A National Audit Office (NAO) Report found: 'Cleaning and portering service unit costs were higher at PFI (i.e. privatized) hospitals and were perceived as providing a lower quality of service.' Also see Kushner, Carol "Inside-out/Outside-in" study of outsourcing 3 service contracts at the Toronto Hospital, March 21, 2002. There have been a number of failed contracts, quality problems, infection-rate controversies and other quality problems as a result of contracting-out hospital support services in Canadian jurisdictions which we can provide reports on, if these would be of assistance. Several jurisdictions have moved to limit or regulate contracting out of hospital support services in response to increased hospital-borne infections, including antibiotic-resistant infections such as C.difficile and MRSA.

[32] For a full report with examples and sources, see "Flawed Failed and Abandoned: 100 P3s - Canadian and International Evidence" Ontario Health Coalition March 2005

[33] See ACCA 2004, pages 50 - 55.

early years of the contract[34].

In reality- as opposed to P3 theory - the hospital board is constrained in its ability to leverage control over the companies involved, because such action may risk or entail costs that would cut into clinical budgets and detract from the core mandate and urgent service needs of the hospital. In the context of tight hospital budgets, and since all the support service budgets are tied up for the duration of the 25-year contract, the hospital faces a stark choice of spending on lawyers or spending on nurses and doctors if quality problems, requirements to change the service regime, or other contractual issues arise. This observation is underlined by the findings of industry credit-rating agency Standard and Poors, who have noted that the P3 companies benefit from strong and stable revenue streams and carry little risk after the construction phase, and in the ACCA report among other evidence-based studies[35].

While services may be contracted out, the hospital retains risk and legal liabilities for their management. As Vern Edwards, Ontario Federation of Labour Director of Occupational Health and Safety and Environment notes: "Case law holds that hospitals may contract out services but they retain the liability for health and safety." In the P3 deals, this can mean the worst of both worlds, with the hospital and public authorities facing additional complexities in leveraging their control over hospital services while retaining the legal liabilities and cost implications in their provision.

- The deal allows the consortium to sell off its interest in the hospital - and take a 50% of the proceeds, and allows for the creation of additional commercial ventures within the hospital and on hospital lands

  The WOHC PA allows for the consortium to sell off its interest in the facility. This has happened frequently in the UK experience where a Public Accounts Committee Report from May 2007 found that part or all of the equity had been sold in 32 of the 80 P3 projects it surveyed[36]. Closer to home, in one recent example, the Hamilton-Wentworth wastewater P3 project was sold four times before a massive sewage spill entailing unrevealed public costs precipitated the return of the service to public hands. This raises concerns about the fundamental asymmetry of power and responsibility in the contract, and the risks entailed by changing personnel and relationships between the two entities that now run the hospital.

  A continuous cooperative relationship is required for the hospital's ability to get maintenance done, to ensure continuity and quality of services, and for the functioning of all clinical services. Changes in key personnel and companies can

[34] "PPP in Scotland: Evaluation of Performance", 2005.

[35] Standard and Poor's. "Public Finance/Infrastructure Finance: Credit Survey of the UK Private Finance Initiative and Public-Private Partnerships" London, 2003. For additional research on risks, asymmetry, power imbalance and ability to enforce P3 contracts see Froud, Julie "the Private Finance Initiative: risk, uncertainty and the state" Accounting, Organizations & Society 28, 2003;567-589. See Shaoul "A Critical Financial Analysis of the PFI" Critical Perspectives on Accounting 16, 2005;441-447. Also see ACCA 2004 pages 50 -55.

[36] "Private Finance Initiative or Punish Freeloading Investors?" The Telegraph, May 25, 2007.

mean the loss of understanding of the intention of the complex provisions and processes in the Project Agreement.

While the hospital, and the public health system, have an obligation to provide universal health services to the community, the consortium is primarily concerned with reduction of risk and maximization of returns. These divergent mandates, with fundamentally differing sets of accountability and responsibilities, can create pressures on even the most collegial of relationships. The consortium is able to use the hospital as an investment vehicle, and sell its interest if it so desires. It limits its liability by creating a series of limited companies to undertake the P3 project. But the community hospital is required by the public health system and by its own mandate to stay in the community and provide services based on the universality and values that underlie the public health system; whatever circumstances arise, the hospital must continue to provide the services. This imbalance in obligations and accountabilities is evidenced in the legal disputes that have arisen in a number of P3 projects.

Box 2. Legal disputes and management breakdown in recent P3 experience

Norwich and Norfolk University Hospital P3, UK - After a nurse lifted ceiling tiles and found that the ducting to two negative pressure "containment rooms" designed to contain airborne viruses and bacteria was not connected, the hospital trust spent 80,000 pounds to fix the problem. They then got embroiled in a lengthy and costly legal dispute with the consortium in an attempt to reclaim the costs. The hospital reported a serious budget deficit, and the case resulted in a public inquiry and an investigation by the National Audit Office. (The Observer, Saturday June 20, 2004 Antony Barnett, public affairs editor. Also see Health Services Journal "Probe request into PFI ventilation system", May 20 2004. Also see www.publictechnology.net, evening news, May 1 2004. The Observer, Sunday July 4 2004.)

East London and City Mental Health Trust P3, East London, UK - A leaked report from consultants revealed that the bidding and negotiating went on for two years beyond deadline; the architects were not paid; there were serious design flaws; the staff were ill-informed and alienated; and the contractor was deemed uncooperative and adversarial. (London Health Emergency, leaked document from Hornagold and Hills, January 13, 2004.)

LaTrobe Hospital P3, Victoria, Australia - The Victoria government had to buy back the hospital from Australian Hospital Care in October 2000 after the consortium lost $10 million on the LaTrobe Hospital and announced it was suing the government. (Canadian Centre for Policy Alternatives- Manitoba office "Health Care Privatization Down Under" March 31, 2000.)

Exeter Schools P3, UK - Concerns over a string of quality problems including unusable sports grounds and an infestation of fleas culminated in the summer of 2007 when classrooms became too hot for people to work in, leading to legal wrangling between Carillion and public authorities. (See "Public Private Finance December 2007/January 2008 and media coverage.)

Cranbrook Civic Arena P3, British Columbia - In 2004, the P3 project officially failed five years after implementation following lengthy construction delays, cost overruns and legal disputes.(Vancouver Sun, 5 August 2004, pp B3)

Hamilton-Wentworth Water and Wastewater Treatment P3, Ontario - The 10 year P3 deal, signed in 1994, changed hands four times. The project resulted in the largest sewage spill in Lake Ontario's history. The full cost of clean up fell to the City of Hamilton. The cost of clean up and details of the City's attempt to hold the corporation responsible have been kept secret. As of January 1, 2004, the P3 was abandoned and the system was re-publicized. (Hamilton Spectator, Pg A1 "City eyes takeover of water, sewer operations" August 31, 2004)

Halifax School P3, Nova Scotia - After arsenic was found in the school water, the school board and consortium were embroiled in legal wrangling for over a year in an attempt to get the consortium to pay the costs of fixing the water system. Pupils and teachers were forced to drink bottled water paid for by the school board. (Winnepeg Free Press, "Warning: the P3s are coming" by Murray Dobbin, July 21, 2002.)

Highway 407 P3, Ontario - This 99 year lease has been plagued with well-publicized legal wrangling over toll hikes and control. Ultimately the provincial government lost its final appeal.

Lister Hospital P3, Stevenage, UK - Patients faced potentially dangerous delays in receiving test results following a P3 in pathology, according to the British Medical Association. The problems followed the end of a contract and the return of pathology services to the hospital trust. The trust and OmniLabs could not agree on a formula for technology transfer during a changeover period leading to delays in data trasfer and problems tracking specimens. (Publicnet - www.publicnet.co.uk Friday, December 14, 2001.)

4 c. Changes to PA Inadequate to Assert Public Control

In November 2003, shortly after taking government, the McGuinty government required changes to the Project Agreement which resulted in its claims that the hospital is now publicly owned, publicly-controlled, transparent and accountable[37]. These claims are overstated. For example:

- The limits on public control are evidenced by the inability of the government to accomplish the public disclosure of the documents pertaining to the WOHC P3, even after the Premier announced they would be disclosed, and even after the WOHC was directed to ensure disclosure in the PA and the WOHC amended the PA. Months after the government promised release of the documents, in March 2004, a version of the Project Agreement was made available for public review. But the document was severely redacted, with whole sections of the main body of the PA were removed, Schedules were missing, and virtually all the financial information was removed. Even this redacted PA was only accessible under strict conditions that required any person desiring to see the documents to travel to the WOHC administrative offices, sign a promise not to copy any portion of the documents, limit viewing to one hour by one person at a time under supervision. Much of significance relating to costs and control including financial details and significant portions of the Project Agreement and accompanying schedules and correspondence between the MOHLTC and WOHC remained secret until a court order forced public filing in 2007. Even so, many documents pertaining to the deal remain secret including the Direct Lender's Agreement, the names and associations between the various companies involved in the scheme, the Value for Money documents and correspondence regarding these, among others.
- Hospital documents are not transparent, even within the hospital. The PA includes a protocol about who can see what documents. In the ROH P3, managers complain that they are unable to access the terms of the contracts, forcing them to take the word of Carillion regarding the company's entitlements[38]. Thus, ability to monitor or enforce the contract, which relies on access to the terms of the contracts, is governed by the PA and subject to the cooperation of the consortium. It is hard to imagine how such an arrangement can be deemed "public control".
- The limits on hospital board control have been outlined in Section 4b, and include severely constrained ability to terminate the Service Contract and increased risks and costs for monitoring and enforcement.
- Lack of transparency has been pervasive and continuous during this project. Information vital to the public interest has not been disclosed, or has been inadequately reported, including changes to the hospital design and reduced capacity, increases in cost, delays in construction, and the scope of privatization.

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[37] On November 21, 2003, the government issued a press release stating that the hospitals were publicly owned, controlled and accountable, and transparency had been assured. The Premier promised to reveal the Project Agreements to full public view. See "McGuinty brings new Ottawa and Brampton hospital into public hands: Affirms commitment to publicly owned, controlled and accountable hospitals." The MOHLTC issued a letter dated November 13, 2003 signed by ADM Maureen Adamson requiring changes to the PA. This was followed by correspondence between the WOHC and MOHLTC, correspondence from government lawyers, and several amended Project Agreements. We have provided the documents from this period that have been filed with the court to you on a CD. Note: several of the documents referred to in this sequence of correspondence and amendments are not publicly available and therefore not included.

[38] See report on ROH P3 management and service problems by the Ontario Public Service Employees Union at http://www.opseu.org/bps/health/P3Report.pdf

5. Misalignment with Public Hospitals Act and Ministry Hospital Policy

The WOHC P3, and the P3 program in general, are misaligned with stated provincial government health care policy and processes and the "Health Transformation Agenda". This is not the first time that hospital restructuring policy has been inadequately aligned with hospital infrastructure policy. Notably, the Provincial Auditor raised significant issues of cost and alignment with respect to the Harris government's hospital restructuring program in the1990s. At that time, the Auditor found that hospital restructuring mis-timing and misalignment with the development of community health services combined with unforseen and inadequately planned infrastructure requirement led to costs escalations $2.8 billion over budget, and costs were projected to rise by billions more[39]. The lessons from the last restructuring experience should sound a strong note of caution. Without commenting on our agreement or disagreement with provincial government health care policy, similar issues of mis-alignment and timing are at risk regarding the infrastructure renewal program and other health restructuring and health policy, as follows:

- Under the guise of the "Wait Times Strategy", the provincial government is introducing a new form of hospital restructuring. Its stated intention - and current practice - is to move hospital budgetting, away from global budgets to a policy of pricing and bidding that is variously termed "payment for procedure", "patient-based funding", "volume-based funding" and a variety of other euphemisms. Through the office of Alan Hudson, the province is working on pricing various hospital procedures, setting a central price and asking hospitals to bid for such procedures. It has assigned new powers to the Local Health Integration Networks to override hospital board's powers to enable them to order hospitals to provide a set level of services, or to cease providing certain services. Hospitals that bid at or under the assigned price will receive funding for these procedures. (This is already being done for cataracts.) Thus, hospitals will be forced to specialize and services will be rationalized - as they were in the last round of hospital restructuring, but this time, over the large geographic areas covered by the LHINs.

  Such an approach - which carries with it significant implications for service accessibility, human resources, cost etc. beyond the scope of this submission - requires flexibility in infrastructure. It necessitates the ability to move services from hospital to hospital and change the uses of sites. This is at odds with the high cost and reduced flexibility of the P3 program. Moreover, a significant number of large P3 hospitals are now in progress before the restructuring plans for location of services and levels of service have been set. We have asked Alan Hudson and various officials at the Health Ministry about how these policies are aligned, and no one has been able to answer this question.

- The provincial government has issued guidelines for hospitals to eliminate their deficits. In order to do so, hospitals have been required to follow a seven step process for finding opportunities to increase revenues or find budget cuts (see Box 3)[40] starting with revenue maximization in parking and commercial contracts on the site, then moving to support service cuts and rationalization, and finally to cuts in clinical services. In the WOHC P3 the

[39] See Provincial Auditor's reports on Ministry of Health and Long Term Care Institutional Health Program - Transfer Payments to Public Hospitals during years covering hospital restructuring in the late 1990s.

[40] See MOHLTC Hospitals Branch, Acute Services Division "2007-2008 HAPS Guide" (Hospital Annual Planning Submission) starting pp. 12 "Priorization Framework"

ancillary business revenues must be negotiated with the consortium and all the support services are privatized into the P3 deal at contracted prices for the next 25 years. The hospital board only retains budget flexibility over direct clinical services. Thus, it is unable to find budget cuts starting at Step One of the government's identified process. All future budget cuts will have to come starting at the level of clinical services, among the last options proposed in the government's guidelines.

- The provincial government has won two elections on an explicit platform of stopping health care privatization and, in the case of the 2003 election, stopping P3s. But the P3 projects embrace a scope and duration of hospital privatization that is unprecedented. Although the government recently issued a directive requiring hospitals not to bundle cleaning and food services into the privatization deals, there is no legislation or regulation in place to limit such privatization for the duration of these deals, and even the current directive allows for a vast range of long-term privatization[41]. Further, all the current P3 Project Agreements expressly invite the consortia to propose additional "Innovation Proposals" for commercial and business opportunities on the hospital sites that would then be bundled into the P3 arrangements for the duration of the contracts. The P3s provide unprecedented means and opportunity for private companies to set up for-profit or two-tier health services located inside and on the grounds of our hospitals. This has already happened in the Royal Ottawa Hospital P3, where, despite government claims of opposition to private clinical services and privatized health care, a private mood disorders clinic owned by MindCare Centres is selling services for profit inside the P3 mental health facility[42].

- The government has repeatedly expressed a policy direction of containment of hospital costs and a movement of patients to other modalities of care. But the high costs of the P3s have, in the UK and in Brampton, placed competing demands on scarce resources repeatedly led to a shrinking of the scope of health services available, starting with hospital clinical care budgets and rippling out to community care budgets, in what has become termed "the P3 effect". P3s have been associated with cuts to community care budgets and planning to accommodate the what has become known as "the affordability gap".

- Ontario's Public Hospital's Act and regulations never anticipated and are not designed to cover the complexity and scope of the WOHC P3 arrangement with its deep and long-term service privatization; commercial secrecy and lack of public access to information; bifurcated management structure; complex monitoring, oversight and compliance regimes; and complex array of leases and subleases, commercial contracts and subcontracts; and which now relies upon the cooperation of a host of corporations whose principle motivation and mandate is to provide maximum profit and growth opportunities to multinational investors. The requirements for governance and management of a P3 are

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[41] The Bulletin and covering memo are in Appendix III. Note: the list of services allowed to bundle-in for future P3 contracts, termed "Hard Facility Management" in the bulletin includes a range of soft services not usually defined as "hard facility management".

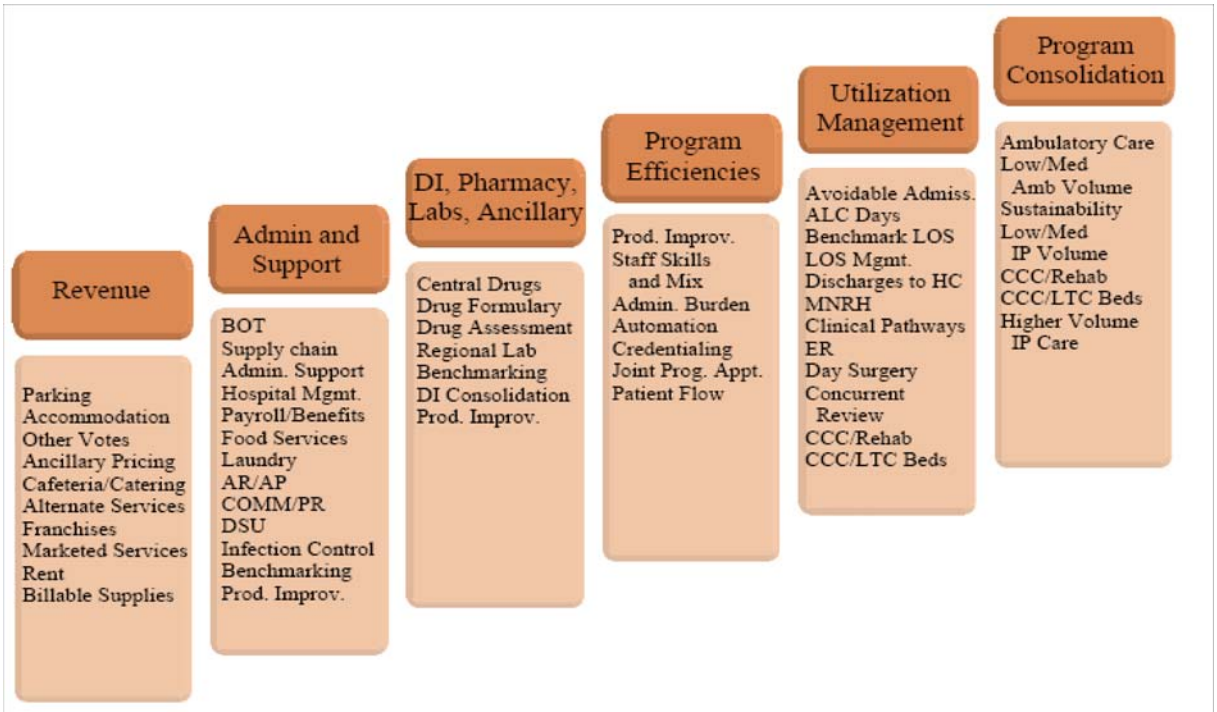
[42] See "Risky Business II: Hidden costs, security breaches, poor design, two-tier health delivery and very expensive water: one year later at the secretive Royal Ottawa Mental Health Centre, Ontario's first P3 Hospital by OPSEU at http://www.opseu.org/bps/health/P3Report.pdf

significantly different than those of a traditional non-profit hospital and the requirements and interests of the multinational investors involved in this project are misaligned with the WOHC hospital's mandate and the Public Hospital's Act relating to quality service provision and access within the hospital's community.[43]

- The Canada Health Act requires the provincial government to provide medically necessary hospital and physician services under the principles of universality, comprehensiveness, accessibility, portability and public administration. These requirements are put at risk due to the high costs and privatization in the WOHC P3.

[43]In other jurisdictions, P3s have been preceded or accompanied by an array of legislative, regulatory and policy requirements to govern them. In the UK, for example, the Treasury has regularly issued and updated policy directives regarding financial matters, the government has created policy regarding contracting, privatization, wages and a host of other matters. These have been available for public scrutiny and, particularly regarding the Treasury directives, there has been robust public debate and analysis which has resulted in tightened guidelines (See, for example, UK Treasury Guidance for VFMs -various iterations from 1999 on, Revised Green Book and critiques and analyses including that referenced in footnote 1 and David Hall, Public Services International Research Paper "PPPs: a critique of the Green Paper" 10/03/2008

Box 3. Priorization Framework for Balancing Budgets: MOHLTC Hospital Annual Planning Submission (HAPS) Guide 2007 - 08



The ministry's Prioritization Framework provides a stepped methodology to approaching decisions toward achieving a balanced operating position. Examples of hospital strategies that can be used in the various steps have been provided in Appendix A to generate ideas for expense reductions during hospital planning. The examples provided are not an exhaustive list and hospitals are also encouraged to consult with other peer hospitals to benefit from the learning experienced during the 2006/07 HAPS process.

These guidelines have been vetted through consultation with several hospital sector leaders prior to their completion. They are meant to assist the hospitals in consideration of opportunities for greater efficiency of operations and to align any changes in clinical services offered by the hospital with more strategic considerations. The ministry will use these guidelines as an evaluative framework in assessing hospital's expenditure reduction or revenue generation strategies identified in the HAPS.

Hospitals are expected to clearly outline the decision-making tool utilized in order to identify and categorize savings and revenues within the Prioritization Framework. The goal is to clearly portray the relationship between the savings and revenue options presented by the hospitals in the HAPS in comparison to the Prioritization Framework.

6. Loss of Public Accountability

The decision by the provincial government to move forward with the WOHC P3 and adopt the P3 policy across more than 30 hospital projects to date is the result of a deeply disturbing lack of public accountability and total absence of sound public and parliamentary process:

- From the outset of the WOHC project, hospitals were given the message by the Finance Minister that P3s were "the only game in town", leading to assertions by WOHC officials that if they did not embrace the P3 model they would not see a new hospital for decades, despite community need. This was not an auspicious context under which to obtain value for money.

- Despite the evidence that P3s warranted a skeptical approach and without any Value for Money Assessments having been undertaken, Finance Minister Jim Flaherty announced the P3 policy as the default for all new infrastructure projects stating that P3s would have to be considered before approvals would proceed (see quote in Section 1.)

- At no point prior to tendering, or during the tendering phase when costs were escalating, or when the McGuinty government took office prior to Financial Close, is there any evidence that public procurement options were considered for this project.

- After the McGuinty government had run an election campaign promising to stop the P3s and did not do so, it appears that government and hospital disclosure became subverted to public relations concerns and a desire to avoid public opposition. The attempt to re-name the P3 policy and downplay the extent to which it is a departure from traditional procurement and non-profit hospital development runs counter to democratic principles and the public interest. In an attempt to distance themselves from the P3 policy, which the McGuinty government engaged in elaborate and prolonged sophistry, re-naming the program "Alternative Finance and Procurement" or "Alternative Finance Mechanism" (AFP/AFM), and downplaying or denying the extent of privatization and change in policy repeatedly in the Legislature, in legislative committees, and in public statements. In contradiction to government claims, by all industry, legal, and academic definition of P3s, the WOHC project is a P3 including deep and long-term service privatization and significant implications for cost and patient care.

- Two successive governments failed to lay the statutory framework and have disregarded appropriate public and parliamentary consultation processes for this change in public policy. There has been no legislation, no public consultations, and no substantive response to concerns raised.

- The commercial secrecy that surrounds the P3 project at the WOHC and other hospitals is not in keeping with claims of public control, nor does it meet the requirement for appropriate accountability in publicly-funded institutions. It took a failed Freedom of Information Request and four years in court to force the public filing of some of the documents pertaining to the WOHC P3 scheme. A significant portion of the documents remains shielded from public scrutiny.

- The secrecy is not getting better as new projects proceed. The publicly-released documentation of the Royal Ottawa Hospital P3 is severely redacted and is not equivalent

even to the limited disclosure provided in the WOHC P3. The Project Agreements and Value for Money documents released in the new P3 hosptials (post- WOHC and Royal Ottawa Hospital) are more severely redacted and reveal less information than the redacted versions of the Project Agreements and VFM documents in the first two P3s. All the assumptions used to calculate risk transfer and public sector comparators, and the full Value For Money reports on all new P3s are secret. Since all the brief VFM summaries for these P3 projects show that the financial cases rest entirely on the controversial notion of "risk transfer", the lack of any public disclosure regarding these is deeply disturbing.

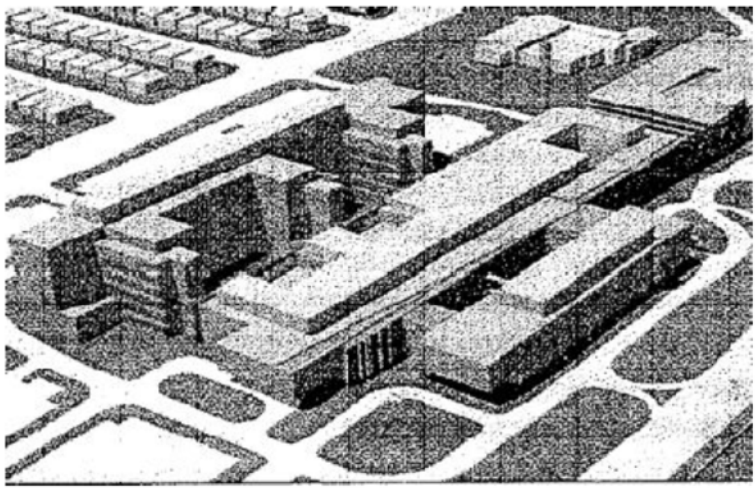
- The government and local hospitals are now refusing to disclose projected costs for new hospitals asserting that such revelations would compromise the competitive tendering process as a justification.

To date the the government and hospitals claim that P3 policy requirements for "commercial secrecy" stifle public disclosure of all financial information on P3 projects including final costs, projected costs for new hospitals, value for money evaluations, accounting processes used to determine due diligence, and information about the companies involved in taking over public services for generation-long contracts. This amounts to a "carte blanche" regarding public spending decisions encompassing tens of billions of dollars. There is sufficient evidence that legislation, regulation, public debate regarding accounting assumptions and processes for P3s exist in other jurisdictions and that commercial secrecy and a desire to avoid public opposition does not and ought not to supercede the public interest in government accountability[44]. However, limitations on public accountability and access to information in these projects in Ontario to date makes the P3 policy inappropriate for use and antithetical to fundamental principles of both our publicly-funded health system and our parliamentary democracy.

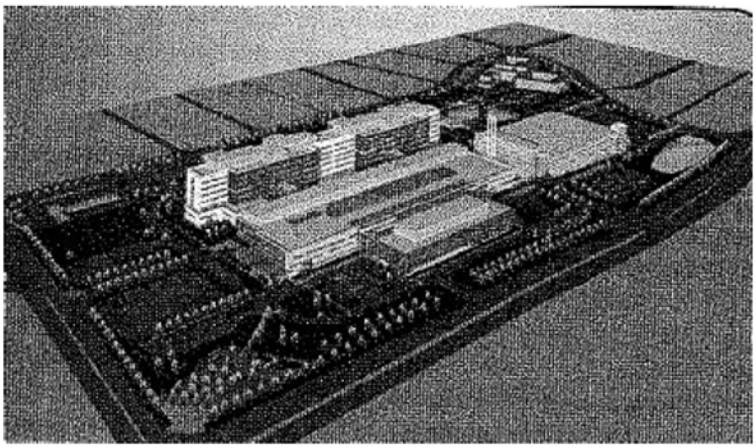
[44] See "What are they hiding?", Public Private Finance, December 2007/January 2008 pp 16, for current debate and policy considerations regarding commercial secrecy in P3s in the UK.

Appendix I

From "Osler Connections" newsletter 2002
The newsletter describes three clinical care buildings: "three distinct blocks; an Inpatient Tower, a Diagnostic/Therapeutic Wing with a state-of-the-art Emergency Department, and an Outpatient/Ambulatory Care Block. It will house 608 beds and 20 operating rooms...."

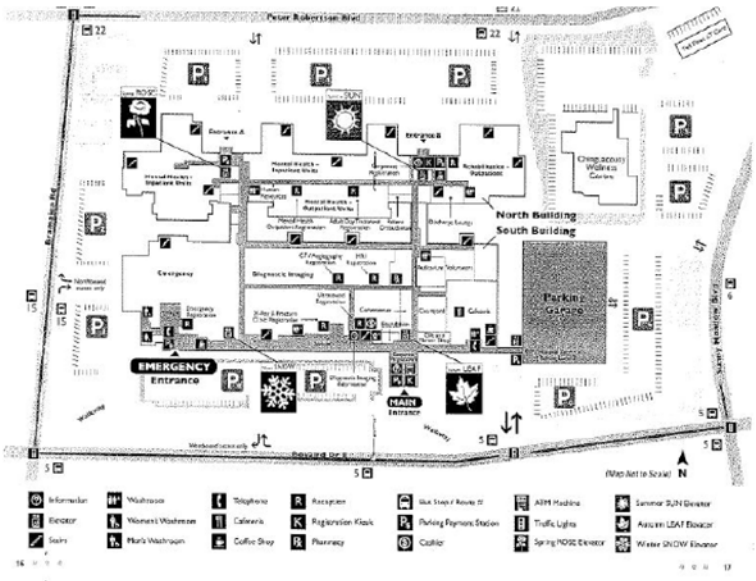


From "Osler Connections" newsletter 2003
Without noting the difference, this picture shows a redesign of the plans. Again, without noting the difference, the remaining two buildings are described as housing 608 beds with 18 operating rooms this time. The third clinical care building was removed from the plans to deal with "financial pressures" the hospital CEO revealed to the media more than a year later. He said the changes did not impact patient services.



From an information circular delivered to Brampton households in 2007. The picture shows the two clinical care buildings as per the redesign. At this point, the hospital opened with 479 beds, at nearly double the cost.

Though it was never noted publicly, the latest version "Brampton Civic Hospital Guide" shows the new hospital houses 12 operating rooms - not 20 - with a plan under "Future Capacity" to ramp up to 18 operating rooms. (Brampton Civic Hospital Guide October 2007)



Appendix II

from WOHC Briefing Note: October 31 2003:

Planned hospital bed capacity in WOHC (P3) and planned redevelopment for Peel Memorial

The details of planned hospital beds is illustrated in the following table:

William Osler Health Care	Current # Beds	Planned/Directed #Beds
Lynch Site	Acute Health.....283 Other: Mental Health.....68 Rehabilitation.....69 CCC.....110 Total.....530	Continuing Complex Care (CCC).....112
Bovaird Site	Beds.....0	Acute: Medical/Surgical.....304 Critical Care.....36 Paediatrics.....26 Maternal Newborn.....38 Total.....404 Other: Mental Health: Adult.....81 Mental Health Child/Adolescent.....14 Rehabilitation.....64 Transition Beds.....45 Total.....204 Grand Total 608

Appendix III

Ministry of Health and Long-Term Care

Office of the Deputy Minister

Hepburn Block, 10th Floor
80 Grosvenor Street
Toronto ON M7A 1R3
Tel.: 416 327-4300
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Ministère de la Santé et des Soins de longue durée

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Ontario

C06-00708

MEMORANDUM TO: All Ontario Hospitals

FROM: Ron Sapsford
Deputy Minister
Ministry of Health and Long-Term Care

RE: Services Excluded from Hospital Alternative Financing and Procurement (AFP) Projects

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Please find attached a bulletin concerning the government's policy regarding the inclusion of services in AFP projects.

This policy directive immediately affects hospitals to be developed using a Design Build Finance Maintain approach.

If you should have any questions regarding this matter I encourage you to contact Maureen Adamson, Assistant Deputy Minister, Health System Investment and Funding Division at 416-327-0985.

Ron Sapsford

Attachment

cc. David Livingston, CEO, Infrastructure Ontario
Maureen Adamson, ADM, Health System Investment and Funding

1615-02 (06/10) 7530-4659

Bulletin

Ministry of Health and Long-Term Care

A bulletin for hospitals and communities with Design Build Finance Maintain AFP projects

Ancillary Services Excluded from Hospital Alternative Financing and Procurement Projects

A policy decision has been made by the Ministry of Health and Long-Term Care that only Hard Facility Management and Life-Cycle Maintenance Services (see insert) will be included in the Alternative Financing and Procurement (AFP) hospital projects developed under the Ontario government's five year infrastructure investment plan.

This means that Soft Facility Management Services will no longer be considered as part of the AFP Design Build Finance Maintain projects. The government is committed to ensuring that the services involving direct patient care cannot be outsourced as part of these projects. The new direction reaffirms that AFP hospital projects are about the design, construction and maintenance of quality public hospital facilities and not about outsourcing ancillary services.

Effective immediately, this policy will apply to AFP hospital projects already in the market for North Bay Regional Health Centre, Sault Area Hospital and Niagara Health System, as well as for future projects such as Markham-Stouffville/Salvation Army Grace, London St. Joseph's Parkwood Site, St. Joseph's Mountain Centre Hamilton, Halton Healthcare Services, Bridgepoint Health, Humber River Regional Hospital and the Centre for Addiction and Mental Health.

If you have further questions, please contact your Ministry contact person or Doug Murray at 416-212-4646.

Hard Facility Management (Hard FM) - Services associated with the day-to-day management of the physical plant: maintaining the elevator, electrical and ventilation systems, and similar maintenance work; and utility costs, namely the costs of heating, electricity, lighting, and similar inputs. Other services would include non-patient food services, moving, security, parking, grounds maintenance, IT backbone, and coordination of medical equipment procurement.

Life-Cycle Maintenance
Life-Cycle Maintenance represents the total cost of ownership of products, structures or systems over their useful life. For the purpose of this submission, 'life-cycle costs' are defined as the costs involved in the replacement and refurbishment of a facility's base building and its systems and equipment. These include the costs of managing and maintaining the facility, including the base building (i.e. the hospital itself), and base building equipment (for example generators or HVAC systems). These costs are meant to address the replacement / refurbishment needs of those components that fall within hard FM, as well as the fabric of the building (walls, floors, etc.). Lifecycle costs are typically capital costs.

Soft Facility Management (Soft FM) - Services (non-clinical) unrelated to the physical plant. These might include laundry and linen services, portering and housekeeping and waste services. Other services not included in AFP are patient food services, material management, medical equipment maintenance, diagnostic services, hospital management, pharmacy and clinical care.

Ontario