Public Private Partnership in Hospitals

Presentation to the International Health Seminar Brazil - Canada

October 20, 2010
Overview

• Healthcare in the Canadian context
• What do we mean by PPP / AFP / PFI
  – What are they?
  – How are they structured?
• Canadian Pilot Projects and CCPPP Guidance
• Scope/policy decisions
• Risk transfer
• Benefits to the Public Sector
• Value for Money
• Hospital Case Studies
Health Care in Canada

• 10 provinces and 3 territories regulate and fund local hospital care
  – province pays substantially all operation costs of hospitals, in part from federal transfer payments
  – province and local communities share in capital costs

• Universal public clinical insured care

• ± 30% private participation in uninsured care

• $100 billion annual spending
Health Care in Canada (continued)

- Provinces spending ± 50% of budgets on health
- Health care expenses are escalating faster than other expenses, and eventually will crowd out other public services
- Significant operating cost pressures
- Significant infrastructure deficit in facilities, IT and equipment
- Criticism of PPP focuses on potential private scope within non-clinical services
What is a PPP or P3 or PFI or AFP?

It goes by many names, but it is essentially the same thing:

- PPP’s are an alternative procurement model for government infrastructure to traditional design / construction
- PPP’s involve private sector accepting responsibility for Design, Construction, Financing, Maintenance and in some cases Operations
- Facilities management over a long term concession period (25 – 35 years) with pre-defined hand back conditions
- Single entity (“Project Company”) contracts with government and in turn sub-contracts with consortium partners
- PPP’s are performance based contracting arrangements
  - Payment from Government only begins upon completion of construction
  - On-going payments remain subject to deduction for failures in service delivery
What P3 is Not

• **It is not** about the FINANCING:
  – Accounting rules tightened – regarding off-book treatment
  – Government borrows at lower cost
• **It is not** about sale & leaseback or asset sales (“privatization”)
• **It is not** about a Real Estate transaction
  – Does not require private sector ownership of the asset
• **It is** about **Performance Based Infrastructure & Facilities** - **RISK transfer**:
  – The partner is repaid through incentive-based availability of the asset either from the government or through user fees (tolls) or combination
PPP Structure

Public Sector Agency

Project Co (Developer/Equity Provider)

Design & Construction
Operator & Life cycle Manager
Senior Debt Provider

Sub Contracts

DBFM / O Agreement

Availability Payment

Senior Debt Agreements
Payment Guarantee

Structure Attributes

- Strong balance sheet – credit rating
- Efficient Risk Allocation
- Payment Guarantee
- Parent Company Guarantee + Security

Non-recourse project finance
License structure – no charge on title
Significant risk transfer
Strong value proposition

Investment Grade Transaction
Models of PPP in Canada

Degree of Private Sector Involvement

Degree of Private Sector Risk

PPP Models

- Design – Build
- Operation & Maintenance
- Build – Finance
- Build – Finance – Maintain
- Lease – Develop – Operate
- Design – Build – Operate
- Design – Build – Finance – Maintain
- Design – Build – Finance – Operate
- Design – Build – Finance – Operate - Maintain
- Build – Own – Operate
- Concession
- Privatization
Hospital PPP Case Studies

- 2003 publication of CCPPP
- Theoretical analysis and empirical case studies.
- Review of ten hospital PPP projects in U.K., Australia, Canada, U.S. and U.A.E.
- helped to stimulate Canadian PPP pilot projects

Canada Update (2010)
- 18 hospitals operational
- 26 hospitals under construction
- 10 hospitals in procurement
- 10 hospitals planned
CCPPP Guidance - Action Steps to Advance PPP Projects

1. Develop pilot projects to test, refine and adapt the PPP model for broader implementation.

2. Develop an appropriate financing model, including any legislative reform required.

3. Identify champions – political, bureaucratic and within the hospital sector.

4. Develop private and public sector expertise in the complex and burgeoning field of PPPs (an “intelligent client”).
5. In order to prove value for money, develop a methodology for how to value and allocate risk.

6. Engage prospective bidders by facilitating the PPP process, e.g. top-level government approval before engaging bidders.
Proposed Scope of PPP Hospital Services

Canadian studies suggest serviced infrastructure expense as a % of annual budgets would account for 16% (CIHI), 31% (OHA) and 38% (Abbotsford).
Risk Transfer - PPP Comparative Advantages

Level of Risk Transfer

- Design
- Build
- Maintain
- Operate
- Finance
- Own

- Multiple Designs
- Whole life perspective
- Innovations – Life cycle costing
- Risk transfer – time / cost overruns + availability
- Long-term redundancy risk

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Benefits to the Public Sector - How Are P3s Different From Typical Build Projects?

**Traditional**
- Scope evolves through design and construction
- Multiple contracts / complex administration
- Conflict between consultants and contractors
- Building operator left with deficiencies
- Owner exposed to deficiencies
- Government risk of cost overruns

**PPP**
- Scope resolved at outset
- Single contract
- Cooperation between consultants and contractors
- Annual service payment based on performance
- Proponent not paid until project delivered as specified
- Budget, schedule and scope certainty

CM = Construction Management
CM GMP = Construction Management “at risk”
DBB = Design Bid Build (Stipulated Sum)
DB = Design Build
DBF = Design Build Finance
DBM = Design Build Maintain
DBFM = Design Build Finance Maintain
Value for Money

• LSE study showed 17% average VFM for PPP projects across multiple sectors

• Hospitals tend to show VFM of 8 - 18%

• Examples:

<table>
<thead>
<tr>
<th>Project</th>
<th>Contract Value</th>
<th>VFM</th>
<th>VFM (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Niagara Health System</td>
<td>$759 million</td>
<td>$96 million</td>
<td>12.6%</td>
</tr>
<tr>
<td>Women’s College Hospital</td>
<td>$460 million</td>
<td>$86 million</td>
<td>18.7%</td>
</tr>
<tr>
<td>Centre for Addiction &amp; Mental Health</td>
<td>$293 million</td>
<td>$51 million</td>
<td>17.4%</td>
</tr>
<tr>
<td>Abbotsford Regional Hospital</td>
<td>$355 million</td>
<td>$39 million</td>
<td>11%</td>
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Hospital Case Studies
Case Study - Abbotsford Hospital

- Procurement started in September 2002
- Construction started December 2004
- 300 Bed Acute Care and Cancer Centre
- Total Capital Cost - $450 m
Case Study - Abbotsford Hospital

Key success of project to date:

- Full scale P3 healthcare “DBFO”
- Innovation, efficient delivery and value for money

- No $ of change orders to public sector to date – first for Canadian healthcare capital projects
- On time – May 7, 2008
Case Study - Abbotsford Hospital

- No preconceived design
  - Performance-based specifications
- Partnership attitude
- Strong political commitment
- Health Co P3 knowledge & strong project management
- Learned from others
Case Study - Vancouver Convention Centre

• Large scale project undertaken by public sector with external project managers and construction management contract

• Started as PPP, but changed approach to traditional Construction Management

• Recently announced:
  – Increase in price to over $880m – up from original $565m
  – Will not meet scheduled completion date by at least 6 months

• Reason for cost overrun and delay was attributed to extremely strong construction market.
## Comparison – ARHCC / VCC

<table>
<thead>
<tr>
<th>Abbotsford Hospital &amp; Cancer Centre</th>
<th>Vancouver Convention Centre</th>
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</thead>
<tbody>
<tr>
<td><em>(relatively more complex)</em></td>
<td></td>
</tr>
<tr>
<td><strong>Architect:</strong> MCM</td>
<td>Architect: MCM</td>
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<tr>
<td><strong>Constructor:</strong> PCL</td>
<td>Constructor: PCL</td>
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<tr>
<td><strong>Construction Start:</strong> 2004</td>
<td>Construction Start: 2004</td>
</tr>
<tr>
<td><strong>Procurement:</strong> DBFM – P3</td>
<td>Procurement: Construction Management</td>
</tr>
<tr>
<td><strong>Result:</strong> On-time &amp; On / Under Budget</td>
<td>Result: 6 months late/Over budget (155%)</td>
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Niagara Health System

Size: 1,000,000 ft²

Services Available:
• 375 Bed Acute Care hospital and ambulatory care facility
• Regional Longer-Term Mental Health Centre, Cardiac Catheterization Centre and Renal Dialysis services
• Regional cancer centre

Project Value: $722 m

Client: Niagara Health System
Consortium: Plenary Health: Plenary Group, PCL, Johnson Controls
Est. Completion: Fall 2013
Structure: Design, Build, Finance, Maintain
Status: Under construction