Commentary on Abbotsford Hospital and Cancer Centre RFP

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Terms of Reference

This commentary is undertaken at the request of the Hospital Employees' Union. The author, a former Director at the Office of the Auditor General of Canada, was asked to examine the Request For Proposals (RFP) from Partnerships British Columbia and to comment on issues that may deserve further examination from the perspective of risks to taxpayers and patients.

Executive Summary

The starting assumption, in undertaking this commentary, is that the Province wants the new hospital built and operated at the lowest possible overall long-term cost to patients and taxpayers, compatible with a high level and quality of service. There are seven issues related to this assumption that arose through an examination of the RFP.

The first significant issue concerns the role of Health Co, as the decision maker and body that will award the contract. Health Co is the public sector party that will negotiate and sign the contract for the new public-private partnership (P3) Hospital in Abbotsford with private sector consortium. Health Co's only shareholder, Partnerships British Columbia, has a mandate to pursue only public-private partnerships and not publicly owned and operated facilities, even if the latter are less expensive. This leaves open the question of who represents the public interest. For example, Health Co will judge bidders' proposals on how much money they can save Health Co rather than, more appropriately, by how much they might save the taxpayers of British Columbia.

The second significant issue arises from asking bidders to search for "opportunities to enhance the value of the Project through entrepreneurial development strategies." The criterion by which these proposals will be judged may not lead to outcomes most in the public interest. For example, although there is nothing in the RFP that explicitly encourages more private health care, there are implicit incentives to do so, since a portion of profits to Project Co can be transformed directly into savings for Health Co.

The third significant issue is that the 30-year operational part of the contract is far too long and includes too many disparate elements. From the point of view of the taxpayer, one large umbrella contract provides fewer opportunities to share in the savings that could result from changing technologies, productivity improvements and similar developments. Thirty years is an unreasonably long time to delegate to a private sector facility manager the task of deciding what sorts of technology, upkeep and maintenance tasks will be undertaken, how and by whom.

A fourth issue is the potential for the P3 to "crowd out" or pre-empt other health care initiatives. Since a P3 involves a legal contract to pay out substantial sums of money over a long time period, it therefore will be a fixed, rather than a discretionary expenditure within the health budget. The risk is that the necessity to pay the obligations in the 30-

year contract might at some point crowd out needed expenses for other health services, and in other parts of the region.

A fifth issue is that the RFP assumes that the current labour legislation in health care, the Health and Social Services Delivery Improvement Act, will be in force for the 30 years of the agreement. This seems unrealistic and potentially expensive if there were to be a change in government and labour legislation were to change.

A sixth issue is that the current estimated announced cost of the hospital will be significantly increased over the life of the contract. This is because the contract will provide complete compensation, perhaps even more than inflation, for inflation risk, as well as for various contingency payments and bonuses. While there is nothing wrong in principle with such provisions, the danger for excess and unwarranted additional payments is real and should be subject to audit by an independent third party, both in terms of the formulae and the data used to calculate the payment.

A seventh issue is that the RFP does not indicate how adequate monitoring and audit will take place, or if it will take place, and who will bear the costs. Nor does it deal with the issue of whether the performance and quality reports will be made public or kept secret due to claims of commercial confidentiality. If a P3 proceeds, it is vitally important to think beyond Health Co's responsibility for the construction phase of the hospital. Concerns about safety, patient satisfaction, and costs require that government establish regulatory and oversight mechanisms that do not appear now to be in place.

Finally, the province will apparently pay the winning bidder to assume risks that may be beyond its financial capacity and might be better assumed by the Province. There are a variety of truly serious and large risks that could put the project in financial jeopardy and require a government bail out, step in, or result in a bankruptcy.

Preliminary Observations

The RFP - Making key documents public is important but more disclosure is needed

The RFP for the Abbotsford Hospital exists and most of it has been made public. This degree of transparency is in significant contrast to the P3 process followed in Ontario for the Brampton and Royal Ottawa hospitals. However, the draft project agreement for the Abbotsford Hospital, a key element in the RFP, remains secret. And no process has been announced stating which requests from proponents for amendment of the RFP have been accepted.

Transparency has advantages, not the least of which is providing an opportunity to make commentaries like this so that there can be wider input into the process, and to generate more informed discussion of whether to continue down the P3 road. Indeed Partnerships British Columbia, and the provincial government, have within the RFP, allowed sufficient flexibility and discretion for changes to or cancellation of the RFP. Specifically, the RFP states that Health Co, reserves the "right to reject any and all proposals" submitted in response to the RFP, subject only to an obligation to pay a predetermined amount partially covering the expenses of preparing proposals that meet the mandatory requirements of the RFP. This is an important reservation, and should be exercised, if appropriate.

The role of Health Co creates concerns about who represents the public interest

Health Co is the public sector party that will negotiate and sign the contract for a new P3 hospital in Abbotsford. As stated in the RFP "the interests of the public sector stakeholders involved in the Project, such as the Health Authorities, the Ministry of Health Services, Partnership B.C. and the Fraser Valley Regional District will be co-ordinated through Health Co."[1]

A key question is whether Health Co adequately represents the public interest.

Health Co has a single shareholder, Partnerships B.C. In turn, Partnerships B.C. is a registered company, wholly owned by the Province and reporting to its single shareholder the Ministry of Finance. Its "overall mandate is to promote, support, and in some cases, manage Public-Private Partnerships in order to maximize the value of public capital projects such as hospitals and highways."[2]

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[1] RFP, page 7.
[2] RFP, Appendix 6, p. 17.

Given the mandate of its shareholder, Health Co's approach to the Abbotsford Hospital has the following constraints:

- Its sole shareholder will fulfill its mandate only if Health Co uses public-private partnerships.

- Health Co's criteria for selecting the winning bidder emphasize how much the bidder's proposal will produce savings to Health Co, rather than to the public as a whole, or even the government as a whole.

As well, as might be expected in a "turn key" arrangement, the control and shares of Health Co will be transferred to the Fraser Health Authority only after the terms of the P3 are in place with the winning bidder, Project Co.[3] It is unclear, given its mandate, how well Health Co's interests in ensuring a P3 will align with that of the ultimate owner of the facility, the FHA, whose mandate it is to provide health services.

In other words, it is vitally important to think beyond Health Co's responsibility for the construction phase of the hospital. Concerns about safety, patient satisfaction, and escalating costs pose significant risks to the health services that this hospital is expected to deliver. Such concerns will require government to establish regulatory and oversight mechanisms that do not appear to be in place now.

General P3 Issues: Value for Money, Innovation, and Capital Availability

Governments in other jurisdictions claim that they cannot afford to finance important infrastructure projects and have turned to the private sector for capital. However lack of capital is a totally self-imposed constraint in situations where government is prepared to sign contracts for P3s that are almost certainly more expensive in the long run.
With respect to Abbotsford, the government intends in any case to guarantee the loans as if they were obligations of the Province of British Columbia.

Other fundamental justifications for pursuing P3s are that they produce "innovation" and that, due to transfer of risks, they are better "value for money."

Risk transfer in P3's provides "value for money" – or does it?

P3 proponents acknowledge that such arrangements often cost more. However, proponents point out that because the private sector takes on significant risks formerly borne by the public sector the transfer of risk provides value for money. The underlying belief is that risk transfer creates synergies and positive incentives by putting risk where

[3] RFP, page 7.

it belongs, with those who stand to benefit from minimizing it – the private sector partners.

A P3 project has four major cost components – the building, the ongoing operation of the facility, the risk transfer to the private sector, and profit.

Risk transfer is essentially the purchase of an insurance policy that limits the risks (i.e. cost) to the taxpayer through a premium paid to the insurer (i.e. the private sector).

What makes the project "value for money" according to proponents is when the costs of a P3 are less than the value of risks transferred, the profits of the winning consortium, and what it would cost the public sector to build and operate the facility. This comparison is the "public sector comparator".

As Ron Parks and others have pointed out, this calculation can be manipulated by choice of discount rates based on, among other assumptions, the amount of risk that can be transferred.

In practice, P3s in various jurisdictions do not transfer risk as intended. A 2003 review paper by the Ontario Association of Architects has concluded, "Consulting and construction firms around the world have failed because they have been ill-prepared to manage the risks transferred to the private sector in P3s."[4] As a result, the public sector must then assume the risk that it has already paid the private sector to assume! Because there may not be alternate suppliers, the public sector partner could be forced into renegotiating the contract terms at higher costs to the taxpayer or users of the facility, as an alternative to having no services at all.

A major explanation why corporations have been "ill prepared to manage the risks" of P3s is that they do not have a sufficiently large asset base to insure against large risks. An analogy is useful. The payment for transferring risk from the public sector to the private sector is like the purchase of a house insurance policy. A wise consumer prefers to purchase from a company with a large asset base, which also has reinsurance arrangements. A less cautious consumer who purchases insurance, perhaps at a lower price, from a relatively small company that has few assets, runs a serious risk of not collecting in the event of a major catastrophe such as a large fire that burns down hundreds or thousands of homes. For this reason, governments impose regulations that are designed to minimize this risk to the consumer and ensure that the consumer is indeed protected against the risk for which the insurance was purchased. However, with P3s governments seem content to sign contracts with corporations with few assets other than the contract for the P3. While the consortia bidding on the projects may be large entities, it is their subsidiaries, legally separated, that build and operate the hospitals. In practice, the winning bidders ability to assume a risk that it actually encounters cannot exceed its underlying assets, including any accumulated surpluses.

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[4] Ontario Architects Association, "A P3 Primer", 2003, p. 3.
http://www.oaa.on.ca/client/oaa/OAAHome.nsf/object/P3/$file/P3Primer.pdf

The possibility of bankruptcy is not mere speculation. The Australian Auditor General has recently released a thorough and thought provoking assessment of P3s.[5] He has raised a number of concerns that bear on the Abbotsford Hospital RFP including examples of problems that arose in drafting contracts and promises of efficiencies that were not achieved. All of these problems resulted in greater costs to the taxpayer including the tendency for government to bear a disproportionate share of the risks; the potential for reduced transparency and accountability; and the loss of short-term flexibility resulting in unforeseen downstream costs. He also observed that there is not nearly enough attention given to what will happen in the event of bankruptcy.

One remedy for these problems is to insist that risk be transferred not only to the winning consortium companies, but also to their parent companies. In other words, the RFP would insist that the winning consortium create a corporate structure where liability is assumed by each of the parent companies. Another, approach would be to revise the RFP and propose to transfer far less risk and retain all large risks outside the control of the bidder within the public sector. This more modest transfer of risk is also certain to cost less since the only risks transferred would be those that were reasonable relative to the assets of the winning bidder. Such a remedy would also encounter fewer issues of goal congruence.[6] However, it would also make it more difficult for a P3 to demonstrate "value for money" since the premiums paid for risk transfer would now be much lower and more realistic.

Goal congruence - highly desirable but hard to achieve

The very word partnership implies people working toward the same goals. If the public and private sector have aligned goals, then the potential for synergies, including savings and higher outputs, is enhanced and more likely. However, if the incentive structure for projects reviewed appears to do just the opposite, (leading not only to higher costs, but in some instances, also compromising the public service objectives - including quality and level of service -for which the partnership was established in the first place), then the benefits of the contract are not likely to be achieved.[7] The following example illustrates the issue. It reflects the divergent needs of a corporation that must make a profit, and the interests of those paying for and receiving a service.

In Ontario, the equivalent agency to Partnerships B.C. is SuperBuild. Its *SuperBuild Guide* has some practical caveats for those contemplating P3 ventures and concerns itself directly with several examples of likely goal congruence issues. One is the incentive to reduce maintenance toward the end of a project. As the *Guide* candidly concedes, "*Ensuring private sector commitments during ongoing operations is equally challenging. Once the "excitement" of the development phase has passed, the public sector*

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[5] Pat Barrett, "*Public private partnerships – Are there gaps in public sector accountability?*" 2002 Australasian Council of Public Accounts Committees, 7th Biennial Conference, Melbourne, 3 February 2003

[6] See related discussion on p. on page 15 15

[7] Auerbach, op.cit, p. 30.

organization typically views monitoring during ongoing operations as a routine task to be handled by an individual of lower qualifications. As a result, private sector parties are often able to erode various commitments, particularly with respect to service levels and operations".[8] Unfortunately SuperBuild's suggested solution to these "key challenges" is only that "appropriate care must be devoted to ensure that these commitments are fulfilled." The *Guide* does not discuss the public policy mechanisms required for adequate and ongoing monitoring, audit and evaluation. Its caveats to those thinking about undertaking these projects only serve to underscore the need for public knowledge and monitoring of the details of the contract, if the project is, in fact, undertaken and "appropriate care" is required.

P3's more innovative - but from whose perspective?

A widely held view is that a private sector project will be more innovative than one done by the public sector. This is used as a justification for the promotion of P3s. "Innovation", however, is an imprecise term, although typically it is used as a word that connotes improvement.
However, what may be an innovation from the point of view of Project Co or the provincial government, in terms of saving money to Health Co, may impose unwanted additional financial and health costs to patients and taxpayers. The question must always be asked, "from whose perspective" is something an improvement? Simply calling something innovative does not mean it necessarily improves health care or makes it, from an overall perspective, less costly. For example, an "innovative" way of providing private diagnostic services within the hospital might be an improvement from Health Co's perspective, but a negative development from the perspective of those who now have to pay more out of their own pockets for diagnostic tests, or for those who are firm believers in universal, single-tier health care.

Accountability and access to information - problems with commercial confidentiality

Achieving accountability for decisions on costs and performance is essential for any government contract. Therefore, access to information is needed both before and after decisions are taken to proceed. After proceeding, annual audits are needed to ensure that both financial and performance data are accurate and that value for money is actually being achieved. In order to do this, there must be adequate information available to independent monitors and auditors, and to the public.

Unfortunately, access to information has been a difficult issue in other jurisdictions with P3s. Typically, the public and Auditors General have not been allowed sufficient access to private sector accounting records and performance management information needed to assess what has actually happened. In the United Kingdom, for example, the National

[8] Ontario, SuperBuild Guide, p.23

Audit Office has argued that it needs access to private sector accounting records,[9] something it does not now have.

The Australian Auditor General, while noting private sector interests in protecting trade secrets and competitive advantage, quotes from an observer, "While [commercial confidentiality] may be good for business, it is inimical to the fragile processes of participatory democracy."

P3s potential to crowd out other health care needs

A P3 involves a legal contract to pay out substantial sums of money over a long time period. It therefore becomes a fixed, rather than discretionary expenditure within the health budget. This can cause distortions in budget planning. Predetermined and fixed funding demands may have system-wide impacts by establishing prior claims on provincial health spending for decades to come. In Britain, the Private Finance Initiative - that country's version of a P3 - is doing just this. For Abbotsford, the risk is that the necessity to pay the obligations in the 30-year contract might at some point crowd out needed expenses for other health services, and in other parts of the region. We discuss additional problems with a contract of this length in the following section.

Specific Aspects of this RFP

Value to Health Co is not equivalent to the public interest

Health Co's sole shareholder, Partnerships B.C., has an "overall mandate to promote, support, and in some cases, manage public private partnerships in order to maximize the value of public capital projects such as hospitals and highways."[10] As we have pointed out earlier, this means Health Co is mandated to pursue a P3 route even when alternative forms might be more economical or effective. Therefore it is not surprising that the RFP indicates that an important aspect of selecting the winning bidder will be how much the bidder can achieve savings to Health Co. However, the interests of Health Co, though congruent with those of Partnerships B.C., are not necessarily congruent with those of patients throughout the Fraser Valley region, the public as a whole, or even the Government of British Columbia as a whole. They are clearly narrower.

"Entrepreneurial" uses of land and equipment

The RFP urges proponents to search for "opportunities to enhance the value of the Project through entrepreneurial development strategies." These might include medical

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[9] Allyson Pollock, Jean Shaoul, David Rowland and Stewart Player, "Public services and the private sector" Catalyst Working Paper, London, 2001, p. 26.
[10] RFP, Appendix 6, p. 17.

offices, conference facilities, hotel or other short-term residence facilities.[11] The RFP also opens the door for Project Co to provide health care services "as expressly allowed in the [still secret] Project Agreement or with the prior written consent of Health Co."[12]

While a public provider might only pursue cost recovery for extras such as telephone or TV rental, a private provider would have the incentive to make this a profit centre and explore as many entrepreneurial opportunities as possible. This would maximize profit to the consortium, and achieve greater "savings" to Health Co.

Other entrepreneurial opportunities might be far more significant, from both a financial and a public policy point of view. Consider, for example, the use of the land for commercial purposes. A hotel might not wish to provide subsidized rooms for the family of terminally-ill patients. The land around the hospital might be quite suitable for affordable housing, seniors' health services, and the like, but this potentially desirable use might be of less commercial interest than other uses of the land. The issue for taxpayers is that the criteria on which such decisions will be made is solely dependent on a bidder designing an arrangement in which it can offer Health Co a share of its profits. Whether these profits will materialize, and/or whether they are the most desirable, and cost effective, from an overall point of view, is not part of the equation.

Contract is too long, has too many services bundled together and is inflexible to future changes in the labour relations environment

The length of the contract - 30 years after completion of construction - is another central issue. While a long-term arrangement is usually appropriate for the financing or lease of a major capital asset, it is less obviously appropriate for providing services in an environment where costs, laws, technology, disease prevalence, medical practices and labour relations all may change radically over the course of a contract that will be literally for a generation. From the point of view of the taxpayer, one large umbrella contract provides fewer opportunities to realize and benefit from new competitive forces in the marketplace and share savings from changing technologies, productivity improvements and similar developments.

An analogy helps make the point. The arrangement for facility management of the Abbotsford Hospital envisioned in the RFP is analogous to a homebuyer who must take out a mortgage. However, instead of just borrowing the money to acquire the house, as part of the mortgage contract, the buyer also agrees to bundle together the provision of all "necessary" maintenance, painting, laundry, snow removal, and cleaning in a 30-year commitment, with the bank arranging subcontractors of its own choosing. Some purchasers might object to such an arrangement whereby they are obligated to pay significant sums, most likely in excess of what it would cost to purchase the services separately, to a facility manager. They might also feel 30 years is too long to delegate to a

[11] RFP, p.26.
[12] RFP, p. 27.

facility manager the task of deciding when it was time to paint the house or shovel the snow.

Labour relations illustrates another aspect of the difficulty and impracticality of such a long-term operational contract. This very problematic part of the RFP requires bidders to "ensure that no part of the AHCC and none of the Health Authorities or Health Co can be temporarily shut down or otherwise compromised in its or their operations as a result of labour relations/collective bargaining matters related to Project Co's performance of the Project Agreement."[13] How could a private sector company assume such a risk and agree to give such a guarantee? After all governments can change. This is certainly beyond the control of a company.

However, in the current legislative environment, there is no problem. The Health and Social Services Delivery Improvement Act gives employers far more flexibility with respect to contracting out than they had previously, and reduces negotiated protections previously afforded employees.[14] This clearly assists employers in their negotiations with employees and unions. The RFP says that bidders are to assume that current laws will remain in force throughout the term of the Project Agreement. But, it is entirely conceivable, that sometime during the 30 years of the contract, a future government might pass different legislation in response to changes in the political and labour relations environment. Presumably, if Project Co is to give undertakings about no labour stoppages, it will need some assurance against legislative change in the draft Project Agreement. Would the wording of the Agreement tie the hands of a future government? Would a new government be required to compensate the operator of the Hospital if it changed labour legislation? If there is no such provision, and Project Co bore the risk of a changed labour environment, and was not compensated, would there be an impact on Project Co's ability to recruit hospital staff? It is hard to know the answers to such questions without seeing the draft Project Agreement, but the answer may well be yes, that some of the anticipated "savings" of a P3 are contingent on government support to maintain present labour legislation for the 30 years of the agreement.

These examples underline the importance of unbundling the capital and operations so that there is not a single, long-term contract with only a single, private facility manager of operations. This unbundling and reduction of contract length would be, without question, a more economical and flexible way to operate the hospital over a 30-year period. It would also give more flexibility to retain certain facility services in the public sector where this is warranted. Unfortunately the mandate of Health Co's only shareholder to promote P3s appears to give an unwarranted preference to long and multi-bundled operational contracts with private sector providers and to preclude consideration of this more sensible and flexible way to proceed.

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[13] RFP, p. 29

[14] HEU, Backgrounder, March 2002.

Risk transfer - what is transferred, what not, what seems appropriate, what not - why pay for something not received?

The successful bidder for the Abbotsford Hospital is expected to bear a significant number of other risks. They are required, among other things, to:

> "allow ... sufficient flexibility to accommodate future changes in clinical workloads, changes in the delivery of Clinical Services, and changes in clinical practice, technology, and service delivery."[15]
>
> "procure, install, deliver and maintain all equipment..."[16]
>
> "allow for and provide effective and efficient installation, maintenance, repair, decommissioning, upgrade and replace of equipment ... which will minimize to the greatest extent reasonably possible all disruption of services and additional costs to Health Co."[17]

This list reads, at first glance, like a set of typical requirements that one might find in many types of contracts. What makes this contract different from most contracts for facility management services is its length. This is not just a contract for a year or two. In the normal course of events, it may well be that there will be no major problems. Maintenance requirements will be routine, and there will be no unanticipated major increases in costs, whether for equipment or labour. Indeed part of the contract cost involves compensating Project Co for the assumption of routine everyday risks. However, it is just those situations that are not routine - where the risk assumption becomes more expensive than anticipated - that may lead to expect increases in cost to taxpayers.

The RFP does not encourage proponents to anticipate these risks. In fact it does the opposite.

It has potentially significant exculpatory provisions. It suggests that Project Co should "minimize to the greatest extent reasonably possible all disruption of services and additional costs to Health Co.". What does "greatest extent reasonably possible" mean in practice? This may be a phrase, in the event there is such a disruption, for lawyers to debate, but it would appear that if Project Co acts in a "reasonable" fashion, it would not have to bear the risks it is being paid to assume. It is safe to assume that Project Co will always claim to have been reasonable if unanticipated and costly disruptions of service should occur. The leads to the question, why should Project Co be paid what appears to be a potentially large sum for risk transfer if it can only assume routine risks of relatively small dimensions?

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[15] RFP, p. 14.
[16] RFP,p.17.
[17] RFP, p. 25

Such significant risks may include floods, fire, terrorism, vandalism, and epidemics such as SARS, over optimistic assumptions in the bid, energy crisis and blackouts. Each of these could have a devastating impact on the projected operating profits of this hospital. Individually, of course, each of these events is highly unlikely in any relatively short time frame. On the other hand some of these highly improbable events have happened over the last few months, some in B.C., some elsewhere. One could well happen again.

The key questions are, is it truly appropriate to pay for the transfer of such risks when if the risk occurs, there is a high probability that the public will have to bear the cost anyway? The Ontario Association of Architects thinks not:

This is often seen here in Ontario in onerous and unrealistic requirements being added to construction contracts and client/consultant agreements by managers, more often than not, on advice of legal counsel. In too many cases, this is not an exercise to transfer to the private sector as much risk as is reasonable or practical, but rather to transfer excessive amounts of risk ... risk which cannot be fairly measured or managed by the private sector. This might include, for example, demanding that an architect contract to accept risk which is significant in terms of potential damages, and for which insurance is unavailable. Or, demanding that the contractor in a stipulated sum contract accept the risk for unforeseen environmental conditions below ground on the owner's land. [18]

Risks assumed by Health Co will increase total contract costs and should be subject to audit

While some hard-to-predict risks seem to be transferred, some completely foreseeable risks are not transferred. In the RFP, Health Co explicitly assumes all inflation risk by indexing the operating portion of the Annual Service Payment. The RFP says Health Co also explicitly assumes responsibility for commodity price risk by providing for a price adjustment linked to increases in commodity prices such as heating fuel.[19] It appears to state that this commodity price risk adjustment is in addition to the inflation adjustment. It would appear, therefore, that Health Co could end up overcompensating Project Co for inflation increases, since commodity prices are themselves a component of inflation. Clearly this is inappropriate - it should be one or the other.

The RFP also proposes adjustments to payments to Project Co for volumes of laundry and similar services that differ from expectations outlined in the Output Specifications. It says that adjustments will be based on an individually prescribed formula. Whether, in a situation where there are clear economies of scale, this formula will be appropriate is impossible to say. Such additional payments, at a minimum, deserve to be subject to review by an independent third party, both in terms of the formula and the data used to calculate the payment. However there is no mention of how and whether this will be done.

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[18] OAA, *A P3 Primer*, p. 16.
[19] RFP, p. 38.

With respect to energy use volumes, the RFP says Health Co will share the risk by establishing an "Annual Utility Target". If consumption is 5% less than this target, Project Co keeps the savings, below this it shares the savings with Health Co. Consumption above the target is the responsibility of Project Co. Clearly the idea is to provide incentives to conserve energy. The RFP says this target is to be mutually agreed upon. It does not say how often the agreement will be reviewed and whether this target will be subject to audit or evaluation by an independent third party, like the Auditor General. Obviously if the target is slightly too high, it will be easy to beat. If the target is very high, then the danger for Project Co is that it would have to share savings with Health Co that it could otherwise keep with a lower target. While the aim is admirable - to create an appropriate incentive to conserve energy-given the many other competing incentives Project Co will have, it will be surprising if a Utility Threshold is effective in practice. Moreover, the details of these calculations, if they exist, are in the Project Agreement and not publicly available.

This lack of transparency and the difficulty of assessing such an arrangement if data were available suggest that this is the sort of operational matter better left in the public sector. The costs of monitoring alone are likely to exceed the savings from energy reductions.

Access to Information - will it be adequate?

The RFP says that subject to legislation, all proposal documents will be considered confidential. But what happens afterwards? The RFP does not indicate how financial, performance and quality reports will be treated during the course of the contract. This is a serious oversight that could significantly diminish accountability.

Claims of commercial confidentiality must be judged on their merits, not simply accepted. The wording of the RFP suggests there will be a presumption against disclosure, wherever possible. As well, the British Columbia Freedom of Information and Protection of Privacy Act provides for heads of public bodies a specific exclusion for commercial information from a third party. Decisions can be appealed to the Information and Privacy Commissioner. This takes time and there is no guarantee of success. Indeed, as the Australasian Council of Auditors General has observed, "*Some private and public sector bodies are instinctively apprehensive and protective about the disclosure of any commercial information. But such views often overstate the implied risks to an entity that might be occasioned by the release of commercial data. After-the-event commercial information has significantly less value than commercial information concerning events that have yet to occur. But even where commercial information might have commercial value to others, there are often overriding obligations that require it to be released.*"[20]

At several points in this paper, we have pointed out that important aspects of this project are not in the RFP, but in the draft Project Agreement. The fact that the Project Agreement is not public means that many relevant specifics of the proposed hospital

[20] Barrett, op.cit.

cannot be fully assessed. As well, other aspects of the bidding process remain under wraps. For example, the RFP indicates that bidders that meet the basic requirements of the RFP will receive Partial Funding. How will this be calculated and how will the public be assured the sum is not actually Full Funding? It would also be appropriate to know what sums are involved, as well as to know how much has already been spent on arrangements with Pricewaterhouse Coopers and others, to prepare for and to run the bidding process. Typically these are very high costs in P3 projects elsewhere in the world.

Audit, performance measurement, bonuses and penalties

For the Abbotsford Hospital, there are a number of key areas that will require a high degree of public expertise and effort in order to ensure that services are delivered in a quality fashion and that net costs are as low as possible. The RFP does not indicate how in fact adequate monitoring and audit will take place, or if it will take place, and who will bear the costs. Nor does it deal with the issue of whether the performance and quality reports will be made public, or whether they will be kept secret due to claims of commercial confidentiality. These details need to be made public and openly discussed.

In any event the RFP describes various incentive schemes designed to reward good performance and penalize poor performance.

Failure Event deductions will be calculated "according to a specified formula".[21] It is not stated what this formula is, or whether the data upon which it is based will be subject to audit.

Quality Failure deductions are also calculated according to a formula that is not publicly available. Clearly, establishment of the benchmarks and the quality of the data will be essential if such a formula were to work. There will also be reliance on surveys of users. The details of the surveys will be subject to negotiations after the winning bidder is chosen. Whether these formulae are appropriate, the data verified and the results public is not known. Nor is mention made of renegotiating the formula, (or imposing one) as technology and other changes occur over the course of a very long contract.

Finally, the RFP allows for Bonus Payments "depending on the results of both Customer Satisfaction Surveys and Health Co's own evaluation of Project Co's performance over the Contract Year."[22] This payment can be up to $250,000 annually, fully adjusted for inflation increases. A significant aspect of this is immediately evident in the use of the word "customers". This suggests an emphasis on patients' commercial relationship with the hospital rather than on one that involves the various aspects of publicly provided medical care. No mention is made of how the "specified requirements" to qualify for the bonus will be determined and whether they are appropriate, whether they can be changed,

[21] RFP. p.39.
[22] RFP, p.40.

whether they will be subject to audit, and whether the details of the payments, and the information on which they are based, will be made public.

Although the proposed bonus payments are not large relative to the level of the anticipated Annual Service Payment, the current estimated value of the project does not include a provision for these payments.

Final thoughts

Is privacy a problem?

The RFP instructs bidders to assume that Project Co has certain benefits and rights as if it were a public employer supplying essential services under the Health and Social Services Delivery Improvement Act and the Labour Relations Code. However no such rights or obligations that might apply to a public employer are mentioned with respect to privacy or access to information, although one could reasonably infer that Project Co would, subject to claims for commercial confidentiality, be subject to privacy protection legislation. A particular concern, therefore, may arise with respect to employee and patient records, since it may be that provincial legislation that would protect employees and patients from release or sharing of information would not apply or would not be as well enforced with respect to a private employer. The absence of any mention of this as an issue to be dealt with in the proposal is potentially of great concern. In Australia this is clearly recognized:

"As the private sector becomes more and more involved in the delivery of public services, it is important that there is clear accountability for the protection of personal information contained in records gathered by either the public or private party in the delivery of those services."[23]

Will Abbotsford encourage more private health care?

Is this RFP an invitation to offer private MRIs and other diagnostic services now publicly provided? The answer seems to be yes. Although there is nothing in the RFP that explicitly encourages more private health care, there are clear implicit incentives to do so since a portion of profits to Project Co can be transformed directly into savings for Health Co. In fact, the RFP provides some not so subtle encouragement to create private facilities within the hospital. "Proposals are, in respect to equipment, encouraged to be creative...and to identify opportunities that challenge and improve current business and clinical practice."[24] The language is vague and general. However it would certainly be consistent with, for example, a proposal to run an MRI privately "after hours." If an MRI

[23] Barrett, op. cit.
[24] RFP, p. 17

were funded by Health Co for just 8 hours per day and there were long waiting lists for medically necessary tests, both Health Co and Project Co would have an incentive to allow Project Co to run the machine on a private pay basis for the remaining hours and to share the net proceeds. However would this overall really produce any savings? The money made by Project Co and saved by Health Co would have to come out of the pockets of those paying for the test. This may not really be a savings overall (it may even be more expensive) but rather a transfer of costs from Health Co and Project Co, to patients. Supporters of a public health care system might not find this outcome desirable.