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Mercredi 25 mars 2009

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Ministry of Energy
and Infrastructure

Ministry of Health
and Long-Term Care

Chair: Norman W. Sterling
Clerk: Katch Koch

Comité permanent des comptes publics

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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON PUBLIC ACCOUNTS

COMITÉ PERMANENT DES COMPTES PUBLICS

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The committee met at 1238 in committee room 1, following a closed session.

2008 ANNUAL REPORT, AUDITOR GENERAL

MINISTRY OF ENERGY AND INFRASTRUCTURE

MINISTRY OF HEALTH AND LONG-TERM CARE

Consideration of section 3.03, Brampton Civic Hospital public-private partnership project.

The Chair (Mr. Norman W. Sterling): My name is Norman Sterling. I'm the Chair of the public accounts committee of the Legislature. We're welcoming today a group of guests. At the witness table we have Saad Rafi, Deputy Minister of Energy and Infrastructure; John Gerritsen, director, infrastructure policy and planning division; and Lindsay Allison, manager, infrastructure policy and planning division. As well, we have, I believe, Ken White, who's the supervisor of the William Osler Health Centre.

I'd like to welcome you all here. Our normal process—

Interjection.

The Chair (Mr. Norman W. Sterling): Oh, did I not say—I've never seen the deputy minister from health before, so I didn't recognize him. He seems to be here every second week. I don't know what that means, Deputy Minister, but it just means that it's not the committee's choice, it's the Auditor General's choice to have you in his report so often. Welcome, Mr. Sapsford. I believe you are going to make the opening the remarks, and then the committee will go to questions after that.

It's quite warm in this room, so if any of you feel like shedding your jackets, please do.

Please proceed, Mr. Sapsford.

Mr. Ron Sapsford: I'd like to thank the Standing Committee on Public Accounts for this opportunity to address the Office of the Auditor General's report on the Brampton Civic Hospital public-private partnership project. I will be delivering remarks for both the Ministry of Health and Long-Term Care and the Ministry of Energy and Infrastructure, and then both of my colleagues Saad Rafi, the deputy minister, and Ken White, supervisor of William Osler, will be pleased to answer the committee's questions.

Let me state at the outset that the Ministry of Health and Long-Term Care and the Ministry of Energy and Infrastructure fully support and appreciate the work of the Auditor General to complete this report.

I'd like to start by outlining the roles and responsibilities of the various players in the context of the report that we are addressing today.

The Ministry of Health and Long-Term Care oversees and promotes the health system for the physical and mental well-being of the people of Ontario, and is responsible for the development, coordination and maintenance of comprehensive health services. This includes a balanced and integrated system of hospitals, long-term-care homes, laboratories, ambulances, community-based services and other health providers in Ontario engaged in providing timely and equitable access to health services to all the residents of the province.

In this particular case, the Ministry of Health and Long-Term Care works closely with its provincial partner, the Ministry of Energy and Infrastructure, in the implementation of capital construction projects.

The Ministry of Energy and Infrastructure's mandate includes overseeing the delivery of major capital projects for the province, such as hospitals, courthouses, roads, bridges, water systems and other public assets.

Infrastructure Ontario is a crown corporation that uses alternative financing and procurement, often referred to as AFP, to rebuild the province's infrastructure. Infrastructure Ontario also provides Ontario municipalities, universities and other eligible public bodies with access to affordable loans to build and renew local public infrastructure.

In terms of hospitals, these are complex capital projects that take a great deal of time to plan, design and build. As a consequence, I'd like to summarize the process for you.

The Ministry of Health and Long-Term Care and the Ministry of Energy and Infrastructure develop major capital projects together with hospitals. The Ministry of Health works closely with hospitals and the local health integration networks to determine the extent of the programs and services as well as space and design.

The Ministry of Energy and Infrastructure and Infrastructure Ontario oversee the delivery of the approved project, while the Ministry of Health works with the

hospital to develop the capital cost share, the local share plan and post-construction operating funding.

I'd like to outline for the committee some of the background relating to the construction of the Brampton Civic Hospital.

Brampton and the surrounding area is one of the fastest-growing regions in Ontario. The Health Services Restructuring Commission recognized in the late 1990s that the residents of the area needed a new hospital. This was to be the largest hospital building project undertaken in the province in decades: 1.2 million square feet of new construction. Delivery of a project of this size and complexity inevitably poses challenges.

The development of the new hospital in Brampton was approved in 2001 by the government of the day using public-private partnership, or P3, as it is referred to, as the model.

In 2003, William Osler Health Centre and its selected partner, the Health Infrastructure Company of Canada, entered into a project agreement to build a new hospital in Brampton, to be called the Brampton Civic Hospital and to function as one of the sites of the William Osler Health Centre.

The 608-bed, state-of-the-art Brampton Civic Hospital officially opened its doors in October 2007, with 479 beds in service. The number of beds in operation is slated to increase over the next few years.

The P3 model used to build the Brampton Civic Hospital entailed a contractual agreement between the hospital corporation and the private sector company. The private sector partners were responsible for design, construction, financing and maintenance of this new hospital project.

Under the Brampton Civic agreement, the Health Infrastructure Company of Canada would design, build and finance the new 608-bed hospital. It would also provide some non-clinical services, such as laundry, housekeeping, the transportation of patients within the hospital, food services and security, as well as maintaining and servicing the facility over a 25-year period. William Osler Health Centre agreed to pay the consortium a monthly payment over this 25-year period, beginning on the completion date of the hospital.

As the audit report points out, governments enter into alternative financing models because these models allow for the transfer of risks to parties that are best able to manage them, allowing both the public and private sectors to focus on what they do best, and as a consequence they may accelerate investment overall.

The AFP—alternative financing and procurement—approach to services is quite different from the former P3 projects. In December 2006, the government decided to exclude hospital ancillary services from alternative financing and procurement projects. By "ancillary services," we mean laundry and patient food services, among other services. Under this policy, only the so-called hard facility, or the physical plant, which would be managed by an external entity, such as building, maintenance and engineering, is included in the AFP projects. This decision reaffirmed the government's commitment that AFP hospital projects are about the design, construction and maintenance of hospital facilities. Services involving direct patient care are not part of AFP agreements.

Since the completion of the Brampton Civic Hospital's construction, there have been significant changes in the way that large infrastructure projects are built and financed in Ontario. In fact, most of the issues related to project procurement that were highlighted in the Auditor General's report are now being better handled by Infrastructure Ontario, which was created subsequent to the start of the construction of the Brampton Civic Hospital.

The two ministries' responses to the audit recommendations demonstrate how the current AFP process differs from the previous P3 process. For example, in recommendation 1, the audit report suggests that "The costs and benefits of all feasible procurement alternatives should be evaluated." In effect, individual projects are evaluated against policy priorities to ensure that they are consistent with those priorities. Investment decisions are made independently of the assessment of procurement alternatives.

The Ministry of Energy and Infrastructure also conducts an initial assessment of projects to determine whether they may be suitable for alternative financing and procurement and should be assigned to Infrastructure Ontario. Infrastructure Ontario now also conducts its own value-for-money analysis at different stages of the projects. Projects that do not provide the province with value for money as an AFP are then delivered through traditional financing and procurement mechanisms.

Further, in recommendation 8, the Auditor General suggests that "All significant costs of AFPs should be assessed in the decision-making process." Currently, under the AFP process, all alternative financing and procurement costs are considered, including all transaction costs, financing costs and contingencies. This falls under the assessment of the procurement alternatives process. Among the costs considered, for example, are private sector financing, private sector contingencies, bid costs, special-purpose-vehicle fees and advisory fees.

Finally, in recommendation 12, the report suggests that "To ensure transparency, Infrastructure Ontario should establish and communicate a policy on disclosure of AFP information." Infrastructure Ontario follows a disclosure policy consistently on all projects. Requests for qualifications are posted on MERX, which is the government's electronic tendering service, and all requests for proposals, project agreements and value-for-money reports are posted for public view on Infrastructure Ontario's website.

In more general terms, alternative financing and procurement is a method of delivering large, complex infrastructure projects that leverages private sector resources and expertise. Under AFPs, substantial risks associated with design, building, financing, operation and maintenance are transferred to the private sector, which commits to deliver projects on time and on budget.

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All of the projects undertaken by Infrastructure Ontario using the AFP methodology are guided by five key

principles: public interest is paramount; value for money must be demonstrable; appropriate public control and ownership must be preserved; accountability must be maintained; and all processes must be fair, transparent and efficient.

All of the hospitals built using AFP are publicly owned, publicly operated and publicly accountable. The province is getting best-value bids by looking at options to transfer the risks associated with the building project itself.

Alternative financing and procurement entrenches the obligation of the private sector to deliver hospital projects on time and on budget, and protects the public interest in significant ways. For instance, under the AFP model, most construction delays and cost overruns are at the expense of the private sector. If there are delays related to incomplete or uncoordinated drawings, the private sector carries the cost of the delay. Only if value for money is achievable will AFPs be used to deliver an infrastructure project. Value for money is determined by directly comparing the estimated cost of delivering the project under the traditional delivery method versus the cost of delivering it under AFP. The cost difference is the estimated value for money.

Infrastructure Ontario uses a value-for-money methodology that has been reviewed and judged sound by major accounting firms and Ontario's internal auditor. As well, the government of Canada's public-private partnership screening guidelines list Infrastructure Ontario's value-for-money assessment guide, which is available on its website, as its preferred tool for determining value for money.

The assessment of procurement alternatives takes place before a project may be assigned to Infrastructure Ontario, and value-for-money assessments are conducted at three stages during the AFP procurement process: prior to releasing the request for proposals, prior to awarding the contract and immediately following the financial close.

As we all know, quantifying risks based on future events is not an exact science. Infrastructure Ontario uses industry experts, value-for-money advisers and historical data to quantify the probability of the risk occurring and the related cost impact. Throughout the process, all participants—bidders, Infrastructure Ontario and the hospital—are bound by a clear project governance structure that manages and monitors key project approvals and the related decision-making process. Infrastructure Ontario has a rigorous internal procurement policy that is used for hiring advisers, and all contracts are fixed-price arrangements. Procedures are in place to review, document and follow up on lessons learned from project to project. Furthermore, management continuously monitors project-related issues through various working groups and project reporting to ensure the timely resolution of those issues.

Finally, Infrastructure Ontario is committed to transparency. Infrastructure Ontario posts all key documents related to its projects on its website, including the request for proposals and the project agreement. Methodologies related to value for money and risk transfer are also freely available.

Once again, thank you for this opportunity to address the Auditor General's report on the Brampton Civic Hospital public-private partnership project. Now my colleagues and I would be pleased to answer the members' questions.

The Chair (Mr. Norman W. Sterling): Thank you very much. Perhaps you could clarify for us off the top—because we had some discussion in our briefing session about this—the relationship between the hospital and the corporation that they are contracting with. As I understand it, the hospital owns the land and the buildings where it stands.

Mr. Ron Sapsford: Yes.

The Chair (Mr. Norman W. Sterling): The contract between the provider of the services and the financing and the hospital, what is the nature of that contract? Is it a lease? Is there a lease portion to it?

Mr. Ron Sapsford: No, the hospital is the owner. There are two pieces to it, I suppose. The contract relates to the construction of the land and buildings and then the operation of the facility over a 25-year period. The private company is providing the staff and support to those very specific services that were included in the project agreement as well as a whole series of specifications around service levels and ongoing discussion of quality measures and provisions for volumes. Mr. White can probably give you more detail, but that's the nature of, firstly, the construction of the hospital and, secondly, the operational aspects covering the 25-year period.

The Chair (Mr. Norman W. Sterling): So there's no cross-lease or -leases in that document?

Mr. Ken White: Actually, I have with me our general counsel, who is also a vice- president of the hospital. He was there and very involved in negotiating the contract. He's there yet monitoring the contract, so if you'd like to have him come forward and give you a description, I'd be happy to ask him to do that. Would you like that?

The Chair (Mr. Norman W. Sterling): Yes.

Mr. Ian Marshall: My name is Ian Marshall. I'm vice-president and general counsel at William Osler Health Centre and have had the pleasure of being involved in this transaction since the preferred-bidder stage, so I am familiar with it. I hope I can provide just a high-level view.

There's a prime agreement between the hospital corporation and a special-purpose project company which we call the project agreement, which envelops the provision of the facility. It's a contract for design, build, finance and maintain, together with the ancillary services that the deputy minister referred to in his remarks.

There are a number of underlying agreements to this project agreement between various entities to make the whole transaction work. One of those is, in fact, a lease between the hospital corporation and the project company, this special-purpose vehicle through which all

services in the facility are provided, and then there's a leaseback to the hospital corporation.

The hospital, being the owner of the fee simple and the land, is by virtue of that—and this is a matter of legal opinion—the owner of the fixture built on the premises, which is the facility. But as I understand it, this lease was provided because it provides to the project company, for the lender's satisfaction, some interest in the facility that they've in fact lent all the money for and constructed and have not yet been paid for until the final payment is made over 25 years.

The Chair (Mr. Norman W. Sterling): So would that allow them to declare capital costs on the depreciation of the building over the 25 years?

Mr. Ian Marshall: Not being an accountant, I don't feel qualified to answer that question, I'm afraid.

The Chair (Mr. Norman W. Sterling): So it's a lease-out for 25 years, and then—

Mr. Ian Marshall: And there's a leaseback.

The Chair (Mr. Norman W. Sterling): A leaseback? What does the leaseback do?

Mr. Ian Marshall: It provides the hospital corporation with its right to occupy the premises, short of its own default.

The Chair (Mr. Norman W. Sterling): So instead of transferring the ownership to the private corporation and then buying it back for $1 after 25 years, you basically have done it with a lease and a leaseback?

Mr. Ian Marshall: Yes.

The Chair (Mr. Norman W. Sterling): Okay. I think that clarifies it.

In terms of the payment that goes to the corporation, what is embodied in that payment? Is it specified or is it one lump sum?

Mr. Ian Marshall: If I may continue, in the aggregate it's a lump sum we call the unitary charge, the unitary payment, all calculated in accordance with a 200-page financial model. There are a number of line items in that model which break out all of the various components that comprise the unitary charge, whether they be for the construction of the facility, the financing costs associated with it or the services that are being provided on a day-to-day basis to support the clinical operations of the hospital.

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The Chair (Mr. Norman W. Sterling): Is there a financing charge identified in that agreement on the capital?

Mr. Ian Marshall: Yes, there is, and the summary page of that model is a publicly available document on request.

The Chair (Mr. Norman W. Sterling): And what is the interest rate on that capital?

Mr. Ian Marshall: I believe it's 6.35%. I'll just double-check that for you.

The Chair (Mr. Norman W. Sterling): That's 6.73%?

Mr. Jim McCarter: It might be 6.7%, but it's in that range.

The Chair (Mr. Norman W. Sterling): That's fine as far as I'm concerned in terms of understanding the groundwork.

France, did you have some questions?

M^me^ France Gélinas: Yes. The first one will go to the Deputy Minister of Health. One of the things that strikes me when we talk to people who support P3 is that they will say it comes on time and on budget. Well, it kind of leads everybody to believe that the traditional way of procurement didn't come on time or didn't come on budget; otherwise, we wouldn't make such a big deal of the fact that it comes on time and on budget when it's P3. Has the Ministry of Health ever conducted a review of traditionally procured hospital projects, let's say over the last 20 years, to see how many of them were on time and on budget?

Mr. Ron Sapsford: Not to my knowledge. Not over such a period of time. I think there have been in the ministry's experience a variety of projects that have not come in on time and on budget, and of course each project is different. Part of that factors into issues about which kind of funding model and how one handles risk, but whether it's alternative financing or whether it's a traditional method, there has to be fairly aggressive management of these projects to make sure that they do come in on time and on budget.

M^me^ France Gélinas: I would agree. They have to be well prepared ahead—

Mr. Ron Sapsford: Yes. One doesn't exclude the other.

M^me^ France Gélinas: But it still leaves me a little bit uneasy, the fact that it's like P3/AFP equals on time and on budget, when really we could say the same about traditional procurement equals on time and on budget; we just don't know. I mean, everybody will remember the one or two that went off the rails and caused you a lot of headaches, but what about all of the other ones that did come on time and on budget? Right now, you're telling me that we certainly don't have a solid body of evidence in Ontario one way or another.

Mr. Ron Sapsford: Perhaps my colleague can also help with this. I don't think that's the only reason. It's one factor contributing to why one would use alternative financing, and I think the way the current policy is constructed, it's limited to fairly large-scale projects that tend to be complicated by definition; and the larger the project or the more complicated it is, there's more risk associated with those sorts of projects going off the rails or having more complexity. So I think the choice is not just a flat statement: "It's about on time, on budget." I think there are other financing issues that factor into that kind of a decision as well.

M^me^ France Gélinas: Okay, thank you.

My next question is for Mr. Rafi. This was the first time today that I actually heard the cost of borrowing of 6.35%, but we're not too sure if it's 6.7%-some?

Mr. Ian Marshall: I'd like to clarify and correct slightly the answer I earlier gave. The senior debt interest rate under the project agreement—the benchmark bond

rate used was 4.95%. The credit spread was 1.35%, for a total senior debt coupon rate of 6.3%.

M^me^ France Gélinas: Okay. It's basically the first time I got such a clear answer, so I'll thank you. But in general, when we ask the ministry for the cost of borrowing, like the part that has to do with the cost of financing that the ministry is paying for, we have a hard time. When we ask your ministry, why is it that you won't reveal the cost of financing for specific projects?

Mr. Saad Rafi: First off, I should say that the cost of financing for projects is going to be project-specific and consortium-member-specific. Depending on their credit rating, depending on their consortium structure and depending on their ability to finance the project, that rate will vary depending on the consortium and how they can get committed financing. In various markets like today, it's going to be different than it was six months ago, than it was 12 months ago, than it was some years ago, and I suspect the same into the future.

One of the other aspects to how I would answer your question would be to say that that becomes the proprietary information of the consortium as to what their borrowing rate is and that wouldn't be revealed across bidders or within a bidder. However, the overall value-for-money number and other redacted elements of the RFP and the project agreement are available after the award of the particular project or contract. So the disclosure policy that my colleague Deputy Sapsford referred to in his remarks is trying to make as available as possible throughout the process, from the posting of RFQ material, RFP material and then the redacted version of the contract, as much information as possible to allow for as much transparency without impacting the proprietary information of a bidder.

M^me^ France Gélinas: I'm not sure if I agree with your interpretation of the proprietary thing of a bidder, but if you're not willing to share it project by project, would you be willing to share the average cost of financing that are included in those P3/AFPs?

Mr. Saad Rafi: I guess I'd have to take that under consideration. I'm not sure what that's providing you in the way of information. It would be a data point that would be taken out of context, to be perfectly honest. Providing an average of a whole host of differing projects, design-build-finance versus design-build-finance-maintain, size of project, consortium membership, ability to borrow and other covenants that they may have, depending on the nature of the consortium, would create a bit of disinformation that I feel wouldn't provide a lot of value.

M^me^ France Gélinas: I would certainly be willing to do my own interpretation of the numbers you would be willing to share, but as I said, I would like you to consider sharing with this group the average cost of financing, and if you want to break it up by build-and-manage or plan-build, you can break it up in whichever way you feel would give more valid information. But it would surely be something that I, as a committee member, would like to have.

My next question has to do—

Mr. Saad Rafi: May I just address that, if you don't mind, please? This is Infrastructure Ontario policy, so that's their board's decision. But currently my understanding, and I certainly stand to be corrected, is that their policy, as part of the disclosure policy, which is on their website, is not to disclose that information.

M^me^ France Gélinas: Yes. I understand project-by-project. But the ministry point of view: You could share it as an average and lump together whichever projects you figure are good to be lumped together to give us an average so that you respect this fiduciary confidentiality that seems to be so important, but at the same time you come forward with some information as to how much the people in Ontario are paying for the financing of those deals.

Mr. Saad Rafi: Okay. I guess we'll have to take it under consideration.

M^me^ France Gélinas: My next question has to do with the credit crisis that is presently going on in Ontario. Have it had any impact on those AFP projects?

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Mr. Saad Rafi: Sorry; I wasn't listening to your question. I was just trying to find the reference where I can point to a few projects since the fall of 2008, so the approximate time where we saw some dramatic changes in the credit markets. There have been three IO projects that have come to financial and commercial close, so I think the overall statement is that, within private equity and infrastructure funds, there is a tightening of credit and credit facilities, as you're suggesting; no doubt about that. But in this credit market, with infrastructure projects there is a flight to quality, and that is defined by the nature and the support or the sponsor of projects, government infrastructure sponsors. Projects are getting capital and are getting capital interest from a wide array of financiers and financing institutions. One indication of that would be, I believe, the three projects that have closed successfully since the fall for Infrastructure Ontario.

M^me^ France Gélinas: Do you know if the ministry has produced a market assessment that addresses the economic crisis? If you have, could you share this with the committee as well?

Mr. Saad Rafi: The ministry has not produced a document that assesses the financial crisis, which is a fairly broad-ranging set of criteria. Infrastructure Ontario, as an agency, does have a project-staging approach, where they are looking at weekly credit conditions. They are examining how they evaluate financing and committed financing in their project agreements and RFP processes, such that it is their job, since they're the project procurement agent for the government, to monitor credit and credit availability.

The change in the markets has been so rapid over the last several months that an assessment today is not the same assessment tomorrow. Witness the comments made by the governor of the Bank of Canada. One week his view, based on a consensus assessment of his, I think, economists beyond repute, was that there would be a

quick recovery. The week after, he's having to re-examine and perhaps restate that position. So providing analysis and assessments in a point of time is not advantageous, in Infrastructure Ontario's view.

M^me^ France Gélinas: Okay. When the ministry decides to send a project to Infrastructure Ontario, it is for having it go under the alternate financing and procurement model. But we understand that Infrastructure Ontario does an analysis and decides if this is the right way to go. Could you tell us how many projects have been referred to Infrastructure Ontario where Infrastructure Ontario sent them back to the ministry to be done in the traditional way?

Mr. Saad Rafi: If I might just clarify a couple of things you said, and then try to address your question, with the Ministry of Energy and Infrastructure, we would examine several criteria before determining whether a project should be included in an AFP structure. Among those criteria under examination would be the amount of effective risk transfer that can take place. Is there an opportunity for innovation to be brought forward? But, most important, risk transfer and potential size of the project: Is there a large enough volume or size of project that it will get financing interest and it will get consortium interest? So in a design-build-finance model, you're looking at various-sized projects: $50 million-plus and around $100 million.

In addition to that, there are several other criteria that are looked at, from what types of risks, what types of legislative and regulatory constraints may apply that wouldn't allow for an AFP. Are there other conditions that have to be assessed?

When those projects are provided to Infrastructure Ontario, as you indicated, value-for-money assessments are done, as my colleague mentioned, at three stages.

I believe there were two in recent occurrences that Infrastructure Ontario determined, at the value-for-money stage, didn't warrant an AFP model. One was Quinte Health Care, where there were two projects, I believe, Belleville and Trenton, and the Trenton project did not meet the value-for-money test sufficiently. So it was suggested that it be done through a traditional procurement-and-build method.

I believe a significant reconstruction at the Ottawa General Hospital was also deemed not to have value for money. I believe the reasoning for that was related more to the nature of the reconstruction across various aspects of the Ottawa General Hospital. It wasn't easily put together in a transaction, is my understanding.

So, yes, and those were the two examples.

M^me^ France Gélinas: Back to the deputy: Right now, the hospital in Brampton sits at 479 beds, plus the 27 beds that you recently announced for, I think, pediatrics and ICU. Are we still on target for 2011 to be at 608 beds?

Mr. Ron Sapsford: Yes, and from a planning perspective, there were additional beds to be added in 2009-10, 2010-11, and then the final ones post-2011. For upgrading services, it's a discussion that goes on between the hospital and the ministry taking in a number of factors: the hospital's ability to provide the staff necessary to support the expansion; are the growth estimates that were originally projected in fact taking place, so is there a continuing need? That enters the discussion of volume of services, be it in-patient or out-patient or emerg. The third consideration is the financial capacity of the ministry to support it. Each year we go through our fiscal projections and make provisions through the budget process.

That process is underway now for 2009-10, and we're in discussion with the hospital about the amount of expansion for the coming year.

Mr. Saad Rafi: May I? I just want to elaborate on a question that M^me^ Gélinas had. I might have said two hospitals had closed since the fall. I just wanted to be clear. In September 2008, Woodstock General Hospital closed, which was a design-build-finance-maintain; Royal Victoria Hospital in February of this year in Barrie; and also in February of this year Lakeridge Health in Oshawa.

M^me^ France Gélinas: Okay.

Mr. Ron Sapsford: Just to be clear on the beds, in 2009-10 we're working with the number—527 beds is the target that we're planning with.

M^me^ France Gélinas: Okay, and you're still on target for 527 beds?

Mr. Ron Sapsford: That's still the discussion, yes.

M^me^ France Gélinas: Given the information you've just given, Mr. Rafi, of the projects that exist—and I forget the numbers; I know the number of projects that have gone under P3 or AFP is high—none of them are running into problems because the private partnership is having problems with financing or credit?

Mr. Saad Rafi: In the AFP model, part of the requirement is providing committed financing at the point of commercial close. Getting from commercial close to financial close can take a number of weeks or sometimes a number of months. In a credit market like today, it could take a number of months, meaning two or three months, as opposed to six to eight weeks. But projects thus far have all come to fruition and have come to closure based on the ability of those proponents to secure financing.

M^me^ France Gélinas: Okay.

The Chair (Mr. Norman W. Sterling): Mrs. Sandals.

Mrs. Liz Sandals: Yes, a few questions: One of the things that I've noticed is if the local Guelph branch of the Ontario Health Coalition—so I think this is a question for Deputy—

Mr. Ron Sapsford: Sapsford.

Mrs. Liz Sandals: —Sapsford; I'm thinking Deputy Ron. Anyway, when I have the Ontario Health Coalition come to visit me, or the CUPE representatives from the local hospital, which are pretty much interchangeable, their concern around a P3 label seems to be that patient services are being farmed out as part of the contract. We've talked about ancillary services. You mentioned in your opening remarks that with the Brampton Civic

Hospital some of the ancillary services are part of the P3 contract.

Just to be absolutely clear, when we look at the new AFP models, other than the design-build-maintain part of it, is there anything that's ancillary services that is being bundled into the AFP models?

Mr. Ron Sapsford: The short answer would be no. In December 2006, the ministry published for hospitals the new policy guidelines around that—I think the clerk is handing out a copy for your information as we speak—to specify those services which could be included inside the agreement versus those that had to be maintained under the hospital's direct control. All the ongoing day-to-day management of the facility—heat, light, power, walls, electricity, lighting, as well as things like security parking, which are always outside—are allowable. I say "allowable," not mandatory; the hospital may consider including them. Then, what we've called "soft facility services," things like laundry, linen, portering, housekeeping, food services and some of the support services in the hospital, are excluded from these agreements. That took effect in 2006.

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Mrs. Liz Sandals: My sense, when we see design-build-maintain projects coming forward, is that the "maintain" isn't custodial services, which I think sometimes people assume is what "maintain" means, but means you're responsible for making sure that the floor covering stands up for 25 years. You might put in a really high-quality terrazzo floor—the proponent might choose a lower-quality floor, but if the lower-quality floor doesn't stand up, then they would be responsible for replacing it. That's my understanding—whichever of you it makes sense to answer, go ahead—but that's my sense of what "maintain" means, that the building has to be kept in good condition, but it isn't caretaking.

Mr. Ron Sapsford: Well, it's both. It is the day-to-day caretaking, but also, as you've suggested, and perhaps more importantly, maintaining the standard of the physical plant over the period of the agreement.

Mrs. Liz Sandals: Okay, that was what I was getting out of it that "maintain," when that was part of the contract, was primarily to do with making sure that the building is in good physical condition for the life of the contract.

Mr. Ron Sapsford: That speaks to the issue of life cycle, which is an innate part of these long-term agreements.

Mrs. Liz Sandals: As I say, that's much different from the concerns that have been raised with me by some of the people who were very concerned about the P3 model. It doesn't seem to be a part of the AFP model.

One of the things that I've noticed, sitting in the House for the last five and a half years, is that there have often been questions around hospital projects that started off where maybe the ministry committed to paying, I don't know, 60% or 70%, and then there's a cost overrun, and you get into an argument about who will pay the cost overrun or whether the ministry is going to end up paying 80% or 90%. I notice in the material we've received that you have now gone to a share which is fixed at 90-10—90% ministry, 10% local. I wonder if you could talk about (a) the rationale for that and (b) the benefit of that.

Mr. Ron Sapsford: Sure. The ministry, over a number of years, has had different funding ratios for capital projects—by that, I mean the bricks and mortar part of it—as well as funding policy around the equipment that's used, furnishings and equipment. In June 2006, the government changed the policy that was in place. Over the years, the share methods have varied from 50-50 to 80-20, and in some cases the ministry has paid 100% of costs, mostly related to mental health or very specialized facilities. Irrespective of what the ratio is, the smaller proportion has always fallen to the hospital, and hence its local community, to raise that amount of money. You can appreciate that in a 50-50 project, which was exclusively used for new hospital construction, 50% of the total capital cost is a lot more for a local community to consider paying for than would be 10% of the capital cost, which is currently the government's policy since 2006; so 90% province, 10% local community. I think the rationale is pretty straightforward. As the size of these projects grew, the costs associated with full rebuild of hospitals and replacement of infrastructure grew in total cost, the ability of local communities to raise a large amount—20%, 30%, 40% of it—became pretty difficult, and the government decided that it was more important to replace the infrastructure and to reconsider the funding share model and, consequently, changed it to 90-10. So the fundraising burden on a local community is substantially less, and I would argue it's easier for hospitals, then, to put together their local share plan based on that.

The other change at the same time, however, was that the equipment purchases would be funded 100% by the hospital, where before in new capital construction the ministry would pick up a significant part of new equipment. So there was an adjustment in the shares between construction versus capital equipment, but in the analysis that the ministry did of the projects—we actually did a comparison of the change in the policy to understand what the impact on local share would be—in every case, the change in policy benefited the local community inasmuch as they had to raise less money in the new policy approach than in the previous one that had been in place.

Mrs. Liz Sandals: My observation would be that community fundraising is often more easily done when people can point to the MRI or the X-ray or the whatever it is and they can sort of say, "I furnished this room" or "I contributed to the equipment in this lab." People feel comfortable with being able to point to having contributed to equipment.

One of the concerns that the auditor raised in his report was the whole issue of value for money and how that's determined. Perhaps this is more for Deputy Saad, but—I'm doing it again; I've got Ron and Saad here—Deputy Rafi. There's this concern that the auditor has

highlighted about value for money that was done in a couple of different time frames and seems to have different things in and different things out. I think I'm understanding that Infrastructure Ontario has come up with a process that is being used consistently. I wonder if you could explain a bit to us about what all components it is that you're actually looking at when you do value-for-money assessments so that there is some consistency.

Mr. Saad Rafi: As Deputy Sapsford mentioned as well, the amount of risk transfer is clearly not scientific but has been brought to some level of discipline, and the consistency of application that Infrastructure Ontario has applied, and has published in Assessing Value For Money: A Guide To Infrastructure Ontario's Methodology, available on their website, is that they look at the cost of borrowing for the consortium, the cost of borrowing for government, they look at the base costs of the construction being the same for the public sector component, the traditional, and under the AFP model so that there isn't any suggestion that one is inherently lower; the cost to construct should be the same. As I mentioned—

Mrs. Liz Sandals: So the bricks are the bricks. It doesn't matter who buys them.

Mr. Saad Rafi: Yes, and then the amount of risk premium that is retained by government under a traditional design-bid-build versus an AFP model is also assessed. Now, that is assessed based on a risk register for hospitals that has been developed with input from and in consultation with a firm called Altus Helyar, a very well-known cost consulting or property surveyor—whatever you want to call them—firm that advises Infrastructure Ontario, I'm told, that developed the risk register. Risk assessment is done on probability and severity of risk and then measured against the capital costs, therefore creating a value-for-risk transfer. So an assessment is made, risk category by risk category, for each specific project, determining who will retain the risk, and then looking at the probability and the severity of that risk.

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An example that is perhaps somewhat simple: The probability of it raining is high; the severity of that rain is low. The probability of a hurricane may be low, but the severity may be high. So you go through the risk register for each example, and I don't mean to use such a facile example to denigrate the register. It's quite a sophisticated document.

In addition to that, and as a result of experience from other projects, Infrastructure Ontario will also include the transaction costs and the advisers' costs associated with that project to get to the total cost, comparing the public sector or the traditional method with the alternative financing, the current method. If the second is less than the first, then there is a positive value-for-money.

Mrs. Liz Sandals: I take it from your examples of places where IO has rejected it—and I'm assuming that MEI rejects lots of projects and doesn't even send them to IO. You look at them and say that conventional tendering makes more sense. So it would be reasonably large projects that you would send over to IO for evaluation. But if I hear you correctly, things which are quite large would be more inherently risky, and also sometimes the complexity and the uniqueness of one-off, weird things—it sounds like you may treat them a little bit differently.

Mr. Saad Rafi: Yes. As you've suggested, the government supports a myriad of capital projects that are maintenance projects, rehabilitation—they may be small in size relative to the particular asset class that is under consideration. It also, though, does very large capital construction projects that don't lend themselves to an alternative financing and procurement model. As you're suggesting, it isn't just the size of the project; it is the risk associated with the project: Can the public interest be properly protected? Is there a likely, demonstrable value-for-money opportunity? Will public control be preserved for the project when it's concluded and right through its life cycle? Accountability must be maintained and all processes must be fair, transparent and efficient. Then you get into more sophisticated and more detailed assessments that have to do with innovation, scope, program definition, etc.

Many criteria are used to assess the viability of an AFP model versus a traditional build. The majority of infrastructure projects in the province are not AFP, even though there are several in play now. There is a considerable amount of spend; for example, on average, almost $8 billion in the last four years has been spent on infrastructure. That represents a lot of projects and a lot of planning for projects.

Mrs. Liz Sandals: Thank you. Do we have more time this round?

The Chair (Mr. Norman W. Sterling): Yes.

Mrs. Liz Sandals: I'll turn it over to my colleague Mr. McNeely.

Mr. Phil McNeely: I'm just looking at the Auditor General's report, which states that the planning for the installation of medical and IT equipment was not integrated with the construction process for the Brampton hospital and indicated a $63-million overrun, which is about 13%. I was just wondering: Going into the new 3Ps, did we go light on consulting engineers and architects and defining the project? How have we dealt with this on other projects?

Mr. Saad Rafi: With respect to equipment?

Mr. Phil McNeely: There were $63 million in additional costs, primarily from modifications for equipment installation, that the building wasn't suited for the equipment that the doctors wanted to buy.

Mr. Saad Rafi: We'll do it in parts, if that's okay.

Mr. Ron Sapsford: The auditor's comment was specifically about Brampton, and I'll let my colleague speak about how it has shifted as a result.

In this case, there was a delay in decision-making around the capital equipment itself. There was a variety of reasons for that, mostly to do with the hospital and their slowness in making those decisions. As a consequence, the building was going up, and when final decisions were made about equipment, they had to go back

and redo some parts of the construction, undo what was done, in order to accommodate the new equipment. That's what led to the variance in the cost that the Auditor General brought forward in the report.

In the AFP approach, the correction that has been made is that all these specifications—and I can let Saad speak to that—are now part of the upfront consideration, so that when the building is constructed, the major equipment decisions have already been made and are incorporated into the agreement.

Mr. Phil McNeely: What additional efforts are made by IO now? When you're contemplating a project, you're looking at value-for-money and doing that analysis, how much has that changed since 2003 when you're contemplating projects? How much additional effort is being put in to make sure that the dollars that are being set up—and is that effective?

Mr. Saad Rafi: Several elements have been improved upon and evolved based on lessons learned, not just on the project that was examined by the auditor but on projects that have taken place in other jurisdictions, predominantly the United Kingdom, which is the leader in, in their case, PFI, and in Ontario's case, alternative financing and procurement.

The project specifications that the hospital is required to have in place are critical up front, because they determine what elements will be required of the bidder, and that goes right into the RFP documents. So there's a clear understanding by bidders as to what is at play and what they're bidding on, which also puts in a very definitive and high set of discipline once the project proponent has been selected, such that the changes in scope have a great deal of significance and are quite limited in the opportunity to change scope.

You have to understand what you need in the hospital. That is a key requirement and a key role that the Ministry of Health plays with its transfer payment partner, the hospital, before an RFP is issued. I think that's one significant change, which limits scope changes during construction, keeps the costs on budget and allows the contractor to deliver on the time frame that they had bid on. Therefore, it doesn't allow for cost changes throughout the construction period. I think that was one of the findings that the auditor and his staff found on WOHC.

The second piece is, the value-for-money test is more rigorously applied, and applied more often, as also mentioned by my colleague, at three different stages. Prior to release of the RFP: That's critical because it relates to the previous point I made, in that if the project scope, the project specifications, have been nailed down, then you have the ability to make cost assumptions and cost estimation. But it is only an estimate, as you well know, at that stage, because you haven't received bids and you don't have a competitive tension to understand how others would value the engineering and the design requirements for that particular facility. Nevertheless, it gives the engineering firm that is the adviser on the project with the hospital, along with its architectural adviser, an opportunity to do a cost estimate and therefore generate a value-for-money. If that value-for-money is positive, the Infrastructure Ontario board then gives the go-ahead on the design-build-finance-maintain project to issue the RFP.

At the point of bids coming in, my understanding is that a value-for-money is done on the lead bidder. Again, it's getting close to final now, and that value-for-money is getting more fine-tuned.

Then, just at financial close, when the rates are set for the capital costs and the borrowing costs—it's almost a very final bid—another value-for-money is done. So you're getting more and more specificity in the value-for-money.

Those things are key because it demonstrates whether you're going to have a project that will lead to success, because you are contracting with that consortium to deliver on the very things that they have bid on.

I would say that those are the few things that have changed, and I'm sure there are processes in the ministry as well.

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Mr. Ron Sapsford: I think because of the substantial investment that is being made, there are a number of projects, as was indicated.

Partly as a result of the auditor's work, we've also looked at other processes. For instance, in that specification process up front before you go to tender, there's the notion that every time we do a hospital we don't have to start over again. We've spent a fair amount of time with our colleagues developing what are called "generic output specifications" so that if you're going to develop a new-build hospital, there are some generic specifications that apply consistently that save a fair amount of time in the consulting and design phases, because they're now built right into the specifications of all like projects right up front. So that's a substantial improvement in the overall process that's been incorporated as well.

I think the auditor also alluded, in the case of the Brampton Civic Hospital, to associated operating issues with taking on a large, brand-new building. Part of the rationale for the appointment of Mr. White as supervisor was related to the complexity of finishing a very large construction project and moving into it while maintaining quality patient services. So partly through Mr. White's work, we're also looking at a process for the future so that as new projects complete, we're developing a much more consistent approach to assist hospitals in moving from old to new facilities and managing in a much more anticipatory and consistent way of taking on and commissioning new hospital buildings. That's another addition to the work the ministry has been doing as a result of recommendations that have come forward.

Mr. Phil McNeely: I was used to the traditional approach, where you designed and the whole thing went to tender. I see that you got docked down to just two final proposals on this hospital. Probably part of that was that the soft facility management services were included, and that became a bigger part than the construction, actually, by looking at the figures, in any case. You made the decision in 2006 to take the soft facility management

services out of the AFP design-build-finance-maintain projects. Why did you do that and what are your comments on that—that you have removed those soft facility management services?

Mr. Ron Sapsford: The policy was changed in 2006, so I think every other large project in fact is only based on hard services.

The rationale I think was the second part of your question. I think as a package, really, the prime rationale for alternate financing and procurement is around the design and construction. It seems to me that's the risk that we're trying to manage. It seems to me that's where the benefit comes from. So to continue to move further with larger and larger parts of the hospital's operation was the question mark, and on review the government decided not to pursue that. As my colleague said, in other countries, in Britain, they have different models where large parts of the hospital operation in fact are part of that. I think because of the operating difficulties that can arise, the decision was made to exclude it from future projects.

Mr. Phil McNeely: Has this change in the process been helpful to managing the projects better from Infrastructure Ontario's perspective and from your perspective?

Mr. Ron Sapsford: From my perspective first, it simplifies the size and shape of the project. Mr. White can talk about the contractual agreement that's necessary in order to manage a very large service agreement in terms of housekeeping, laundry and so forth. Each of those areas requires pages and pages of contractual understanding in order to get the continued value for money. So on the management side of these agreements over a long period of time, leaving those services out simplifies substantially the contractual understandings and agreements that have to be put into place.

Mr. Ken White: I would say amen to that, actually. Having been kind of parachuted in when the hospital had basically three months under its belt, as far as the move was concerned—moving onto a greenfield site is complicated enough, and these contractual arrangements, as my colleague Ian referred to them, are very detailed documents that, first of all, I think are difficult for folks to understand, and it's even more difficult to figure out what measures you want to use to make sure that you're getting the level of service that you need. As Ron says, simplifying these projects is a great step forward, so I think the work that IO and the Ministry of Health have done on that front is fabulous.

I would add one thing here, though, and that is that the life cycle piece of this puzzle that the IO projects offer, which I think is really an important piece, is really something I don't hear people talking about. For investors to want to put their money into these things, they have to be sure their money is safe, hence the life cycle component.

I've been running hospitals for a lot of years. The ministry finds it tough to fund the whole inflationary piece, so usually the squeeze ends up on the maintenance side of the hospital. To give you an example, very often what we've seen in our aged infrastructure in Ontario, in hospitals, has been the evidence of maintenance deficiencies. That's a factor as far as sustaining what we have, so that's a very important point. Another one is that if people, including donors, are going to invest in these places, they want to see their investment safe and housed in a place that they'd like to see it housed in. To give you an example, we met last summer with a couple of chaps who were contemplating a large donation to the hospitals, and one of the comments that was made was, "We don't like hospitals. They're dirty and they're not well maintained." I was able to say to them, "Well, this one will be very well maintained, because it's got the life cycle costs built right into the arrangement." We think that was the tipping point, actually, for those donors. Those two donors actually gave $10 million to the hospital. So I think there's a very important investment side of this. I'd hate to see us confuse the importance of the life cycle piece—I think somebody raised that earlier—with the whole confusing and complex side of putting the soft services into these arrangements.

Mr. Phil McNeely: Thank you. That's all I have.

The Chair (Mr. Norman W. Sterling): Could I ask a couple questions of Mr. Marshall again? I'm still not clear with regard to the borrowing on this contract or in this transaction. As I understand it, THICC is given 6.3% financing on a certain portion of the overall project. It may not be 100%; it could be 80% or whatever number.

Mr. Ian Marshall: There is a debt and equity component also.

The Chair (Mr. Norman W. Sterling): Right. And is that public?

Mr. Ian Marshall: I believe that is on the summary sheet of the model.

The Chair (Mr. Norman W. Sterling): Okay. So the 6.3%—was that a negotiated amount? When did that amount—

Mr. Ian Marshall: I'm glad you're asking that question, because one of the things that was done with the foresight of the Ministry of Health at the time, which conceived the scheme of the two pilot projects to go forward, was that we didn't want to be paying too much in Ontario for these hospitals. At the time the proposals came in, they had to provide a representative credit term sheet. So they undertook, at that time, to provide a benchmark interpolated rate on government of Canada bonds and a credit spread of the specified amount I referred to earlier, which was 1.35%, and that if they couldn't meet that credit spread—and this was new in the market at the time, at least in Ontario—then there was an opportunity to walk away.

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Now, I grant you, there would have been some costs on both sides, but it was their obligation to raise financing the way they promised in the first instance and not to go above that cost, and they did.

The Chair (Mr. Norman W. Sterling): Do you know whether or not they can claim capital cost allowance under their 25-year lease?

Mr. Ian Marshall: I don't know. I'd rather defer to some of the accountants in the room on that, if I could.

Mr. Jim McCarter: We actually chatted about that. We don't know either whether the corporation is claiming capital cost allowance on the hospital or not. It gets back to the issue of, do they actually own the facility or do they not own the facility? We're not sure.

The Chair (Mr. Norman W. Sterling): Would the Ministry of Health or the Ministry of Infrastructure not know that? It's got to be a matter of law or tax policy.

Mr. Saad Rafi: I think it's more a matter of accounting policy in terms of what's generally accepted for a capital lease, and I have to defer to Jim on that.

I think your earlier point at the outset, Chair—or maybe it was Mr. Marshall who said that the ability to have a leasehold arrangement for the building is the method of financeability. The other covenant that the lender is looking for is, who's behind the project? That's the government, and sometimes there's a funding letter or just a simple statement in the request for proposal.

Now, how the consortium structures itself in a special-purpose vehicle and then how it has its own tax treatment and where it's domiciled—Delaware, Switzerland, Toronto—is not of material perspective to the evaluation. Rather, the competitive aspects of this and their committed financing and their total cost for the project are of greater interest and applicability to the province.

It's sometimes very difficult, as you will know, to break down an SPV and to understand where the tax treatment is done. These organizations are quite sophisticated in that regard.

The Chair (Mr. Norman W. Sterling): But if I was negotiating a $500-million contract, I'm sure I would know on my side whether they could write off or have capital cost appreciation, because the interest rate you accepted, which is 6.3%, I find extremely high, if they can in fact take capital cost appreciation. Given bond rates are now at 4%—30-year money is at 4% now and might have been slightly higher at that point in time.

Mr. Saad Rafi: That was five years ago. When the deal was signed was 2003, was it not?

Mr. Ian Marshall: Commercial close was August 2003.

Mr. Saad Rafi: Six years ago—five and a half. I can't speak to what the rate spread was between Ontario's or government of Canada bonds and the interest rate of the private sector in that regard, but the current model—the debate is not about the cost of capital, it is about the risk, and under P3s in that era as well it's about the transfer of risk and what is the core business of a hospital, and that is to run the clinical services.

While I take your point, which is that if there is a CCA opportunity for the special-purpose vehicle or a member within that consortium that could be a gain-share opportunity for the province, it's not a pure negotiation in the sense that might be thought of. It is a procurement that is looking at certain criteria, and the competitive process and the process that is followed yields a result, and that result is based on a series of criteria that we've talked about.

So how they choose to structure themselves and take advantage of tax treatment in Delaware is actually not something the province can reach into and effect.

The Chair (Mr. Norman W. Sterling): You can effect it by negotiating for a better rate if they in fact have a capital cost appreciation advantage, because you can shift that cost onto another level of government or whatever, or another government somewhere else.

Mr. Saad Rafi: Yes, and the government is capitalizing its construction costs as well because it's a consolidated asset. The issue is, where do you stop with that? I'm not trying to be argumentative with you. I'm just saying that the consortium could then, in part of the negotiation, expect to get the gain share from government's consolidation of its assets as well, and then you're into a series of things. I think the choice that has been made, and I believe was made in 2001 through 2003 when this transaction was being undertaken, was to look at, in that case, what's the social discount rate—very different model today—and does this project fall within that?

The Chair (Mr. Norman W. Sterling): Well, I guess my question is, do you know whether or not capital cost appreciation was taken into account in the negotiation of this contract?

Mr. Ian Marshall: No. I can tell you—hopefully this answers your question—that the general approach was that the hospital wanted to be insulated from whether they could take advantage of tax treatments or they couldn't. We didn't want to be affected. The tax liabilities and how they could be treated in a tax way—it was up to them how they structured the deal and then presented the final, all-in price. But we didn't want to be affected if they couldn't claim what they thought they could. Those were opinions they had to have on their side of the transaction to feel comfortable with the overall price they gave.

The Chair (Mr. Norman W. Sterling): So you were aware of the issue. You wanted to be insulated from the issue—I can understand that—on your side of the deal, but you didn't know or you didn't care to know?

Mr. Ian Marshall: I wouldn't say we didn't care to know. I could undertake to look into that issue further—I wasn't the prime on finance at the time—to see what specific consideration was given to that. I can tell you, though, that how they structured themselves they considered to be proprietary and confidential, because not all consortia came together structured the same way. So how they structured themselves and took advantage of tax allowances if they could was an added benefit that one team or another said was proprietary to themselves at the time, something they kept close to the chest.

The Chair (Mr. Norman W. Sterling): Well, if you could provide me with more information, I would appreciate that.

Questions?

Mr. Jerry J. Ouellette: Thank you for your presentation. I have strong concerns regarding the health care sector as a whole where this is just a typical example that I see where I believe the initial cost was $357 million—

or estimate—and it expands up as we go through request for interest, request for proposal, request for qualifications, and we end up with $614 million. Is there not some way to minimize those impacts on the public sector so that when the cost comes in or when it initiates, we get a better sense of where the actual end result is going to be?

There are some other questions that are going to follow on this.

Mr. Ron Sapsford: Well, without getting into the specificity of these particular numbers, I guess my impression of it is that it depends on which number you're talking about at which point in time. With this project, it includes the full life cycle costs, including the ancillary services; in some cases we're talking only about the construction cost. In some cases, the costs that were identified were earlier in the planning process. And it is the case where sometimes the scope changes—it's going to be bigger, the square footage changes, we're putting more services into the planning—and the numbers change.

Mr. Jerry J. Ouellette: Yes, but when you start changing the services and the planning, you're moving away from the initial intent which was originally there. When you come forward and now you're saying that you have different services to provide, different aspects, would that not all be considered at the very start of the process?

Mr. Ron Sapsford: I think that's part of the point we're trying to make today, that for this project there was some drift. The way the structure is organized now is that the program specifications, the volumes, the size, the scope of the project are specified at the beginning, because once it's into the RFP process, the tendering, the value questions, those decisions—I won't say they're absolutely fixed, but they are fixed from the perspective of a clear understanding of the size and scope. So there will always be cost escalations over time based on money costs, construction costs, where is the general economy? Even when we know "This is the program and the size and the scope," simply moving through the RFP process you will see a drift, generally upward, in the overall costs. But that's not only an AFP issue; that's an issue for all of our construction projects.

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Mr. Jerry J. Ouellette: When I talk with contractors on a regular basis, their explanation to me is that a normal expectation would be a 10% cost overrun on the project. When we deal with the health care sector, I don't see anything coming close to 10%.

Mr. Saad Rafi: Under the current AFP model, the opportunity—virtually always, but in the main—to make changes to the program specifications, what footprint the hospital needs, or where the structure should be for this wing and that wing, must be nailed down before the RFP can be issued. Once issued, it's essentially fixed.

Now, there may be circumstances. For example, in one project there may have been a circumstance where, during the construction, there were geotechnical concerns. Infrastructure Ontario's project management capacity, once the consortium has been chosen, is there to represent their client—the hospital and the Ministry of Health—and to push back on the constructor, to say, "Wait a second. You contracted for this bill, and we transferred"—I'm just using geotechnical as an example—"geotechnical risk to you, so you should have been properly prepared by understanding the soil conditions, etc." So I think that's one thing.

I think the other thing is that once a contract has been struck, the effort required to open that contract, on both sides, is a good disciplining process to keep specifications where they are. As well, the pace of construction: You have the financiers, if you can imagine it this way, sitting on top of the constructor, because the financier gets paid out near the end. They need to make sure that the money that they have at risk is not going to be affected, because they're not getting paid until the hospital deems the project complete. So those are some of the checks and balances that have been lessons learned and are applied as distinct from a more traditional design-bid-build.

Mr. Jerry J. Ouellette: Do you have an example that we or I can monitor that's under way currently in this process, right now? That this committee can kind of look at and say, "Okay, here's an example of the way it's working," and we can use that as a standard?

Mr. Saad Rafi: I'll see if we can give an example of a project that is concluded and had some of those issues. We can provide that.

Mr. Jerry J. Ouellette: On the same token, then, what I was leaning towards is the local community component of the contribution. The initial community steps up to the plate with, just to use the figures that would have been explained, $357 million, whichever the percentage of costs may be. All of a sudden you find a much larger percentage there—because I know we had difficulty on the Lakeridge issue regarding the funding component from the local community. How is the community going to gauge that? How are they going to do it, especially when you're looking at changing the dates of the increased bed numbers in the future? I realize that you've mentioned, deputy, that the amounts will change, but what are they seeing or what are they saying about those fundraising components?

Mr. Ron Sapsford: It's always a struggle whenever the number changes, but I guess what I'd try to reflect to you is that there is a natural tension between the ministry and hospitals when it comes to capital construction, and it's from this perspective: First of all, the planning cycle is very long. This is years; it's not a question of months. So when the first approval for planning is given to a hospital, it's based on certain assumptions about what needs to be done. But as time goes on, technology changes, and they move through it. When we come to, then, a next approval, invariably the project has changed: "Well, as long as we're at it, we should—" or "This has happened in the interim. Let's consider that. There's a new technology we want to include." All of these things, over a period of time, if the ministry agrees, "Okay, fine, approval to include that," automatically change the price.

Now, if a hospital has been out in its own community, "We're doing this project, here's the size and the money we need. We need $50 million," by the time you get to the end of the planning process, that number, by virtue of the decisions the hospital has made, has increased. Then you get into the process where you're into RFPs and construction, and the original estimates may not have accounted for construction costs now, four, five or six years later. So people view all these as increases in cost, but the increase is apportioned to very discrete decisions that were made by the hospital, in terms of its ambitions to complete a construction project and what should be included, and then secondly, the incremental costs of actually doing the project, the construction. So when we talked about the cost share originally, when projects were at 50-50, this could be a sizable impact on a community. I think principally, as I've said, that's why the government decided to shift the construction costs to a much larger percentage on the provincial side of it for all of the factors that I've talked about. So this isn't the fault of one party or another. It's simply the way these very large projects are planned over multi-year, trying to balance out the needs of the community, the desires of the hospital, the standards the ministry insists on and the ability of the government to finance it in a reasonable period of time.

Mr. Jerry J. Ouellette: You mentioned actual friction between the hospital and the ministry. After dealing with these issues from a local and from a provincial perspective, I get a sense that from a hospital's perspective, as long as we get our foot in the door and we've got a commitment to proceed, the funding flows. I have some strong concerns that we need to be able to make sure, and quite frankly that's one of the reasons I introduced a bill to review, on a committee basis—a set committee that will only deal with health care and education—and address those very issues. When you look at 62.2% of the entire provincial budget equating to health care and education, we need a little more scrutiny, and this might be one of the ways.

One last question is, how will you ensure that the level of non-clinical services contracted for and being paid for is actually going to be delivered? What checks and balances do you have in place for those non-clinical services to ensure that that will take place?

Mr. Ron Sapsford: In the Brampton case?

Mr. Jerry J. Ouellette: Yes.

Mr. Ken White: That's where the complexity really comes into play here. You heard Ian refer to the 200-page document that cites a substantial amount of detail around what service, timing around the service, that sort of thing. That really gets back to my comment earlier that we really need to simplify these arrangements so that they're achieving goals, rather than a whole lot of people maintaining metrics.

In our case, in the Brampton case, basically any variation between 95% and 105%, say, in volumes—that would be volumes of housekeeping services or portering or anything—is adjusted every month on the bill. So you only pay for what you get. There are also other metrics included that include satisfaction levels and things like that. So again, they're complex, but its intent is to ensure you're getting what you're paying for.

Mr. Jerry J. Ouellette: Okay, those are all my questions for now.

The Chair (Mr. Norman W. Sterling): Do you have any more questions now, France?

M^me^ France Gélinas: I'm kind of curious about your non-clinical services. So it's a 200-page document that sets the ground rules for the private providers to provide non-clinical services to your hospital. There was a quote in the auditor's report that says that your predecessor, I think it was, thought that he was then in a position to get more non-clinical services because of this. Are you familiar with this?

Mr. Ken White: I'm familiar with the comment. I'm familiar with what I found there. I think it would be a difficult one to say yea or nay to. I think the perception is that people put a lot of work into striking a complex but very detailed arrangement. Some might argue the expectations were, if anything, gold standard. So timing around, say, response for a porter, some of the timing around cleaning a unit for the next patient to be able to get into it, some of those targets are pretty rigorous, and perhaps that's what his comment was based on. I think we would argue at this point in time that we need to be able to simplify this thing and really focus on what's needed as far as the service, as opposed to some of these expectations that I think are maybe not reasonable.

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M^me^ France Gélinas: Right now, you use the hospital operating budget to pay for those services?

Mr. Ken White: Yes, we do.

M^me^ France Gélinas: So if they go up, then a larger part of your operating budget is targeted toward non-clinical services?

Mr. Ken White: Yes. Right.

I have to say that as part of the arrangement, the detailed contractual arrangement with the third party is something that is anticipated in the PCOP and flowed by the Ministry of Health to cover, so it is covered by the Ministry of Health.

M^me^ France Gélinas: But separate from your operating budgets—

Mr. Ken White: Yes. The operating budget is really comprised of two things: One is the global budget that was there for the hospital going into this; and the incremental piece is really the PCOP, the post-construction operating plan piece, which really anticipates standard costs around, say, increasing patient levels and also includes the details around this arrangement with the third party.

M^me^ France Gélinas: So where does the impetus to keep those costs down come from if, at the end of the day, the ministry will pick up the tab anyway?

Mr. Ken White: That's a great question. We're working with the ministry right now on this whole thing: How do we really make this (a) a simpler arrangement and (b) one where there are the right incentives there to reduce costs?

M^me^ France Gélinas: If you had all decision power in the world, would you continue with this deal or would you go back to the way non-clinical services are provided in every other hospital in Ontario?

Mr. Ken White: Could I plead the fifth on it? No.

M^me^ France Gélinas: Sure.

Mr. Ken White: I guess what I would say is, I'm pleasantly surprised—and that was the reason I kind of said "amen" to Ron's earlier comments about what services are in or out. I think where the ministry has taken this, as of their decision in 2006, and where this is headed is a way better approach than this one. It remains to be seen if it works in a superior fashion. I think there's a question mark there.

M^me^ France Gélinas: A question mark. I know that before you came in there were a lot of people who were really unhappy with the quality of services that were provided in your hospital. When you see 3,000 residents demonstrating in front of a hospital, that's never good news. Would you say that things are better?

Mr. Ken White: I'm always reluctant to say that, but I'm always happy when we pick up the newspaper and we're not in it.

I think a number of the issues that the hospital was grappling with at the time were internal issues. Again, I think the impact of moving from a facility that really is totally deficient to one that is really extraordinary—it really is. If there's something to celebrate here, it's the fact that there's a state-of-the-art hospital in Ontario that really, with its technology and the team it has there, is leading-edge.

But once you move into a facility, the transition, the shift, is so dramatic that many of the things you experience are things that actually Ron was referring to before. There's a committee or something right now at the ministry—I'm on it—that's looking at how we deal with these transitions. I think we've got to anticipate this going forward, especially as we move into these greenfield sites. There are a lot of impacts that really can jeopardize stability and safe patient care.

To answer your question, I think we've addressed most of those; I wish I could say all of them. I think the other factor was the fact that the community had some different expectations around where the hospital would be located and about what happened to the old hospital, so we've had a lot of work to do with the community. I would say we've made major gains.

M^me^ France Gélinas: And how are you coping with the fact that you're at 479 beds when the plans were for over 600 beds?

Mr. Ken White: This is one of the nice things that you haven't seen often in health care, and not in Ontario either. I think the planning for that facility was well done, from the vantage point that it anticipated being a sustainable hospital for a few years going forward. The anticipation that there were going to be 608 beds on day 1 was an impossibility. In fact, moving from 330 beds in the old hospital up to 479 was a major challenge. Some of the quality-of-care issues and some of the noise in the community had to do with the fact that the hospital was really having a tough time coping with that kind of increase.

We're comfortable; I think the numbers are right. We're looking at moving up to 527 this year. Those numbers are very reasonable. Again, it will cope with program growth and it also will be something the hospital can manage.

M^me^ France Gélinas: Thank you.

The Chair (Mr. Norman W. Sterling): Ms. Albanese, please.

Mrs. Laura Albanese: What I wanted to ask first of all is, this project was, in a way, inherited. When the current government came into power, it decided to go ahead with the project. In your opinion, why was that? Were all the problems that the Auditor General pointed out not known at the time?

Mr. Ron Sapsford: I would have to say no. First of all, the ministry doesn't look at it particularly as an inheritance problem, because the ministry has been managing this project from the very beginning. I think it's fair to say no.

The project was a new project; it was a new idea, I think, as has been illustrated. There were two hospitals, in a pilot sense. This kind of financing model had not been used before. So there was a great deal of effort—perhaps too much effort, according to the auditor's report—about advisers and how much administrative cost went into the analysis of whether the project should proceed on this basis. Some of it, in hindsight, has now been viewed that there are better ways to do it. I and my colleagues have tried our best to point out where those changes have been made, learning from the actual experience that Ken brings to it, as well as the auditor's report.

I think we can't forget the fact that there was a very high need to develop a new facility in that part of the province. This had been a long-standing recommendation. As you said, for a new government looking at it, it would be a question of, "Do we stop and start over again?" And when you look at the public interest, there had a been great deal of due diligence—not perfect, and we've made some changes, but nevertheless, the overriding consideration, in my view, would be, is there a need to proceed with this project in the interest of health care for the citizens of Peel and Brampton? My honest belief is that the answer to that question is yes.

Now, what can we learn from it? How can we improve the—

Mrs. Laura Albanese: That was my next question. We've talked a lot about lessons learned, so could you summarize, in some ways, all the lessons that we've learned from the Brampton experience?

Mr. Ron Sapsford: The importance of what I call the pre-planning pieces: definition of program, being clear on specifications, being consistent about that and, once decided, stick to it.

Secondly, the process of determining value for money, whether that's traditional or alternative, and having much more rigorous processes to make those decisions. My

colleague has explained how that's being managed in the Ministry of Energy and Infrastructure and through IO.

The final piece of it, when the project's done, is, what changes in the way the hospital operates have to be put into place by virtue of the fact that it is a new facility, that it is designed differently and that the staff of the old are not familiar with the new? So how one populates it and takes it over and designs changes in operation to accommodate the new physical premises is equally important.

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I think there are three groupings: deciding what you're building; how you tender it and pay for it, making sure you've got the discipline around managing risk and managing risk and managing the project; and then the final is, what are the operating changes the hospital and its staff have to make in order to continue to deliver effective care? In each of those categories, we've learned lessons. We've now turned a corner and have new policy approaches to try to address them in the future.

Mrs. Laura Albanese: Just out of curiosity, one last question: How many hospital projects are currently under way?

Mr. Ron Sapsford: Lots. Total hospital projects: There are about 117 projects currently; that would be of all sizes and shapes, across the program. Thirty-nine of them are major projects that pre-existed ReNew Ontario, which has the IO approach, and 78 are major projects that this government has announced, which would take us up to 2011-12 in terms of the length of time. Of those 78 that are announced, 10 of them have been completed and 41 are still under construction. So there are dozens of hospital projects either in planning or in construction at the current time.

Mrs. Laura Albanese: Thank you. David?

The Chair (Mr. Norman W. Sterling): I think Mr. Zimmer is going to be the last person to question, but I'm going to give the last word to Linda Jeffrey, who hosts the hospital. So, Mr. Zimmer, you go first.

Mr. David Zimmer: I just have one question, and then I'll leave the wrap-up, so to speak, to my colleague Linda Jeffrey.

I don't have so much a question as an observation; I suppose parts of it are a question. One thing that is very, very clear from sitting here this afternoon is how tremendously complex the negotiation of these arrangements are. Deputy Minister Rafi, you said earlier in the afternoon, "These organizations"—and you were referring to, I think, the financiers and the other parties to the process—"are quite sophisticated."

So my question is, and I don't mean any disrespect in the question in any way, so please don't take it that way, but it seems to me that there is a handful of negotiators involved in one of these projects. There are the huge multinational contractors that can take on this kind of a project, and they are tremendously skilled in negotiating what they're doing. They do that for a living and they've been doing it for years and years, the folks who build these hospitals and mega projects.

There are the financiers involved, and they do this for a living—the big banks, the investment banks—and they're tremendously skilled in negotiating these agreements. They know things and ideas that we wouldn't think of in a million years, and you just have to witness some of the goings-on in the financial world out there today.

Then there are the hospitals and the hospital boards, and they're essentially laypersons, if you will, amateurs at this sort of stuff. They're new to the process. There are the politicians, and they're not experts in this complicated financing construction business. There's the civil service side of things; they don't make their livelihoods from these sophisticated financial negotiations.

So I've always had the sense, from my own personal experience over the years and from some things I've been involved in, that getting into one of these negotiations, it's not really a level playing field in the sense that I'm negotiating with a mega contractor and I'm negotiating with a mega financier, and they're so much more sophisticated in their knowledge and the techniques and what the outcomes are all going to be. It has often struck me that you can never get a level playing field in the skill sets of the various parties—and I don't mean any disrespect to hospital boards or politicians or civil servants or anything. How do you deal with that? Or do you ever have any sense that when you're negotiating one of these contracts, I guess to make it a colloquial expression, the other side knows more than you do or is better than you are at coming up with a deal?

I can't help but notice, Mr. White, that you're, in a knowing way, sort of smiling and somewhat acknowledging that premise of mine.

How do you create that level playing field? My point is, sometimes you're negotiating with real sharks here. How do you cover yourself?

Mr. Saad Rafi: It's hard not to take that in the manner you didn't intend.

I'd observe the following: I think you underestimate the sophistication of hospital board members. Some of them are investment bankers. Some of them are corporate bankers. Some of them are heads of construction firms. Some of them are very well-minded individuals from their communities, as we all know. That's one issue.

The second issue is, Infrastructure Ontario was created to find the individuals out there who have expertise in engineering, construction project management, architecture, design, project finance. I think they've done a very good job in assembling a fairly sophisticated team.

The third thing is, they hire advisers who have worked with some of these financiers in other transactions, and who are there to provide legal advice and who have expertise in Canadian international law regarding deal structuring, transaction and financial advice with respect to credit risk, financial evaluation. Some bureaucrats have worked in project finance and have that experience, like myself for the last three years, in infrastructure projects.

It's easy to use the traditional sense of the word "negotiation." It actually is a procurement process, such

that the transaction and deal structure is set by Infrastructure Ontario with the hospital, with the previous guidance of the Ministry of Health. In order to have a consistent bidding process, that procurement and that deal structure is what people bid on. The amount of face-to-face negotiation that you and I would see as the traditional kind of negotiation that we all imagine is there is less of an issue in these types of transactions. When I look at those things as an amalgam—because the hospital board has a say in this transaction both before the RFP and at selection, as well as the Minister of Health, under the Public Hospitals Act, in the first and last instance. So I would observe and surmise that the public interest is quite well protected in that regard.

Mr. David Zimmer: Just to follow up, we have heard from other—sorry, Mr. White.

Mr. Ken White: I'd like to defend my—what was I?

Mr. David Zimmer: I said you were smiling in a knowing sort of way.

Mr. Ken White: Annoying, yes. I didn't mean to annoy you.

Mr. David Zimmer: Knowing.

Interjection: A knowing way.

Mr. Ken White: Knowing? Okay, great.

I was going to introduce, actually, what we just heard from our colleague here. One of the big problems was, there was no construction in health care for many, many years. Hospitals were not equipped with even basic planning skills.

So a lot of what IO represents is really a beautiful model, because it creates a provincial resource that adds a whole new level of sophistication to the entire process: the planning, the executing, the contracts and executing of the project.

I just want to say that this extends right back to the lack of infrastructure in hospitals and the lack of experience right from day 1 on this.

I think this model is great. If I were to encourage any kind of embellishment of it, it would be to extend that great resource to the other non-AFP projects, because, again, there are a lot of projects out there that are not AFP, and IO has a fabulous team of leaders, folks who really do know the business.

Anyway, Mr. Chairman, I just wanted to add those comments.

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The Chair (Mr. Norman W. Sterling): Are you finished, Mr. Zimmer?

Mr. David Zimmer: Yes, thank you, Chair.

The Chair (Mr. Norman W. Sterling): I'm going to give the final word to the MPP who hosts the Brampton hospital, Mrs. Jeffrey, who is a substitute on our committee today.

Mrs. Linda Jeffrey: Thank you, Chair. I wasn't expecting to have this opportunity, and I appreciate the ability to sit in on something that is near and dear to my heart.

The first thing I would say is thank you to the Auditor General and his staff for having produced such a good report. I have to tell you, I was dreading it when I knew that you were doing an audit on my hospital, having been through a trial by fire in my own community on this issue. But it was thorough, it was thoughtful and it was very constructive in the suggestions—and he hasn't paid me to say that. I thought it was very helpful, and it really helped explain a lot of things that I didn't understand. I'm not a financial wizard nor a health care wizard, but I sure had to be a quick learner in the course of trying to assist my community to get this hospital.

I think the deputy mentioned today that it was the largest hospital project undertaken in the province in decades. I cannot emphasize that enough. I think the Premier came out one day to look at the hospital. Actually, I talked to his driver and asked if he would go that way back; it was the long way home. He came back to me the next day and said, "Do you have trouble sleeping at night?" I said, "No. Why?" He said, "Well, it looks like every hospital dollar in the province is going into your community right now. You must be having trouble sleeping." I said, "Not at all."

We've been waiting a very long time for this hospital. We were certainly a guinea pig for a program that was new. It was a novel experience. It made me grey before my time. I can't imagine how it made the ministry staff feel, because it certainly was a challenge to try to get this project moving forward with all of the players, because there were so many people involved in making it work.

I guess what I do want to say in closing is that I had wonderful health care professionals in the existing hospital, a group of people who were honoured as being in the top five in Canada for delivering health care services. Those individuals picked up, lock, stock and barrel, in one day and moved to a new facility to try to deliver health care in my community. That was extraordinarily difficult for them. They rolled up their shirt sleeves and they did it in a brand-new facility. No matter what facility you move into, it's a challenging process.

I'm grateful I have it. We learned a lot of important lessons that I hope will benefit other hospitals across Canada.

I want to thank Ken for his help in the last couple of years. He's my third CEO, and every time he has been away for a couple of days, I say, "Ken, you are coming back, aren't you?" I get anxious, because it is so important to have good health care in your community, and I know we all appreciate it when we have it. Thank you, Mr. Chair.

The Chair (Mr. Norman W. Sterling): Thank you, Ms. Jeffrey. That concludes our hearing portion. I would ask members of the committee to sit back for a few moments as the room clears so that we can instruct our researcher with regard to writing the report. I would ask those who are here to try to exit fairly soon.

I would like first to thank those who came to us. Deputy Minister Sapsford, I didn't forget you again. We'll no doubt see you again in the near future. Deputy Minister Rafi, Ken White, as well as Ian Marshall, counsel, and all of the others who took time to come here, thank you again for your testimony and your help.

The committee continued in closed session at 1435.

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