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MUHC REPORT
ON UK HOSPITAL PFIs or PPPs

Centre universitaire de santé McGill
McGill University Health Centre

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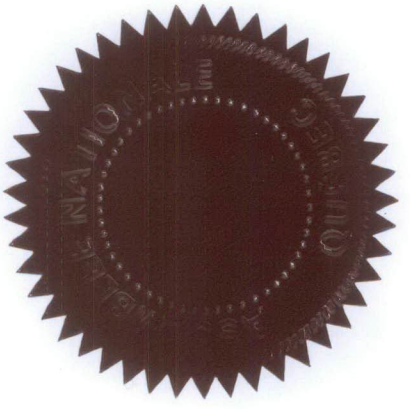

ARTICLE I
INTRODUCTION

1.1 Background

Over the last year and a half, the Québec Treasury Board has expressed considerable interest in financing a number of major projects, including the construction of healthcare institutions, highways and penitentiaries, through public-private partnerships or PPPs. Treasury Board President, Monique Jérôme-Forget, led a government-based team to the United Kingdom in 2004 in order to get an appreciation for its financing model, known as Private Financing Initiatives or PFIs, and its potential application in Québec. Mme Jérôme-Forget has also expressed publicly in the past her desire to use PPPs to finance the $1.6 billion committed by the Government of Québec for the redevelopment projects of the McGill University Health Centre (MUHC) and the Centre hospitalier de l'Université de Montréal (CHUM).

As Director General and CEO of the MUHC, Dr. Arthur T. Porter decided to organize a Montréal delegation that would assess the merits of the PFI model from a healthcare institution's standpoint. MUHC participants, in addition to Dr. Porter, were Mr. Normand Rinfret (Chief of Staff), Mr. René Carignan (Chief Financial Officer; Director of Administrative and Clinical Support), Judith Horrell (Communications Manager, Office of the CEO) and Mr. Morton Gross (Senior Partner, Borden Ladner Gervais LLP). Other participants were Dr. Denis Roy and Mr. Sylvain Villiard (Director General and Associate Director General of the CHUM, respectively) and Mr. John Gauvreau (Director of Investments and Partnerships, Ministry of Health and Social Services, Government of Québec).

This report serves to examine the history of the PFI in the UK; provide a Canadian perspective; address the applicable advantages and disadvantages; and provide recommendations.

1.2 Historical Context

In 1946, the United Kingdom established the National Health Service (NHS), which was to guarantee comprehensive health services to citizens regardless of financial means. The Department of Health, to this day, manages the NHS on behalf of the UK Government.

In 1990, NHS Trusts were established to provide local hospital, mental health and community care services.

Since 1995, there has been an unprecedented drive for investment in health care infrastructure in the United Kingdom. In fact, since 1997, more than £5 billion have been raised through Private Financing Initiatives.

At the time of this report, in all, 37 PFI schemes have been closed while another 24 have been identified with an additional capital value of £6.7 billion. This last fact alone would lead one to believe that the PFI model is a resounding success story. However, in order to truly assess its value, it is important to consider the circumstances that gave rise to the model in the first place.

Prior to Margaret Thatcher's winning the general election in 1979 and becoming Prime Minister, the UK was experiencing a serious socio-economic decline. In order to achieve the rollback Thatcher knew was imperative, the Prime Minister adopted the approach that wherever reasonably feasible, public sector matters should be shifted to the private sector, leading to the creation of the PFI model.

If one were to take a strictly healthcare perspective, 1,000 of the 1,500 hospitals in the UK predate World War II. One can easily surmise the state of the physical structures, from general disrepair related to age to obsolescence of design and functionality. Additionally, due to a long history of insufficient funding for healthcare, further exacerbated by the Government's deficit, hospital administrators tended to apply whatever funds were procured for clinical services rather than physical upkeep of the hospital structures.

Finally, it should be noted that Margaret Thatcher's rollback also involved considerable privatization. In 1980, Thatcher introduced compulsory competitive tendering (CCT). By 1982, hospitals were introducing competitive tendering for various support services, such as catering, cleaning and maintenance. As a result, hospitals found themselves regularly outsourcing most non-clinical services. By 1997, with the Labour Party and Tony Blair at the helm, CCT was replaced by Best Value, which still required CCT to take place, but with an expanded vision, that is to say that cost would no longer be the sole factor in the awarding of contracts.

1.3 Canadian and UK Expressions of Public-private Partnerships

There are various expressions to connote a legal-financial relationship established between a government entity and a private sector entity for the purpose of creating a project. In the UK, the model became known as a Private Financing Initiative or a PFI. This expression emphasized one of the most significant objectives of the UK Government, which was to obtain private financing for Government-related projects. The detailed legal-financial structure of the typical UK PFI is set out in Section 4.1 below.

In Canada, the expression most commonly used has been a Public-Private Partnership or PPP. Although not legally a partnership, the reference to partnership is to connote a "working together" of the public and private sectors to create a project. While there are differences in the detail between the UK and the Canadian arrangements, the basic structure has typically been quite similar.

However, it is important to note that there is no one structure or model that is legally or financially necessary or appropriate to all circumstances. Rather, it is essential to look at the objectives to be achieved and the particular issues involved in a potential project in order to establish the optimum structure to be utilized by the public authority.

ARTICLE II
GENERAL OVERVIEW OF UK MEETINGS

2.1 The Participants

A total of eight meetings were organized with a view to acquiring a comprehensive appreciation for how PFI works in the UK and the level of success it has enjoyed since inception through both a macro and a micro perspective.

A three-day blitz brought together the Montreal delegation and directors of finance, directors of estates and facilities, finance and investment consultants, project directors, commercial directors, contractors, legal counsel, government officials, hospital CEOs, education directors, and communications managers from the UK.

Meetings were held with:

- International Financial Services London (IFSL)
- Royal Bank Capital Markets
- Royal Bank Capital Markets with Bouyges UK and Bromley Hospitals NHS Trust
- UK Department of Health, Private Finance Unit
- University College London Hospitals NHS Trust
- Darent Valley & Gravesham NHS Trust
- University Hospitals Coventry & Warwickshire NHS Trust with Skanska
- PricewaterhouseCoopers LLP

2.2 General Observations

The initial roundtable discussion at IFSL, a group that promotes the UK PFI model to international markets, brought together a well-rounded group of professionals who provided insight into the PFI model's early beginnings and issues, including but not limited to historical context; lack of reality-based focus; too complex, non-standardized contracts; quality of evaluation of bids; risk assessment; and timeframe. Latter meetings involving individuals from the NHS Trusts brought additional points of view; some positive, some negative.

There was a general consensus that PFI succeeded in bringing the UK's healthcare institutions out of the Victorian Age. That said, many of these same individuals expressed concern with the PFI process, including the enormous trade-offs related to huge transaction costs; the need for strong management to shepherd success; the need to get the hospital design right from the get-go; and the havoc created by unwieldy, exhaustive contracts and constantly-evolving medical practices.

The Project Directors responsible for managing the Hospital following refurbishment or new build were more positive about the process, though they conceded (along with Hospital CEOs) that they had differences of opinion, but that they managed to "work things out". In addition, one got the distinct sense that these Directors were fulfilling their role as "Asset Managers", and keeping a particularly tight cap on the budget. There was a feeling that even a request for an extra electrical socket could pose a problem, and design elements were conspicuously absent overall. Furthermore, Project Directors felt that employees who were transferred to the private sector through outsourcing of support services still held an allegiance to the Hospital while the Hospital CEOs felt they had lost control of the employees. Sometimes, support-services employees remain with the Trust, but are seconded to the private sector with a view to maintaining workers within the healthcare system (as discussed in Section 5.4, item d). However, while interesting, this solution has the potential to confuse the lines of management and accountability.

ARTICLE III
OBJECTIVES OF UK HOSPITAL MODEL

3.1 Fundamental Objective

As previously mentioned, the fundamental objective of the UK Department of Health in implementing PFIs was to refurbish or build desperately needed new hospitals.

3.2 Off Balance Sheet Financing

The most significant objective for the Government, however, was to see that the necessary funds were raised without any impact on its balance sheet. The PFI achieved this goal. Although the Hospitals were in fact repaying the principal and outstanding interest raised by the private sector over the term of the arrangement (typically 30 years), the arrangement would not be deemed a Government obligation and therefore would not represent debt for the Government. Technically, however, the Government is really not "off the hook", as it cannot legally permit a Hospital to go bankrupt (see Section 4.1(f) below). Rather, it will merge it with another or create a recovery plan.

3.3 Inter-relationship of Costs of Construction and Maintenance

The PFI's structure typically obligates the private sector Consortium to create the Hospital at a fixed cost and to maintain the building on an agreed upon arrangement during the term of the concession agreement. Since the obligation to maintain the building is established at the outset, there is greater incentive on the private sector to design and build a building of greater quality, than if the private sector merely had an obligation to build the building without any further obligation with respect to maintenance.

3.4 Risks Transference

In structuring PFIs, the Government attempted to transfer a number of risks to the private sector. For example, the risks of completion of construction on time and for an agreed upon budgeted amount are transferred to the private sector. However, as discussed in Section 6.2, risk of construction costs and ongoing maintenance costs following change were not always successfully transferred.

3.5 Gaining Efficiencies of Private Sector

There is a widely held belief amongst those involved in the PFI process that the private sector has more expertise and, due to its being profit driven, the ability to produce and maintain the overall project over its life cycle at a lower risk cost (determined on present value of a discounted cash flow basis) than projects created and operated by the public sector.

ARTICLE IV
LEGAL AND FINANCIAL STRUCTURE OF HOSPITAL PFIs

4.1 Concept

The basic concept contains the following elements:

(a) The Hospital prepares a business plan for the creation of the Hospital for approval by the Department of Health.

(b) The Hospital prepares the design criteria and performance specifications for the creation and operation of the new Hospital.

(c) The private sector Consortium (the Corporation) is selected through a competitive tendering process.

(d) Historically, the successful proponent was selected based on the best financial offer (on a present value discounted cash flow basis). Currently, qualitative factors are also being included in the selection process.

(e) The corporation designs the plans and specifications for the hospital, based upon the design criteria and performance specifications prepared by the hospital.

(f) The Corporation constructs the hospital.

(g) Most PFIs do not include equipment or related software and intellectual property.

(h) The Corporation arranges for financing for the hospital project, and the project agreement between the Hospital and the Corporation is conditional upon the Corporation obtaining financing. In practical terms, the financing is obtained by virtue of the assignment by the Corporation to the lender of the obligation of the Hospital to make payments to the Corporation for the "availability" of the Hospital and non-clinical services during the term of the arrangement.

(i) The operating term of the concession is typically 30 years.

(j) When the Hospital is completed, all non-clinical matters are operated and maintained by the Corporation. This includes maintenance and repair of the building, cleaning, laundry, food services and parking.

(k) In the event that a change is required by the Hospital, the project agreement contains an arrangement by which the Corporation makes the change at the expense of the Hospital. This arrangement has created problems, as discussed in section 5.2(a).

4.2 Legal Structure

(a) The Hospital enters into a Project Agreement with the Corporation. Typically, the Corporation is a newly incorporated company, the shareholders of which are the members of the consortium. The Hospital typically does not obtain direct covenants of performance from the significant contractors and suppliers that are often members of the consortium and who hold shares in the project Corporation. In addition, the Hospital is obliged to deal directly with the Corporation, rather than members of the consortium providing actual services (since the Corporation enters into subcontracts with the various members of the consortium to provide the necessary elements of the project).

(b) The Project Agreement has an initial term during the construction phase and has an operating term of approximately 30 years.

(c) The Hospital provides a lease to the Corporation, entitling the Corporation to use and occupy the relevant land parcel.

(d) Upon completion of the building, the Corporation then leases back (grants a sublease) of the completed building (the "Building") to the Hospital.

(e) The Project Agreement obligates the Corporation to construct the Building by a certain date.

(f) Upon completion of the Building, the operating period of the arrangement commences. During the operating period, the Corporation is obliged to maintain and repair the Building to an agreed upon standard. The Corporation also provides non-clinical services.

(g) The Project Agreement provides for a series of payments by the Hospital to the Corporation over the operating term, based upon the "availability" of the components of the Building and the non-clinical services provided by the Corporation.

(h) Thus, if a portion of the Building or any of the services are not available, an amount is deducted for the lack of availability of that component.

4.3 Financing

(a) As stated above, the most significant objective of PFIs was the obtaining of financing for Hospitals through the private sector and structuring such financing so that it is not deemed to be debt of the Government.

(b) Accordingly, financing for a Hospital project is arranged by the private sector Corporation.

(c) The private sector consortium typically provides a relatively low percentage of equity, ranging from approximately 10 to 13% of the total Project cost. The balance is arranged through private sector financing.

(d) The Corporation uses, as security, the Hospital's obligation to make the payments over the operating Term of the concession.

(e) There is no direct covenant by the Government to make payments under the arrangement. Nor is there an implied legal obligation for the Government to be responsible for payments required to be made by a Hospital.

(f) Thus, in order to satisfy project lenders, the Government enacted the *Residual Liabilities Act*. This act provides that the Government will not leave a Hospital in bankruptcy. In addition, the Government, under pressure from lenders, also issued a letter clarifying its obligations under the *Residual Liabilities Act*. Nevertheless, there remains no technical, contractual or legal guarantee by the Government of the obligations of the Hospital.

(g) Since there is no contractual or legal guarantee of obligations by the Government, there is not considered to be an obligation to include the obligations for payment by the Hospital as an obligation on the books of the Government.

(h) Because the credit of the Hospital will, of course, be less than that of the Government and since the financing is based primarily on the covenant of the Hospital to make payments during the Term, the interest rate on the financing for the project will be greater than the interest rate of government bonds for a similar period.

4.4 Transfer of Employees

(a) Since maintenance and repairs of the building and non-clinical operations are transferred to the private sector, existing employees would be transferred to the Corporation and new employees would be hired by the Corporation.

(b) As discussed above, the prior practice of outsourcing certain non-clinical services made this concept more acceptable amongst employees and unions.

(c) The Conservative Party initiated the PFI process, including the transferring of operations to the private sector. However, when Labour formed the government they continued the PFI process.

(d) Ultimately, to ease labour issues, the Labour Government recently enacted the Retention of Employment legislation. This legislation provides that where there is a Hospital PFI, existing employees shall continue to be employed by the Hospital, but are "subcontracted" or seconded to the private sector Corporation that manages the employees.

(e) Both before and after the enactment of the Retention of Employment legislation, PFI project agreements provide that employees are entitled to the same wages and benefits while under control of the private sector as the wages and benefits to which they were entitled previously under publicly operated Hospitals.

(f) Thus, Hospitals continue to have the "rate risk" that is, increases relating to salaries and benefits. The private sector Corporation has the "volume risk"; that is, if there are increases or decreases in the number of employees, the Corporation is obliged to accept that burden or benefit from a change in the number of employees.

(g) There is a belief that the private sector manages employees in a more productive and cost effective manner and that this element of risk is thus passed on to the private sector in a PFI. However, we were advised that no studies have been done to confirm this assumption.

4.5 Information Technology and Equipment

(a) Although there are several exceptions, generally, PFIs have not included information technology and equipment that are typically obtained by the Hospital in a separate contract.

(b) A number of issues arise where an attempt is made to include both the Building and the information technology and equipment in the same contract:

(i) The Hospital loses the opportunity to make its own selection of the suppliers of each of the components;

(ii) The Hospital also loses the opportunity to deal directly with suppliers if subsequent issues arise, since the Corporation would be the only direct contractor with the Hospital.

ARTICLE V
ASSESSMENT OF PFIs

5.1 Benefits of PFIs

(a) The most significant benefit cited was the fact that PFIs provided financing to create new Hospitals that would not have otherwise been created.

(b) A number of risks previously borne by the public sector are transferred to the private sector in a PFI, such as completion of the building on time and the degree of repairs required over the operating Term. However, issues have arisen regarding the actual benefit of certain of these "risk transferences" in practice (as discussed in section 5.2).

(c) Because the private sector is responsible for maintenance and repairs during the 30-year term of the arrangement, buildings are much better maintained under PFIs.

(d) The prior procurement arrangements had been conducted in an unsatisfactory manner, resulting in projects being completed at significantly greater than budgeted amounts. Because PFIs are conducted under competitive processes, an indirect benefit of the PFI structure has been a significant improvement in the public procurement process in the UK.

(e) There is a belief that the involvement of the private sector has resulted in an overall reduced cost (on a discounted cash flow, present value basis) for PFI projects from the overall cost which would have been incurred if the public sector created and operated the Hospital on its own. We were advised that to date, no objective studies by official audit bodies have been conducted to determine if this assumption is correct.

5.2 Concerns with Hospital PFIs

(a) Dealing with Change

One of the most significant problems raised by Hospital CEOs was the difficulty and costs incurred in dealing with change. As they noted, the provision of clinical services within a Hospital setting requires significant flexibility to deal with change that occurs on a frequent basis. Responding appropriately to change is fundamental to the provision of quality medical care.

In many instances, dealing with clinical change requires changes to the physical structure. Where this occurs, the project agreements contain procedures that have been acknowledged by both Hospital CEOs and Department of Health officials as being inadequate because:

(i) The Corporation is the only party entitled to make the physical change and thus, the Hospital has no realistic financial leverage. Thus, changes prove very costly to the Hospital.

(ii) The Corporation often takes the position that the risk profile increases as a result of the change requested by the Hospital and it is no longer responsible. Thus, a required change often derogates from the original transfer of risk from the Hospital to the Corporation.

(iii) The documentation contains "academic procedures" that often do not work in practice and result in delays, disputes and unrealistic timeframes within which the Hospital must make decisions.

(iv) The procedure and the fees to which the Corporation is entitled merely for providing an estimate of costs for the change are weighted heavily in favour of the Corporation.

(b) Inhibiting Actions of Hospital Management

Discussions with Hospital CEOs and on-site heads of private-sector corporations reveal that there is, in practice, "dual management". In theory, there is a clear separation between clinical services that are operated by Hospital management and non-clinical matters that are operated by the Corporation's management.

In practice; there is a great deal of cooperation and coordination required between the two elements in order for the clinical services to function properly. In a Hospital "owned and operated" by the public sector alone, there is also coordination required between clinical and non-clinical services. However, because they both fall under the same management control, decisions can be made effectively and priority can be given to clinical requirements where the Hospital's senior management determines that such priority is medically necessary.

In the PFI model, there is duality of control that requires cooperation. We were advised that it is not uncommon for disputes to arise between management of each of the components resulting in a degree of frustration on the part of Hospital CEOs, a loss of efficiency and increased costs to the Hospital.

Hospitals are far more complex to operate than many other public facilities in which public private partnerships transfer operations to the private sector (such as a highway).

(c) Monitoring Service Performance

The project documentation is set up in a manner that contains prescribed service levels which, if not met to degrees specified, ultimately result in financial penalties to the Corporation. The project agreements provide for self-monitoring by the Corporation with periodic reports to the Hospital.

→ Hospital CEOs advised us that, in fact, self-monitoring is not effective. The Hospital, as a practical matter, must monitor the services being performed. This requires Hospital staff time and often involves the employment of a person specifically engaged in monitoring the Corporation, which results in increased costs to the Hospital.

(d) Cost of Payment

As previously mentioned, the contract with the Corporation is generally for a minimum of 30 years. During that period, the tenant will essentially pay to the landlord the equivalent of a mortgage. Assuming a 6% interest rate, the annual rental cost will represent approximately 7.2% of the initial capital investment and, given the long amortization → period, the tenant will have paid after 30 years the equivalent of two times the initial capital cost.

Various stakeholders advised us that the costs associated with occupancy and operating costs payable to Corporations under PFI arrangements are higher than those previously → incurred (partially because of the high capital cost), representing close to 20% of the operating budget (including physicians' Income). By comparison, in Québec, the operations and maintenance of facilities represent approximately 6.2% of the operating budget (excluding physicians' income).

It should be noted that, unlike Québec, in the UK system the various health trusts receive funding from the Department of Health for asset depreciation in their operating budget.

(e) Timing of PFI Process

→ While the time period from the initial desire to create a Hospital to the date that the Hospital is constructed and opened has dramatically improved under the PFI process, the time and costs of the process itself are both significant.

Both the Department of Health and the private sector representatives expressed concerns over the time involved in the proposal call process, typically taking approximately two years until the agreements are finalized and the financing has been arranged. In addition to the resultant delay in commencement of construction of the Hospital, there is a significant cost to the private sector preparing a proposal. The delay is significant from the perspective of the Hospitals. In addition, the costs to unsuccessful private sector bidders has become a significant concern to the Department of Health

because of an expected reduction in the number of bidders and the lessening of competition within the private sector.

(f) Scope of Project

UK Health Department officials have come to the realization that there is a maximum size (approximately £400 to £500 Million) for a PFI project. Projects in excess of that amount not only lose the financial advantage of size and scale, but also lose potential bidders unable to bid on a project of such scale. This results in a decrease in competition, which is detrimental to the public sector.

In a similar manner, large-scale refurbishment projects (such as Barts NHS Trust) have proven to be unduly long in the planning and proposal call stage and unduly expensive.

(g) Inter-relationship of Financial Close and Completion of Construction Drawings

One of the significant benefits of PFIs is the transference of the risk of exceeding the budgeted project costs to the private sector. However, a problem has arisen resulting in a reduction in the benefit of the expected risk transference. This arises as the date on which the agreement becomes finalized and financing is secured (the "Financial Close") typically occurs before the plans and specifications for the Building have been completed in sufficient detail to be "construction documents" (that is in sufficient detail to commence construction). The reasons for this are the time required to complete construction documents and the fact the Corporation is typically not prepared to take the risk of expending significant funds for the completion of construction documents prior to a binding agreement existing with the Hospital and the assurance that the Corporation has obtained financing for the project on terms satisfactory to the Corporation.

Thus, we were advised that it is not uncommon that the agreed upon plans and specifications between the Hospital and the Corporation are not sufficiently detailed and, as a result, the Hospital is forced to pay for "extras", thereby significantly increasing the expected costs. As a result, the expected transfer of risk to the private sector for increased construction cost is not effected.

(h) Absence of Covenants from Subcontractors

The project agreements are structured as a contract that is between the Hospital and the Corporation alone; that is, the contractors performing services such as construction of the Building and the subsequent provision of services during the operating period are not a party to the contract with the Hospital. This is the case in all circumstances, including those in which the contractors are also shareholders of the project Corporation. As a result, there is no direct contractual obligation by the contractors in favour of the Hospital. Not only can the Hospital not make legal claims against these contractors but also, when a problem arises, the Hospital must deal with the representative of the Corporation who then acts as an intermediary in dealing with the contractors.

(i) Absence of Design and Quality Indicators

The UK Hospital projects visited and/or discussed within the framework of the meetings are visibly behind North American standards in terms of design, both from an aesthetic perspective and a functional one. Single patient rooms are the exception, while four beds per room and 28-patient wards widely accepted. Any flourishes to promote a "healing environment" are Spartan at best. There is a public expectation in North America for single patient rooms and "state-of-the-art" facilities capable of accommodating the latest technologies. These cultural differences and their impact on design and quality, as well as value for money spent, beg analysis. However, there are no studies to rate value for money in this area.

ARTICLE VI
APPLICATION OF NEW PFI MODEL TO MUHC

6.1 Introduction

While the UK model has characteristics that could benefit the MUHC, it is our conclusion that as a result of certain material and cultural differences that exist in Québec from those of the UK and as a result of the problems that have resulted in the operation of Hospitals created by the PFI model described above, the MUHC should seek to create an alternative structure which would provide the benefits that would be available under the PFI model, while avoiding the problems that may arise if the MUHC followed the PFI model.

6.2 Labour Issues

One of the significant benefits of the PFI model is the transfer of non-clinical services and operations to the private sector. Labour laws in the UK require existing employees to be assumed by the private sector performing the services. However, as noted above, in the UK there had been a history of outsourcing non-clinical services prior to utilizing PFIs. Although there were certain labour concerns in the UK, it was not regarded as a significant issue. In addition, as discussed above, the Labour Government recently passed legislation to alleviate certain labour concerns.

If the MUHC were to transfer non-clinical services to the private sector, the following issues would arise:

(a) The collective agreements entered into by the MUHC with its unions provide that any employee having more than two years of seniority who is laid off is entitled to payments from the MUHC equivalent to the salary provided for that individual's job until he or she has been replaced in another position in the Health and Social Services sector. Thus, if the MUHC entered into a PPP in which the private sector was not responsible for assuming employees, the MUHC would be faced with a significant contingent liability.

(b) On the other hand, if the private sector party assumed the MUHC's employees, the collective agreements entered into by the MUHC provide that the new employer must provide the employees with all rights to which they are entitled under the present collective agreement. This may prove to be a serious obstacle to the private sector.

(c) As in the UK, the Québec Labour Code contains "successor rights" provisions that would obligate the private sector party to be bound by the collective bargaining agreement of the MUHC if it took over a business undertaking of the MUHC (such as food services). However, a new section (Section 45) of the Labour Code provides that if most of the elements of an operation are not transferred, the transferee will not be bound by the collective agreement. While the new Section 45 may provide a technical means of attempting to avoid the existing collective agreements in the transferring of non-clinical services (by transferring a portion but not all of the present undertaking) the matter would not be beyond doubt and it is likely that the unions would contest the matter aggressively.

(d) In addition, it should be noted that the labour climate appears materially different in Québec than that of the UK. The transference of non-clinical services to the private sector is not regarded as a significant practical problem in the UK, whereas the transference of non-clinical services to the private sector by the MUHC may well raise significant issues with labour that would detract from the overall objective and defer the creation of the needed new medical facilities.

If it is determined that it would be inappropriate to transfer non-clinical services to the private sector because of labour issues, one of the most significant advantages of the PFI model, that is, of the private sector carrying out non-clinical services, would cease to exist.

In addition, if the maintenance and repair of the facilities constructed by the private sector were not transferred to it, one of the benefits attributed to the PFI model, being the inter-relationship of the initial cost of the facility with the ongoing obligation for maintenance and repair would also be lost. As discussed, one of the advantages of the PFI model is that the Corporation creating the hospital facility would create a quality structure since it is obligated to perform subsequent maintenance and repair for an agreed upon fee.

6.3 Requirement for Change

As discussed above, one the most significant criticisms of the PFI model came from Hospital CEOs (and acknowledged by representatives of the Department of Health) and was related to the difficulties in dealing with change. It would appear that even if the project documents contained improved mechanisms to deal with change, significant problems would remain given the nature of the requirement for change in Hospitals. It should be noted that the need for flexibility to deal with frequent material change does not occur in many other types of infrastructure projects to the extent that it is the case with Hospitals. This raises a material issue with respect to the use of public-private partnerships for Hospitals.

6.4 Duality of Control

As mentioned in above, the transference of non-clinical services to the private sector results, in practice, in a duality of decision-making and control within a Hospital setting. This reduces expediency in decisions, adversely affects the paramountcy of decisions relating to medical/clinical matters and creates additional significant costs. As with other issues discussed above, if an attempt is made to avoid this issue by eliminating the transference of maintenance and repair to the private sector, one of the significant advantages of the PFI is eliminated.

6.5 Conclusion

In conclusion, there are significant issues in applying the PFI model to the MUHC project in Québec. Labour issues are more significant, resulting in the questionability of transferring non-clinical services as well as maintenance and repair of the Building. In addition, the need for flexibility in a Hospital, the complexity of Hospital functions and the need for paramountcy of clinical/medical matters raises fundamental questions as to the use of the PFI model for the MUHC.

There remain benefits with respect to certain aspects of the PFI model, which could be applicable in Québec if no alternative solutions were available. For example, the ability to obtain financing to create Hospitals without increasing government debt is a significant matter. Thus, the challenge is to determine whether there are alternative structures that would create the benefits available in a PFI model without burdening the MUHC with the difficulties resulting from the use of the PFI model.

ARTICLE VII
ALTERNATIVE STRUCTURE

7.1 Objective

The objective in creating an alternative structure would be to create a structure that achieves the benefits of the PFI model but avoids the issues created by said model. In proposing an alternative structure, it will be assumed that the labour issues are significant and accordingly, the arrangement should avoid the transference of maintenance and repair obligations as well as non-clinical operating services, such as laundry and food services.

7.2 Basic Concept

The basic concepts in an alternative approach would be:

(a) Financing:

- With the assistance of a financial advisor, such as an investment bank, the MUHC, through a newly incorporated subsidiary (ProjectCo) would raise capital for the new project through the sale of bonds to the public. The bonds would contain a covenant of the MUHC for payment, but would contain no guarantee or direct obligation of the Province of Québec. Thus, funds raised would not deem to be the debt of the Province and would be "off balance sheet" to the Province.

- The Province of Québec would provide a "comfort letter" with respect to a general intention to continue to provide annual funding to the MUHC during the term that the bonds remain outstanding. However, this would not represent a legal obligation on the part of the Province.

- In addition, the bond financing would provide a significant practical benefit to the project. The lender administering funds for the bondholders would create a system to control costs of construction, avoid costly change orders and ensure completion in accordance with the requisite plans and specifications. While the MUHC would also have controls in place to deal with these matters (as described in subparagraph (b) below) the existence of a private sector lender would add an additional level of protection by an entity having an interest in the project and being experienced in controlling project costs.

(b) MUHC (through ProjectCo) would make an initial assessment as to whether existing personnel at the MUHC have the experience and ability to manage the project or whether the services of a project manager, or a developer who would act as project manager, should be engaged. Thus, either internally or through a combination of internal and external assistance, the MUHC would ensure that it would have available to it, personnel with the ability to create and manage the project.

Subsequently, ProjectCo would:

- Engage a firm of architects to prepare plans for a new Hospital;
- Upon the plans being resolved in sufficient detail, conduct a public tender process for general contractors to build the new Building on a fixed price contract; and
- Obtain indicative pricing for the project from its project advisors (or a separate quantity surveyor engaged for this purpose).

(c) The MUHC would utilize a proposal call process to encourage competition within the private sector to secure competitive pricing and a quality product.

(d) Upon completion of the new Hospital, the MUHC would operate the Hospital and have sole control over clinical and non-clinical services. As a result, the MUHC would remain in complete control and no new labour issues would arise.

7.3 Achieving Objectives of the MUHC

(a) Financing

The aforementioned suggestion will require the advice of an investment banker to confirm the feasibility and costs of financing. It should be noted that a similar approach has been used successfully in two projects in Ontario, one of which was a hospital project.

(b) Off Balance Sheet Financing

The financing would be structured, as outlined in Section 8.2 above, such that the funds raised will not be deemed to be debt of the Province, and thus will be "off balance sheet" to the Province.

Thus, the objective of the financing approach is to obtain financing for the project at a favourable rate of interest without the debt being deemed to be debt of the Province.

(c) Avoidance of Construction Cost Risk

One of the benefits described in relation to PFIs is the transference of construction costs risk to the private sector. A structure would be put in place to achieve the same result. It would include:

(i) Obtaining third party expertise where required;

(ii) Obtaining advice on anticipated project costs prior to embarking on the tender process;

(iii) Obtaining security from contractor, such as bonding and completion guarantees;

(iv) Entering into a fixed price contract based on plans which are sufficiently detailed to avoid issues and resultant increases in cost;

(v) Preparation of specifications (with expert advice) to ensure quality of initial Building and reduce subsequent life-cycle costs; and

(vi) Receiving the benefit of controls that would be put in place by the private sector lender.

(d) **Benefits During Operating Period**

The concept outlined above provides the MUHC with the freedom during the operating period to:

(i) Obtain the most cost effective alterations where change is required, by use of a competitive process;

(ii) Operate a Hospital in a manner that ensures that clinical priorities remain paramount, without the burden of dual decision-making with a private sector "partner".

ARTICLE VIII

RECOMMENDATIONS

8.1 General

It is recommended that the MUHC only proceed with a "public-private partnership" within a structure that meets the objectives of the MUHC, as well as the practical realities of effecting a new Hospital project in the Province of Québec.

8.2 Proposal Call

In order to ensure a competitive process and obtain the optimum arrangement for the MUHC, it is suggested that a proposal call process be utilized.

8.3 Elements of Arrangement Transferred to Private Sector

It is recommended that:

(a) The design and construction of the project be transferred to the private sector, subject to design guidelines and controls established by the MUHC in the first instance;

(b) Financing be obtained through the private sector, in the manner described in section 8.4 below;

(c) Non-clinical operations, such as food services and laundry, as well as alterations, maintenance and repair of the building be retained by the MUHC. Our reasons for this recommendation are as follows:

- The retention of these services will avoid both legal and practical labour issues.

- The exclusion of the private sector developer from ongoing alterations, repairs and maintenance does not deal with the perceived UK benefit of the developer building a quality building because it will subsequently be responsible for repairs and maintenance. However, the issue of the quality of construction can be dealt with through controls over the plans and specifications, the involvement of experienced project advisors and a competitive process amongst interested developers.

- In addition, the exclusion of the private sector developer from the responsibility for alterations, maintenance and repairs avoids one of the most problematic areas in the UK; that is, the serious difficulties faced by Hospital CEOs who are thwarted in meeting clinical priorities as a result of a duality of control with the private sector.

- In addition, the exclusion of the private sector from alterations, repairs and maintenance avoids the serious problems faced in the UK of the significant costs incurred and time delays when alterations are required to the physical facility to meet the changing requirements of a healthcare centre. As discussed above, the need for change in a healthcare facility over the life of a project is often far more significant than in other public-private initiatives.

8.4 Finance

(a) We recommend that financing be obtained through the private sector, but not through the agency of the developer constructing the project, if possible.

(b) The involvement of the private sector developer in the financing adds an additional cost to the financing, notwithstanding that the essential element in the developer obtaining the financing would be the covenant of the MUHC to make payments over a period of time. In addition, the involvement of the developer's lender will add additional complexity to the documentation to be entered into by the MUHC with the developer in order to satisfy the requirements and demands of the lender.

(c) Thus, the financing approach outlined in section 7.2 above is recommended; namely, that:

- A financial advisor be retained by the MUHC;
- The MUHC create a new subsidiary (ProjectCo);
- With the advice of the investment banker, ProjectCo raises capital for the project through the sale of bonds to the public;
- The bonds would contain a covenant of the MUHC for payment, but would contain no guarantee or direct obligation of the Province of Québec;
- The Province of Québec would provide a "comfort letter" with respect to a general intention to continue to provide annual funding to the MUHC during the term that the bonds remain outstanding;
- The existence of the bond financing would provide an additional, significant practical benefit; that is, the lender administering funds on behalf of bondholders would create a system to ensure that costs of construction are controlled and costly change orders precluded.

8.5 Conclusion

We believe that the approach and structure set out in the recommendations above best meets the objectives of the MUHC, as well as the practical issues of creating a new Hospital project. We also believe that the differences suggested from the structure used in the UK will avoid the current problems with existing UK PFI projects, while retaining a number of the beneficial elements.