HEU REPORT

on the

ABBOTSFORD REGIONAL HOSPITAL

and

CANCER CENTRE

"Achieving Value for Money" Report

December 2005

Table of Contents

Executive Summary

The Abbotsford Regional Hospital and Cancer Centre project is a public-private partnership agreement (P3). Under the 33-year-long agreement, the Fraser Heath Authority will deliver clinical services in a facility to be built and maintained by Access Health Abbotsford, a private consortium.

In February 2005, Partnerships BC released its *Achieving Value for Money* report on the Abbotsford project. The report's primary finding was that the P3 agreement represented "value for money" and was thus in the public interest.

The Hospital Employees' Union (HEU) has serious concerns about the methods and findings of the *Achieving Value for Money* report. In this document we point out problems in the report's comparison of public and private financing options. We also identify pressures on the Office of the Auditor General of BC, which reduced its examination of the project from an audit to a review. Finally, we offer a general critique of the P3 model for constructing and operating new hospitals.

Scrutiny of the Abbotsford process is essential because P3s are a radical departure from the traditional delivery of public services and are, in fact, a form of privatization. In a P3, the private sector not only designs and builds the infrastructure but also operates and/or finances some or all of the project. Under these conditions, the public may face significantly increased risks.

Nevertheless, the BC Liberal government is clearly committed to private sector delivery of public services through P3s. The BC Ministry of Finance created Partnerships BC with a mandate to promote and enable P3 projects. In turn, Partnerships BC created Health Co for the sole purpose of developing the P3 contract to build and operate the Abbotsford hospital. The Abbotsford process was launched and showed no sign of letting up, despite many troubling facts:

- the project had only one bidder;
- no BC company was involved in the bid;
- total construction costs rose over 68% (from $211 million to $355 million) during the bid and negotiation stages;
- estimated service payments to the P3 consortium doubled to nearly $41 million per annum; and
- total costs for the operational contract skyrocketed by 94% (from $720 million to $1.4 billion).

Yet these issues are only part of our concerns about the project.

Value for Money?

The assessment of whether a P3 project is "value for money" is determined by comparing the estimated costs of the P3 bid with the estimated costs of conventional procurement (the public sector comparator). These are sophisticated calculations, involving complex accounting methods.

We have serious doubts about the treatment of two elements in *Achieving Value for Money's* comparison: 1) risk transfer, and 2) discount rates. We believe that

Partnerships BC has failed to assess these critical factors in a thorough and transparent fashion.

Risk transfer: Illusionary savings, heightened perils

No one disputes that the direct financial costs of privately built projects are greater than publicly built projects. In regards to Abbotsford hospital, Partnerships BC acknowledges that the P3 option is $35 million more expensive to build.

But Partnerships BC asserts that the higher financing costs are more than offset by risk transfer to the private sector, estimated at $49 million over the life of the Abbotsford project. Yet their estimate is not based on a comprehensive study of the Abbotsford situation.

Risk transfer is highly subjective and not well understood. To date, the only aspect of contractual risk transfer to be extensively studied is the ability of P3 consortia to construct projects "on time and on budget." Yet even this criterion raises questions. A recent study from the United Kingdom found that:

- P3 consortia charge a premium of approximately 30% to guarantee on-time, on-budget construction; and
- this 30% premium greatly exceeds the costs of actual overruns, based on existing data.

More significantly, this aspect of risk transfer may be irrelevant in the Abbotsford context. Any value from Access Health Abbotsford's ability to perform on time has been negated by protracted P3 contract negotiations. The original plan -- public construction of the new facility -- was slated for a 2005 completion date. The P3 option will not be completed until 2008, adding $68 million in inflationary costs to the project.

In another vein, the potential value of risk transfer is further diluted by the fact that Access Heath Abbotsford has no other assets. The transnational parent consortium that created Access Health designed it as a subsidiary whose sole purpose was to deliver the Abbotsford project. If unexpected risks arise, the parent companies are immune and all risks will revert to the public purse.

Indeed, the Abbotsford P3 project leaves many risks in the public sector and threatens to increase others. The Supreme Court of Canada has ruled that responsibility for public safety remains with the public, regardless of privatization arrangements. For example, if infection rates were to increase at the new Abbotsford hospital, the public sector would be held responsible even though the community neither controls nor maintains the facility.

Other risks that remain in the public domain in the Abbotsford hospital project are:

- inflation risks;
- costs associated with contract enforcement;
- problems associated with self-monitoring and self-reporting;

- problems associated with the length of the service contract (e.g., costs related to changing clinical practices that necessitate a contract revision);
- risks and costs if Access Health Abbotsford fails to provide an acceptable level of service;
- costs associated with changes to labour law and practices; and
- risks associated with providing hospital support services during natural disasters or relief events (i.e. increased patient volume and demand).

Discount rate: Ignoring the contemporary standard

Financial comparisons of public and private options use a discount rate, essentially a form of depreciation to assess costs of capital and services over time. (The discount rate considers factors such as inflation and interest rates.) In a nutshell, the higher the discount rate, the lower the projected costs of a P3 option.

We are very concerned that the discount rate used in *Achieving Value for Money* distorts the long-term costs of the Abbotsford hospital project. Partnerships BC applied a rate of 6%: 30 years of annual payments were discounted at a real rate of 6% annually. The result represents the future costs of the project expressed in today's dollars (net present value). Based on the 6% discount rate, Partnerships BC determined that the Abbotsford P3 option was cheaper than the public option.

But the 6% discount rate is unreasonably high and misrepresents the picture. In the United Kingdom, widespread scepticism about the accuracy of the 6% discount rate resulted in lowering the rate to 3.5% in 2003. Subsequently, researchers found that no P3 hospital in the UK was, in fact, cheaper than a publicly procured project.

Partnerships BC did conduct a sensitivity analysis using discount rates of 5% and 7%. They determined that at 5% the projected benefit of the P3 option declined to a mere $13 million. They did not, however, apply the UK's standard of 3.5%.

HEU did a comparison using the 3.5% discount rate: The public option was revealed to be *at the very least* $150 million cheaper than the P3 option.

Restricting the Auditor General

British Columbians deserve an impartial assessment of the Abbotsford hospital project and its merits. The Office of the Auditor General of BC was expected to assist in this appraisal. However, the Auditor General's role and independence have been significantly constrained by the provincial government.

The Auditor General initially requested $250,000 to conduct an independent audit of the $1.4 billion Abbotsford project. Instead, the office's budget was cut by over $800,000 (10%), which forced the Auditor General to perform a review rather than an audit of the P3 scheme.

Audits and reviews are completely different processes. A review is a low-level examination with the limited objective of assessing the plausibility of the client's information (in this case, Partnerships BC). A review does not require the Auditor General to seek supporting or independent evidence. The Auditor General's review concluded that information in *Achieving Value for Money* was plausible.

Despite the review's severely narrow scope, both the provincial government and the media interpreted it as a sign that the Auditor General had pronounced the Abbotsford hospital to be a sound project. One reporter claimed that the Auditor General had gone over *Achieving Value for Money* with "a fine-toothed comb." In fact, the Auditor General was unable to do any such thing.

The HEU is also concerned that the Auditor General has entered into a quasi-private contractual relationship with Partnerships BC. It also appears that the review was all or substantially completed and the draft report reviewed by Partnerships BC before it agreed to the terms of the review. We are troubled that this unusual relationship may affect the AG office's ability to protect the public interest.

P3s – A Failing Model?

More generally, the HEU is very concerned that British Columbia is aggressively pursuing the privatization of public services, despite growing evidence of flaws in the P3 model. In particular, researchers in the UK have amassed strong data regarding problems with P3s.

Throughout the 1980s and 1990s, the UK made extensive use of the P3 model for health care. Today, the approach finds little support and much criticism among experts. The prestigious *British Medical Journal* (including their online edition) has published over 100 articles, studies, letters and responses on the topic of Private Finance Initiatives (PFIs), the British version of P3s. To date, the journal's editor has been unable to either secure or commission an article that cogently argues the case for PFIs.

In 2004 the Association of Chartered Accountants in Britain slammed hospital PFIs as:

- a costly financing of public services;
- leading to cuts to public services and/or tax increases;
- offering little effective risk transfer; and
- often leading to much higher than anticipated charges a few years after contract signing.

The National Health Service Consultants' Association sent an open letter of warning to the Canadian Medical Association, on the eve of a debate about health care privatization in August 2005. The British physicians' body, representing 650 specialists in a range of practices, made a scathing indictment of PFIs and other types of private sector involvement in health care.

In Summary

We are calling for a comprehensive audit of the Abbotsford project, in light of the negative evidence regarding P3s and the specific concerns raised in this report.

The Auditor General of BC must be provided with adequate resources to independently analyze the discount rate, the value of risk transfer, and other critical issues.

Introduction

The Abbotsford Regional Hospital and Cancer Centre project is a long-term public-private partnership (P3) between the public sector and a private consortium, Access Health Abbotsford.

Under the agreement, the Fraser Health Authority will provide clinical services, while Access Health Abbotsford will build and maintain the facility, and provide facility management services including housekeeping, food, laundry and linen services.

In February 2005, Partnerships BC released *Achieving Value for Money,* a report on the Abbotsford project. The report's primary finding was that the final P3 agreement represented value for money. This conclusion was primarily reached by comparing the estimated cost of the P3 agreement with the estimated cost of a publicly financed and built hospital.

The Hospital Employees' Union (HEU) has serious concerns about *Achieving Value for Money.* We question the report's methods of estimating the costs and risks of a public-private partnership for the Abbotsford hospital. In particular, we are critical of Partnerships BC's assessment of the value of risk transfer and their use of an outmoded discount rate in the public sector comparator.

The HEU is also alarmed by the decision of the Auditor General of BC to limit its scrutiny of the Abbotsford project. Due to budget restraints the Auditor General conducted a review only of the $1.4 billion project, rather than a rigorous audit as originally planned. This review falls far short of being an independent analysis of the assumptions and data provided by Partnerships BC, yet was touted by the government as proof of the credibility of *Achieving Value for Money.*

We are also concerned that the public interest is not being safeguarded. The decision to proceed with a public-private partnership in Abbotsford seems to have been carved in stone despite escalating costs, increasing public risk, and a lone final bidder on the massive project.

The nature of Partnerships BC (PBC), the agency in charge of the procurement process, gives a clue to this full-steam-ahead mentality. The agency is a wholly owned subsidiary of the BC Ministry of Finance and was created to facilitate P3s for the province. Partnership BC's success is largely measured by the number of P3 deals that are finalized. In light of this, the HEU has serious questions about whether the public interest can be properly served by PBC's involvement in the Abbotsford (and other) projects.

We begin with a chronology of key events associated with the Abbotsford Regional Hospital and Cancer Centre project.

Chronology of the Abbotsford P3 Project

The Fraser Valley has needed a new public hospital for a very long time. Cramped and aging structures at regional hospitals have failed to keep up with the area's rapid population growth.

April 2001. The NDP government releases plans to build a publicly financed hospital and cancer centre in Abbotsford, to be completed in 2005.

May 2001. A new Liberal provincial government is elected. They ask Price Waterhouse Coopers (PWC) to make a presentation to the government's transition team on the benefits of P3s. The presentation cites efficiency, innovation, "off-balance-sheet accounting" and the buy-now-pay-later ethos of public-private partnerships.[1]

September 2001. PWC issues a confidential project feasibility study for a 300-bed hospital and cancer centre in Abbotsford, to be procured as a public-private partnership. Construction costs are set at $211 million, with annual lease payments to the private consortium of $20 million. Over the 33-year contract, total P3 project costs are estimated at $720 million, with no up-front public financing of the building. Delivery of the hospital is slated for December 2007.[2] The study's "value for money" comparison uses a 6% discount rate and a 17% risk transfer, which are typical of Private Financing Initiatives in the United Kingdom at the time (PFIs are the equivalent of P3s). The private sector option is projected to cost $2.6 million less than a publicly financed and managed hospital.[3]

May 2002. Forensic accountant Ron Parks does an independent analysis of PWC's feasibility study. His findings are used to inform the public about the P3 initiative. (Parks is able to recreate the deleted data, even though all figures were erased from the report.[4]) He cites extensive evidence about the tentative and speculative nature of the study's claims. Both Parks and the PWC study warn that the data provide no definitive basis or conclusive case for a decision to pursue a P3. The data are described as "very rough" and the expected benefits marginal at best.

Parks adds that these benefits will erode and may vanish entirely when full project costs are factored in (e.g., contract monitoring, legal advice and consulting fees). He also notes that the existing process is neither open nor transparent, and that a full review by the Auditor General is needed to ensure that the public interest is met. [5]

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[1] Price Waterhouse Coopers, Power Point Presentation to the Liberal transition team, May 2001.
[2] Partnerships BC. *Project report: Achieving Value for Money. Op Cited.12 & 30.* –
[3] Parks, Ron & Malcolm, Derek. *Review of the Initial Evaluation of the Public Private Partnership for the Fraser Valley/Eastern Fraser Valley Cancer Centre.* Hospital Employees Union. May 2002.
[4] Because of a technical error in how the data was eared, it was possible to recreate the tables in the PWC report using relatively straight forward computer techniques.
[5] Parks, Ron & Malcolm, Derek. *Review of the Initial Evaluation of the Public Private Partnership for the Fraser Valley/Eastern Fraser Valley Cancer Centre*. Op- Cited.

June 2002. Partnerships BC (PBC) begins operations. The agency's mandate is to promote public-private partnerships, and its primary focus is to procure public services and infrastructure as P3s. The agency takes over management of the Abbotsford hospital project on behalf of the Fraser Health Authority and the Ministry of Health. PBC creates a subsidiary, Health Co, to represent the public interest.[6]

September 2002. Plans for the Abbotsford hospital project change:

- building costs rise 19%, from $211 to $251 million[7];
- annual lease payments increase 75%, from $20 million to $35 million; and taxpayers must pay a $71 million advance, through the Fraser Valley Regional Hospital District.

Despite cost increases and changes in the P3's scope, officials from Partnerships BC confirm that the provincial government is unwilling to reconsider the P3 option.[8]

November 2002. BC Treasury Board decides to proceed with a public-private partnership for Abbotsford hospital, based largely on the uncertain findings of the PWC feasibility study.[9]

January 2003. Expressions of Interest are requested for a 33-year contract to design, build, finance, and operate the new hospital.[10] Four consortia respond: Access Health Abbotsford, Fraser Valley Health Partnership, The Healthcare Infrastructure Company of Canada, and Vancouver Health Care Group.

September 2003. Request for Proposals and Draft Project Agreement are released to bidders.[11] The public is denied the opportunity to evaluate the Draft Project Agreement, which is deemed "commercially confidential."

The RFP includes more budget increases:

- building costs rise to $328 million;[12] and
- annual lease and service payments rise from $35 million to $40 million.[13]

November 2003. Two bidders drop out of the bidding process (Fraser Valley Health Partnerships and Vancouver Health Care Group).[14]

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[6] Partnerships BC. *Annual Report 2002/3.*
[7] Partnerships BC. *Project Report: Achieving Value for Money*. Op Cited. 12.
[8] Beyak, Trudy. *Abbotsford News*, October 4, 2003.
[9] Partnerships BC. *Project report: Achieving Value for Money* Op Cited. 16.
[10] *Ibid* Page 14.
[11] Ibid. 16.
[12] Ibid. 12.
[13] Ibid. 16.
[14] Beyak, Trudy. "Competition for Abbotsford P3 hospital down to two." *Aldergrove Star*, December 11 2003.

December 2003. A follow-up report by forensic accountant Ron Parks warns that, based on available information, cost increases and changes to the project "warrant a revaluation of the decision to pursue with a P3."

Changes since the PWC feasibility study in September 2001 include:

- doubling of lease and service payments, from $20 million to $40 million annually;
- increased construction costs, from $211 million to $328 million;
- 15% increase in the hospital's size, with no increase in the number of beds; and
- total estimated costs increase over the life of the contract, from $720 million to over $1.4 billion

BC Treasury confirms that the Abbotsford project must be accounted for on the province's books, removing the incentive for off-balance-sheet accounting.[15]

January 2004. Yet another bidder withdraws (The Health Care Infrastructure Company of Canada), leaving only "preferred proponent" Access Health Abbotsford.

March 2004. Lewis Auerbach, a former director of the Office of the Auditor General of Canada, issues a report that raises serious concerns:[16]

- Risks associated with the Abbotsford project may be beyond the financial capacity of the private consortium.
- The 30-year contract is too long and may prevent taxpayers from sharing savings from productivity improvements and rapid technological advancements.
- Secrecy surrounding the contract undermines public accountability.

April – December 2004. Sole bidder Access Health Abbotsford submits its final offer and is awarded the contract. Construction costs increase to $355 million.[17]

February 2005. Release of Auditor General's review and Partnerships BC's *"Achieving Value for Money"* report. Full details of the Project Agreement are withheld for reasons of "commercial confidentiality." PBC reveals that Access Health Abbotsford's bid "exceeded the RFP target for capital costs."[18]

[15] Parks, Ron. *Review of the Request for Proposals: Abbotsford Hospital and Cancer Centre.* Hospital Employees Union. December 2003.
[16] Auerbach, Lewis. *Commentary on Abbotsford Hospital and Cancer Centre RFP.* Auerbach Consulting Services. March 2004.
[17] Partnerships BC. *Project report: Achieving Value for Money.* Op cited.
[18] Ibid. 15

1. The Public Interest: Who Does Partnerships BC Really Serve?

Partnerships BC and its subsidiary, Health Co, are the two agencies responsible for procuring the Abbotsford hospital as a public-private partnership. The nature of these two bodies raises significant concerns as to who is protecting the public interest.

1.2 The mandate of Partnerships BC and Health Co

Partnerships BC (PBC) was created in June 2002 as an agency of the BC government. Its sole shareholder is the Ministry of Finance. The agency's primary mandate is to promote P3s. The Minister of Health Services offered this description of PBC's role:

> *"We created Partnerships BC in an effort to promote public-private partnerships, involving the private sector in the development of infrastructure and other services …. Partnerships BC, which functions as government's centre for P3s and alternative service delivery, has a strong mandate to promote, enable and help implement P3 projects."*[19]

Health Co was created by PBC as a wholly owned subsidiary. Health Co's sole purpose was to negotiate, approve and implement a P3 contract for the Abbotsford hospital on behalf of the public. Health Co has oversight of the project until construction is completed in 2008, at which time the Fraser Heath Authority will assume responsibility.

In short, the two bodies that control the Abbotsford process have a singular aim: to deliver P3 contracts. The question arises: Who is representing the public interest by ensuring the suitability of this 33-year-long P3 contract?

In light of the narrow pro-P3 mandate of Partnerships BC and Health Co, it is not surprising that the Abbotsford project was neither re-evaluated nor halted despite budget increases. Between September 2001 (the launch of the P3 process) and September 2003 (the Request for Proposals), the hospital project faced ever-mounting costs and design changes. Yet in October 2003, Mike Marasco, the Chief Project Officer of Health Co, stated that no review of the P3 decision was necessary "because the provincial government had made a firm decision to go forward with the P3 model."[20] Partnerships BC's own *Achieving Value for Money* report confirmed that the "decision to proceed with a public-private partnership" occurred in the fall of 2002.[21]

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[19] Public-Private Partnerships: Focusing on the Nuts and Bolts of Successful PPPs, June 25, 2003, www.gov.bc.ca/health/popt/speeches/minister_Hansen/nuts_bolts_of_successful_ppps.htm.
[20] Beyak, Trudy. *Abbotsford News,* October 4, 2003.
[21] Partnerships BC *Project Report: Achieving Value for Money.* Op Cited 16.

Further, Health Co and PBC proceeded with the lone remaining bidder after three other would-be vendors withdrew. This violates general bidding principles, which require at least three bidders to ensure competitive market conditions.[22] Under treasury rules in the United Kingdom, the absence of competitive bids automatically halts the P3 process and triggers a traditional public procurement process.[23] **No similar protection is built into the BC process for P3 contracts.**

The *Achieving Value for Money* report confirmed that the sole final bid exceeded the RFP's budget target (already increased) for the project's capital costs.[24] As such, PBC appears to have contravened the objectives and guidelines of their own process.[25]

2. What are the justifications for P3s?

Traditionally, governments have worked closely with the private sector to design and build public sector infrastructure. Public-private partnerships are a radical departure from this norm. In P3 arrangements, the private sector not only designs and builds, but also operates and/or finances some or all of the project. Despite the cooperative terminology, P3s are a form of privatization with serious implications for the long-term delivery of public services.

Proponents of the P3 approach believe that superior private sector discipline, innovation and efficiency will result in better services for taxpayers at lower overall costs. They point to incentives in the P3 model that ensure such efficiencies. For example, once a P3 project is complete and operational, the public begins to repay the full cost of construction and ongoing services via an annual fee (in Abbotsford's case, over 30 years). Because the private consortium will not receive payment until the facility is up and running, proponents say that a P3 contract has a built-in financial incentive to ensure the project is built on time and on budget. Similarly, they say that a system of bonus and penalty payments will ensure that ongoing service and operational standards are maintained at appropriate levels.

Champions of the P3 model also believe that the risks of developing and operating public facilities are transferred to the private sector, thus sparing the public these expenses.

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[22] Parks, Ron. *Review of the Request for Proposals: Abbotsford Hospital and Cancer Centre,* Hospital Employees' Union, December 2003, page 4. HM Treasury. *Value for Money Assessment Guide.* August 2004, page 31.

[23] *HM Treasury. Value for Money Assessment Guide. August 2004. Page 31. 6.12 - Market Failure "At any stage, if the procurement team identifies market failure, e.g. lack of competition as a result of a single bidder or perhaps two bidders where only one is credible, then it is unlikely that the project will deliver value for money and should not proceed as a PFI." 6.13 "If there is market failure or abuse this is likely to lead to a bad value for money transaction and should therefore be halted and either procured conventionally or cancelled."*

[24] Ibid, 15.

[25] *Partnerships BC. Request For Proposals Abbotsford Hospital & Cancer Centre. November 2003.*

The BC Liberal government offers several key arguments to support their embrace of P3s. Chief among these are: 1) the introduction of market discipline, and competition; 2) the creation of new opportunities for BC businesses; and 3) the potential for off-book financing.

Yet the Abbotsford project fails on all three counts:

- Three bidders are required to ensure competitive market conditions, yet the Abbotsford project had only one final bidder.[26]
- No BC companies were involved in the bids. All four bidders were trans-national corporations. The only Canadian company involved in the project is PCL, the largest construction company in Canada and one of the largest in the US, with $4 billion in revenue anticipated for 2005.
- The project is an on-book debt, due to funding from Fraser Valley Regional Hospital District and a change in government accounting practices.

These are specific shortcomings. There are also general flaws in the P3 model.

Greater costs: The direct financial costs of P3 projects are greater than their conventionally procured counterparts. In Britain, the Association of Certified Chartered Accountants issued a report on road and hospital P3s that concluded:

> "*Our analysis shows that PFI [P3] is a very expensive way of financing and delivering public services that must, where public expenditure is constrained, lead to cuts in public services and/or tax rises, that is a cut in the social wage. In contrast, the chief beneficiaries are the providers of finance and some of, though not necessarily all, the private sector service providers, leading to a redistribution not from the rich to the poor but from the mass of the population to the financial elite. In short, PFI does not pass the accountability test."* [27]

Uncertain risk transfer: Risk transfer is an uncertain factor, due to both the contract type and the legal structure of the parties to the P3 contract. An upcoming section will explore this issue in detail.

Lack of transparency: Lengthy contract terms and demands of "commercial confidentiality" restrict public oversight and evaluation for a very long time.

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[26] Parks, Ron. *Review of the Request for Proposals: Abbotsford Hospital and Cancer Centre,* Hospital Employees' Union, December 2003, page 4. HM Treasury. *Value for Money Assessment Guide,*. August 2004, page 31.

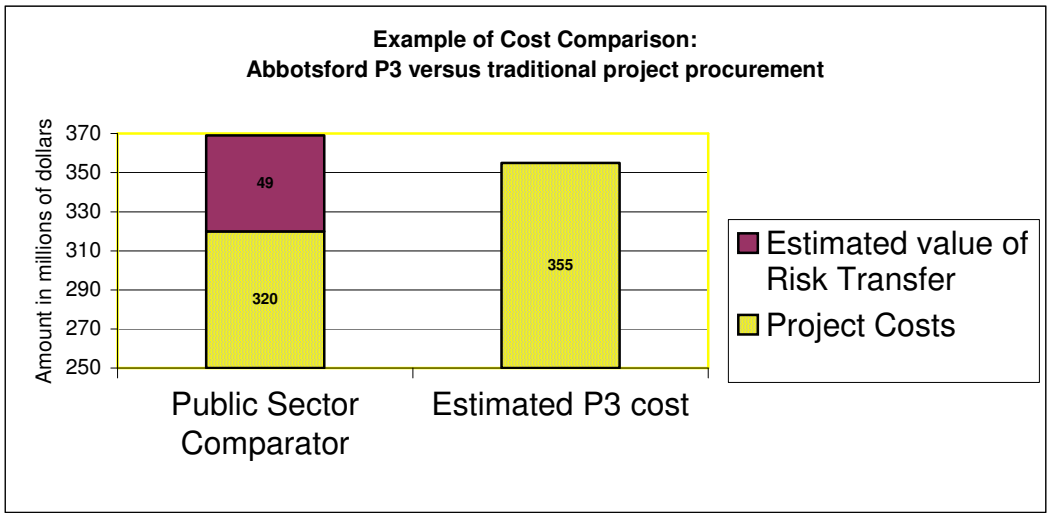
[27] Edwards, Shaoul, Stafford, Arblaster ,"Evaluating the operation of PFI in roads and hospitals", ACCA Research Report No. 84, , at page 224. 20. See Also Partnerships BC Value for Money Report. Op Cited. 12.

These features are highly problematic for taxpayers and are obstacles for advocates of the P3 model. Yet Partnerships BC and other government agencies assert that the superior performance of the private sector gives taxpayers "value for money." Indeed, value for money is now the prime justification for P3s.

2.1. "Value for money:" A slippery calculation

The phrase "value for money" is used to describe the capacity of P3 projects to guarantee on-time, on-budget delivery of a project, with superior levels of service, *in comparison with traditional public provision*. Yet "value for money" operates under very distinctive conditions in the context of P3s:

- "Value for money" is estimated by comparing the costs of the P3 bid with the costs of conventional procurement, called the public sector comparator (PSC).
- The calculations assume that certain financial risks associated with hospital construction (e.g., cost overruns) will be transferred to the private sector. The estimated value of this risk transfer is *added to* the PSC.
- Only after the risk transfer is added to the PSC does the P3 route appear to be less expensive and offer taxpayers better "value for money."



In the "Example of Cost Comparison" chart, data from Partnerships BC indicates that **the capital component of the public sector comparator is actually $35 million cheaper than the Abbotsford P3**.[28] Only after adding the estimated $49 million risk transfer does the PSC become more expensive (rising to $369 million from $320 million).

[28] Partnerships BC. *Project report: Achieving Value for Money – Abbotsford Regional Hospital and Cancer Centre Project February* 2005.

In summary, the current economic rationale for P3s - value for money - relies on two factors:

- calculation of the public sector comparator; and
- estimated value of risk transfer over the life of the P3 contract

These two factors are examined in the following sections.

2.2. The public sector comparator: Easily manipulated

> *"Public sector comparators won't do you much good anyways, because I can make the public sector comparator as bad as we want to, in order to make the private sector look good."*
>
> -- Larry Blain, CEO, Partnerships BC
> BC Municipal Finance Authority Meeting, March 26, 2003[29].

The public sector comparator (PSC) is capable of significant manipulation in order to produce a pre-determined conclusion that favours the P3 option. This is acknowledged by Larry Blain, CEO of Partnerships BC, and the practice is well documented by the Association of Chartered Certified Accountants in the UK, the *British Medical Journal*, and senior staff from the UK's National Audit Office and Treasury.[30]

One way to manipulate the PSC is through accounting elements such as the "discount rate." The discount rate is applied when comparing the full costs of the P3 option with traditional public financing and managing of hospitals. The discount rate is essentially a form of depreciation relating to the costs of capital and services over many years (e.g., inflation and interest rates).[31]

In the case of the Abbotsford hospital, 30 years of annual payments to Access Health Abbotsford were discounted by Partnerships BC at a real annual rate (excluding inflation) of 6%. The estimated costs of the project were then compared as a net present value (NPV), which is effectively future costs discounted (at 6% annually) and expressed in today's dollars. For example, $1000 in annual payments of $100 a year for 10 years to the P3 consortium is estimated to have a NPV of $736 (see Table 1, Appendix A).

When this rate is applied over 30 years of the Abbotsford contract, the P3's "perceived advantage swells" in comparison with the initial costs of a public project paid out today (as is assumed with publicly financed projects).[32] This may explain why P3 contracts are often very long: the "value for money" argument fades in P3 contract terms of only 5,10 or 15 years.

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[29] Corrigan, Kathy. "To privatize or not: The case against." *Canadian Consulting Engineer*. Jan/Feb 2005.
[30] ACCA. *The Private Finance Initiative: A Briefing. Op Cited*. See also *PFI Value for Money Appraisal. Comments from the ACCA.* ACCA, London: March 2004. See also Jones, Judy. Op Cited.
[31] Partnerships BC. *Project report: Achieving Value for Money*, February, 2005Op Cited. 19.
[32] Smart, Victor. *PFI: Beyond Criticism, beyond debate*? Association of Chartered Certified Accountants. February 2, 2003. Data and quote supplied by author.

The real problem, however, is that the 6% discount rate used by Partnerships BC is considered by many to be excessively high, due to falling interest rates in the last decade.[33] After years of criticism the UK Treasury revised their discount rate to 3.5% in 2003, acknowledging that the 6% figure produced artificially low cost projections for P3 projects. Subsequently, researchers applied the revised rate and determined that no P3 hospital in the UK at the time was in fact cheaper than a conventionally procured project.[34]

For example, the West Middlesex hospital was found to be £22 million more expensive as a public-private partnership than as a publicly financed facility.[35] The conclusion drawn from British research can be summed up in one simple statement: "The wrong choice was made."[36]

In Canada, the literature suggests using a discount rate of around 3.2% for projects financed with deferred payments through ongoing tax revenue.[37] The 6% rate used by Price Waterhouse Coopers in their 2001 feasibility study appears to have been borrowed from the UK model at the time, and then maintained despite being outdated.

There is no evidence that Partnerships BC or any independent public body has conducted an objective public evaluation of the appropriate discount rate for P3s in British Columbia. In other jurisdictions with P3 projects (i.e., the UK and Australia), an independent government agency is responsible for setting the discount rate – not a body like Partnerships BC, whose mandate is to promote P3 projects.

As the next section illustrates, a discount rate of 3% or 4% would have shown the Abbotsford P3 option to be significantly more expensive than the public sector comparator. A reasonable conclusion is that "the wrong choice was made."

2.3 A lower discount rate, a very different picture

Partnerships BC does acknowledge that the estimated costs of the Abbotsford P3 are necessarily speculative and subjective.[38] The Auditor General also warns that such "future-oriented information" is not suited to a high level of assurance

[33] ACCA *The Private Finance Initiative: Op Cited.* 10. See also Parks, Ron & Derek Malcolm. Op Cited.
[34] Sussex, John. "The Economics of The Private Finance Initiative in the NHS." London: Health Economics. 2001.
[35] Blaicklock, M. *British Medical Journal*. Letters. 2003; 327: 395
[36] Ibid.
[37] *The Social Discount Rate in Canada*, Moore M et al. *In Building the Future: Issues in Public Infrastructure in Canada.* Eds Vining, A, & J Richards. CD Howe Institute Toronto. 2001: 73-125.
[38] Partnerships BC. Project Report: *Achieving Value for Money*. Op Cited., page 3. Blain, Larry. CEO Partnerships BC. Letter to Barry O'Neill, April 22, 2003.

or verification.[39] Clearly, a realistic range of assumptions must be applied when comparing the value of a P3 option with the traditional procurement model.

Partnerships BC did conduct a sensitivity analysis, using discount rates of 5% and 7% (as well as 6%), and then compared the P3 cost to the $463 million for the public sector comparator.[40]

Net Present Value	Net Present Value	Net Present Value
@ 5% discount rate	@ 6% discount rate	@ 7% discount rate
$450 million	$424 million	$404 million

With the 5% discount rate, the estimated advantage of the P3 option declines from $39 million to $13 million (i.e., $463 million minus $450 million).

A sensitivity analysis using the 3.5% discount rate was performed by chartered accountant Rob Mackay, at the request of the HEU. (See Appendices A and B for details.) Problems emerged in trying to recreate Partnerships BC's data because some key numbers had been deleted. To address these gaps, Mackay based his analysis on two different assumptions, using conservative estimates of the P3 costs. His findings indicate that, even with the most conservative figures, **the 3.5% discount rate shows that the public option is $150 million lower than the P3 option.**

2.4 Risk transfer: The question of time and money

Partnerships BC and other government agencies assert that the higher costs of P3 financing are more than offset by the "value for money" of risk transfer.[41] A P3 is believed to:

- shelter taxpayers from construction cost overruns and delays;
- provide lower operational, service and maintenance costs for the duration of the contract; and
- provide superior service throughout the contract.

The value-for-money argument hinges on effective risk transfer over the entire life of the P3 contract. Yet the only aspect of contractual risk transfer to be extensively documented is the ability of P3 consortia to deliver "on time and on budget." To be exact, the National Audit Office in the UK found that P3

[39] Auditor General of British Columbia. *Report of the Auditor General of British Columbia: Review Engagement Report.* Op Cited.

[40] The public sector comparator is "the hypothetical estimate of costs if the project were built, maintained and operated by the public sector. (Net present values calculated as at April 30, 2004)." It does not include the Regional Health District contribution. Partnerships BC Project Report: *Achieving Value for Money*. Op Cited., page 19. Note also that this number is different than the earlier PSC comparison ($369 million) in 2.1, which only included capital costs.

[41] Partnerships BC. *An Introduction to Public Private Partnerships. Revised June 2002.*

construction was more likely to deliver on time and on budget than traditional public projects.[42]

However, a recent evaluation of P3 hospital projects in the UK found that private consortia charge a premium of approximately 30% on construction costs to guarantee this on-time, on-budget promise.[43] The 30% premium greatly exceeds the available data on actual time and cost overruns, which were running between 6-9% in the late 1990s.[44] In other words, **using a P3 to avoid expensive overruns may actually cost taxpayers, on average, three to five times as much as the overruns themselves.**

Moreover, Partnerships BC has never conducted a systematic evaluation of cost overruns and time delays associated with public hospital construction in British Columbia. The province's P3 process cannot claim to provide a solution to a problem that has never been documented.

At the same time, potential cost increases and construction delays tell only part of the story. When the lengthy and expensive negotiations for a P3 contract are factored in, the time frame for P3 hospital projects is often longer than for traditional procurement methods.[45] The UK Treasury states that "procuring through PFI [P3] can be complex and can involve lengthy negotiations before contracts are signed"[46] and "procurement timetables and transaction costs can be significantly in excess of those normally incurred with other procurement options."[47]

In the UK, the Association of Chartered Certified Accountants notes that negotiations for PFI hospitals took, on average, an extra two years longer than public procurement strategies.[48] Claims that P3 projects are delivered on time may be of limited value when the protracted P3 process is taken into account.

The Abbotsford P3 is a perfect example of this illusory benefit. The original announcement in 2001 aimed for a 2005 completion date for the new hospital and cancer centre. Cancellation of the public procurement plan and launching of the P3 venture has delayed the delivery date until 2008. The preparation, bid and contract negotiation process lasted from 2001 to December 2004, negating the benefits of any on-time project delivery.

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[42] *PFI Construction Performance*. National Audit Office 2003. "In 1999, 73% of UK public construction projects exceeded the price agreed at contract and 70% were delivered late. In 2002 only 22% of Private Finance Initiative Projects exceeded the price agreed at contract and 24% were delivered late".
[43] Edwards, et al. Op Cited. 10
[44] Sussex, John. Op Cited. See also Pollock, Allyson & David Price. "Public risk for private gain." Op Cited. See also "Private Finance and 'value for money' in NHS hospitals: A policy in search of rationale?" Pollock A, Jean Shaoul, Neil Vickers, *BMJ* Volume 324, 18 May 2002.
[45] John Sussex Op cited.
[46] HM Treasury. *PFI: Meeting the Investment Challenge. July 2003.* 4.18.
[47] HM Treasury. *Value for Money Assessment Guide. August 2004. 30.*
[48] *PFI: Practical Perspectives.* Association of Chartered Certified Accountants 2002. 6.

According to *Achieving Value for Money,* inflation increases during this period added at least $63 million in extra costs to the taxpayer. As well, transaction and development costs for the Abbotsford P3 project are expected to be $24.5 million, compared with $8 million via traditional procurement methods. [49]

Constant price escalations and ongoing changes to the Abbotsford P3 are proof that, despite claims to the contrary, P3s do not guarantee certainty about price or date.

2.5 Operational risk transfer: What happens after construction?

The construction phase of a P3 contract is usually very short compared with the operational phase. For example, 90% of the 33-year Abbotsford contract pertains to the post-construction period. Yet research indicates that the main risks borne by a P3 consortium are during the construction phase. Once a project is operational, both the legal structure of the private consortium and the P3 contract itself impose limits on the risks and liabilities for the consortium and protect parent companies from significant risk costs.[50]

The Abbotsford scenario is consistent with the research. The consortium that bid on the hospital consists of transnational giants. They set up a "special purpose vehicle," Access Health Abbotsford, to construct and operate the hospital: a sole-purpose subsidiary with no assets other than the Abbotsford project. If there are unexpected risk expenses, Access Health Abbotsford can walk away from the contract without jeopardizing the parent companies.[51] This legal structure is typical of P3s around the world, a fact that led the Ontario Association of Architects to conclude that P3 consulting and construction firms often fail to take responsibility for risks transferred to them.[52] Instead, the public sector has no choice but to assume "the risk that it has already paid the private sector to assume."[53]

In addition, the taxpayer shoulders many risks regardless of the makeup of the P3 contract. In some cases the risk for the public may actually increase under P3s. The Supreme Court of Canada has ruled that responsibility for public health safety lies with public bodies, even when services are delivered by private sector entities.[54] For example, if hospital-acquired infections were to increase due to substandard cleaning services by private contractors, the responsibility would still remain with the public health authority.

This is not an abstract worry. In the UK, falling levels of hospital cleanliness have been linked to high staff turnover and low wages among privatized cleaning contractors. The problem is so significant that in March 2005, the

[49] Partnerships BC. *Project report: Achieving Value for Money.* Op cited. 34.
[50] Standard & Poor's. *Public Finance/Infrastructure Finance: Credit Survey of the UK Private Finance Initiative and Public Private Partnerships*. London. 2003. See Also Edwards, Pam et al. Op Cited. 215.
[51] Pam Edwards et al. Op cited. 215.
[52] Ontario Architects Association, *A P3 Primer,* 2003, page 3.
[53] L. Auerbach, Op Cited. 7.
[54] Supreme Court of Canada. *Lewis v. British Columbia. File No. 24999. Dec 11, 1997.*

British government extended the "Code of Practice on Workforce Matters" to the Department of Health and wider public sector. The code requires for-profit contractors to offer their employees terms and conditions that are parallel to comparable public sector employees.[55]

Many operational risks remain with the public sector in the Abbotsford P3 project, including:

- **Ongoing inflation risks.** The public sector is responsible for this expense, because elements of the Annual Service Payment are index-linked for the duration of the contract. This feature has the potential to provide over-compensation for the P3 consortium, in some circumstances.[56]

- **Costs of ongoing contract enforcement.** Partnerships BC acknowledges that the functions and procedures associated with P3 contract monitoring have not been fully assessed or finalized.[57] These monitoring costs are thus unaccounted for in the "value for money" assessment. Evidence from other jurisdictions suggests that these extra costs are borne by taxpayers, due to the form of the P3 contract.[58]

- **Risks of self-monitoring and self-reporting.** Relying on a consortium to monitor and report its own service problems may lead to under-reporting (or non-reporting) of deficiencies. This self-regulating approach is inconsistent with Partnerships BC's demand for independent verification of contract items such as completion of construction.[59] Self-monitoring is also particularly problematic in areas such as cleaning, where teamwork and communication are essential but not easily quantified.[60]

- **Costs associated with a long-term contract.** Major clinical changes are inevitable during the project's 30-year operational term, as are evolutions in technology and infection control practices. These changes will require contract renegotiations, the cost of which will be borne by taxpayers.

- **Risks and costs of substandard service levels.** According to the evidence, enforcement mechanisms in P3 contracts are not always applied when service levels fall below contract specifications: "The reality has been that there have been few deductions thus far" even when P3 consortia have failed to comply with minimum service levels.[61]

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[55] UK Department of Health website, www.dh.gov.uk/PolicyAndGuidance; see also the full code of practice at www.cabinetoffice.gov.uk.opsr/documents/doc/copwm.doc
[56] L. Auerbach Op Cited. 14.
[57] Partnerships BC. *Project report: Achieving Value for Money.* Op cited. 25.
[58] Pam Edwards *et al.* Op Cited.
[59] Ibid. 24.
[60] Pollak, Nancy. *Falling Standards, Rising Risks: Issues in Hospital Cleanliness with Contracting Out,* BC Nurses' Union and Hospital Employees' Union, Oct 2004.
[61] Pam Edwards et al. Op Cited. 145.

- **Risks associated with changing labour costs:** The P3 contract assumes that current employment practices and legislated collective agreements (under Bill 29) will remain in force. Yet it is more likely that labour practices and labour laws will change over the next three decades. The P3 contract assumes that any extra costs relating to improved working terms or conditions will be borne by the public.

- **Risks associated with unusually high patient demand.** Partnerships BC confirms that during times of unforeseen patient volume and demand (e.g., natural disasters), the costs and risks associated with hospital services will not be absorbed by the P3 consortium.[62] Rather, these risks will be "shared"[63] between the private and public sectors. Contract provisions for risk transfer may not apply during regional flooding, fires or earthquakes. In short, the public will bear the risks and costs during periods with the greatest needs and expenses.

Evidently, P3s offer a very narrow form of operational risk transfer. **We strongly question the value of paying Access Health Abbotsford large sums for risk transfer, when the risks they are likely to assume are relatively small.**[64]

3. Adopting a Failing Model?

Similarities between the United Kingdom's private finance initiatives (PFI) and the P3 model favoured by Partnerships BC are not coincidental. Officials from Partnerships BC toured PFI facilities in the UK and seconded staff from Britain to formulate and lead their contract negotiations. The BC procurement process, project agreement, and contractual form are described by their UK-based consultants as being "recognisably the UK PFI model,"[65] developed especially for the Abbotsford hospital. Indeed, the UK's National Audit Office and the Canadian Council for Public-Private Partnerships (CCP3) use the terms P3 and PFI interchangeably.[66]

Partnerships BC and the CCP3 frequently refer to the success of UK hospital P3s, but avoid any mention of the criticisms.[67] Yet the criticisms are widespread and well-documented. The *British Medical Journal* (*BMJ*) and *British Medical Journal Online* have published over 100 articles, studies, letters and responses relating to PFIs. The vast majority have been highly critical of both the theory

[62] Partnerships BC. *Achieving Value for Money.* Op Cited. 20.
[63] Ibid. 20.
[64] Auerbach, L. Op Cited. 13.
[65] Hunter, David. *Time to go west again?* Bevan Ashford. October 2004. Available www.bevanashford.co.uk (18/11/2003)
[66] Canadian Council for Public Private Partnerships 12th Annual Conference. Presentation - *Responsible and Transparent Reporting for P3s,* Richard Wade, National Audit Office. November 23 2004.
[67] The Canadian Council for Public Private Partnerships issued a report in 2003 entitled Hospitals*: The Canadian Case for Hospital PPP Projects.* It contained over 20 pages devoted exclusively to UK P3 hospital projects, and referred to the UK's P3 experience over 40 times in the rest of the document. In addition, officials from Partnerships BC have toured UK PFI facilities and hired British consultants Bevan Ashford to lead negotiations and manage the "financial close" on the Abbotsford P3.

and practice of PFIs since 1996.[68] Despite repeated calls for publication of articles that support the use of PFIs, none has ever been submitted. As editor Richard Smith stated:

> *"Several respondents have made the point that they would like to read an article that argues cogently the case for the Private Finance Initiative. We at the BMJ share this desire. We have never had such an article submitted to us, but we have made several attempts to commission a piece. These have all come to nothing, with some of the proponents of PFI arguing that they are 'far too busy to have time to put the case for PFI'. I find this bizarre, and it seems to me that when hundreds of millions of pounds are being spent on PFI schemes it should be possible for somebody, somewhere to find a small amount of money to pay somebody to make the case for PFI. We are continuing with our efforts to find such an article, and I'm optimistic that we will be able to publish something before the end of the year."*[69]

Yet no articles pertaining to the benefits of the PFI model have been submitted since Smith's statement in 2002.

In 2004 the Association of Chartered Accountants in London did an evaluation of the operation of PFI hospital projects. They determined that:

- The annual costs of capital with PFI hospitals was at least £100 million more than it would have been with public financing, and the hospitals were considerably smaller than the ones they replaced.
- Hospitals were paying a risk premium of about 30% of total construction costs to ensure the facility was built on time and on budget. The premium considerably exceeded cost over-runs in publicly built hospitals.
- PFIs are an expensive way to finance public services and may lead to cuts to public services and/or tax increases. About half of the health trusts with PFI hospitals were in a deficit position at the time of the study.
- Private consortia appear to bear little effective risk during the term of the contract, diminishing the value of the risk transfer.
- Within a few years of financial close, PFI charges are often much higher than anticipated.

Physicians in the UK have also voiced their opposition to public-private partnerships. In August 2005 the National Health Service Consultants' Association sent an open letter to the Canadian Medical Association convention, on the eve of a debate about privatization. The British physicians' body, representing 650 specialists in a range of practices, offered a scathing indictment of PFIs and other types of private sector involvement in health care. The following excerpt is representative of their concerns:

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[68] *"Private finance for the public good? Still no sign of evidence based policy making."* BMJ 1996;313:312 (10 August) Editorial – Dawson, Diane & Alan Maynard

[69] Richard Smith, *BMJ*, July 8, 2002.

"We believe that you have already experienced PFI (known in Canada as P3s or public-private partnerships) for hospital construction. This is another example of governments choosing quick, politically useful results without concern for the long-term consequences. Inevitably PFI hospitals are more expensive, as borrowing is at a higher rate and there has to be a profit for the shareholders. As a result, our first hospitals were too small. Now, although PFI hospitals must be at least as large as those they replace, many defects are appearing and the repayments – the first charge on the hospital's budget – are causing financial problems. It is difficult to find anyone in the UK now prepared to support PFI except those in government and those set to profit from it.

Secondly, both financial resources and staff times are being wasted on the bureaucracy inherent in trying to run a competitive market system."[70]

Partnerships BC and the BC government claim that they wish to deliver the most cost-efficient services to patients, yet ignore the considerable evidence that P3s may deliver exactly the opposite.

4. Removing Independent Scrutiny of the Abbotsford P3

In a democratic society, the Auditor General plays an essential role in protecting the public interest. But in regards to the Abbotsford hospital project, the Office of the Auditor General of BC (OAG) has played an unusual and troubling role.

After initial details of the Abbotsford P3 project were released, the Auditor General expressed his desire to conduct a full and independent investigation of the project, comparing the P3 process and outcomes with that of a public sector hospital. An additional $250,000 was requested to conduct this independent audit of the $1.4 billion project.

Instead the budget of the OAG was cut by over $800,000 (10%).[71] The Auditor General announced in December 2003 that lack of funds would compel him to "limit work on the government's approach to public-private sector partnerships" and "scale back our planned work to examine key risks in the health sector".[72]

Subsequent plans for a limited but still independent audit of the Abbotsford P3 were cancelled in May 2004. Ultimately, the OAG decided to conduct a review only and provide a commentary on the efficacy of Partnerships BC's reporting process. In the words of the Auditor General, Wayne Strelioff:

[70] The full letter can be found at the website of the Canadian Union of Public Employees, www.cupe.ca.
[71] Beyak, Trudy. "Tab for planning new hospital sits at $17 million." *Abbotsford News.* January 10 2004.
[72] Palmer, Vaughn. "Auditor General finds Liberals fail to share his fiscal concerns." *The Vancouver Sun.* December 6, 2003. A3.

> *"I decided my approach would shift from a direct report – where I issue a direct report to legislators and to the public – to an attestation report – where my opinion on management's written assertions would be attached to Partnerships BC report in the form of a review engagement report."*[73]

In February 2005 the OAG's review was released as an attachment to Partnerships BC's *Achieving Value for Money* report. The review indicates *only* that Partnerships BC's reporting process for the Abbotsford project was fair.

The HEU has many concerns about the Auditor General's approach to the Abbotsford hospital project. To begin, we believe that the public does not understand the very real limitations of a review and hence attaches far too much significance to the document than is appropriate.

4.1 Audit or review? A substantial difference

Audits and reviews are two very different processes. The Canadian Institute of Chartered Accountants Guidelines (CICA) sets the standards for both. A review is a significantly lower level process than an audit and provides a much lower level of assurance. (Please see Appendix D.) A review focuses on enquiries to management, which may be accepted by the auditor if responses appear to be plausible. A review does *not* require the auditor to seek supporting or independent evidence.[74]

The HEU submits that "plausibility" is not a rigorous enough standard to judge the Abbotsford P3, which is an untested model of hospital infrastructure and services. Rather, a thorough, critical analysis is needed of the assumptions embedded in Partnerships BC's P3 model, especially in relation to risk transfer, discount rate, competitive neutrality and other subjective estimates used to justify the privatization of health services delivery.

Further, we are concerned that the OAG's Abbotsford review was not properly presented. The *Canadian Institute of Chartered Accountants Handbook* states that in a review, "each page of the information being reported on will be conspicuously marked as unaudited."[75] This guideline was not followed. The Auditor General's review was attached to the *Achieving Value for Money* report, yet the relevant pages of the report were not marked as unaudited. Undoubtedly, the effect of a conspicuous "unaudited" stamp on each page would have seriously altered the impact of the Auditor General's assurance.

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[73] Auditor General of British Columbia. *Report of the Auditor General of British Columbia: Review Engagement Report.* February 1, 2005. In Partnerships BC. *Project report: Achieving Value for Money – Abbotsford Regional Hospital and Cancer Centre Project Review Engagement Report February* 2005.
[74] Section 8100.06, CICA Guidelines – attached as Appendix D, this report.
[75] *CICA Handbook,* Section 8100.27

4.2 "New ground:" The relation between the Auditor General and Partnerships BC

In the face of these concerns, the HEU asked the OAG for a copy of the terms of reference and letter of engagement for the Auditor General's review of *Achieving Value for Money*. We were informed that these documents were unavailable for viewing due to the OAG's confidential relationship with its client, Partnerships BC. We were also informed that their relationship was "a departure" in that it was a narrow engagement directly between the OAG and Partnerships BC.

A subsequent Freedom of Information request to Partnerships BC for the same information was refused pursuant to section 3(1)(c) of the Freedom of Information and Protection of Privacy Act. That section states that the act does not apply to a record created by or for an Officer of the Legislature.

Yet another Freedom of Information request was made to the Auditor General, which finally led to the release of the engagement letter with Partnerships BC. There are several interesting things about the engagement letter:

Timing: The letter from the Auditor General to Larry Blain (CEO of Partnerships BC) setting out the detailed terms of engagement, is dated January 17, 2005. Blain's acknowledgment of the services and terms is dated January 27, 2005. The review by the Auditor General included in the *Achieving Value for Money* report is dated February 1, 2005, just five days after Blain's acknowledgment.

In fact, it appears the review was all or substantially completed and the draft report read by Blain before he committed himself to the terms of the review. Strelioff writes "Unless unanticipated difficulties arise, the content of my report will be substantially in the form outlined in the enclosed Draft Review Engagement Report." He also enclosed a draft version of the covering letter to Partnerships BC.

Private terms of engagement: The OAG has broad discretionary powers to report on any matter. But we have deep concerns about what appear to be private terms of engagement by the Auditor General, whose mandate is to protect the public interest. The timing referred to in the previous paragraph certainly reflects a negotiated, private relationship, rather than an independent evaluation by the Auditor General.

Perhaps the most troubling aspect of this private relationship is in the section of the agreement dealing with fees, which reads in part:

> *"As previously agreed, there will be no charge to Partnerships British Columbia for this review. If this approach demonstrates value, and we mutually agree to expand its application to other projects, we will need to review funding options for future services."*

This suggests a less-than-independent relationship between the Office of the Auditor General and Partnerships BC, which calls into question the protection of taxpayers' interests.

4.3 Role of public sector auditors

Public sector auditors are governed by the general guidelines of the Canadian Institute of Chartered Accountants, in addition to assurance recommendations that apply to the public sector only. These measures repeatedly refer to "audits" as opposed to "reviews." It would appear that private review engagements by public sector auditors are not even contemplated by CICA. This is not to suggest that such reviews are precluded, but they are not specifically discussed in the *CICA Handbook.*

Public sector auditors perform value-for-money audits, the guidelines for which appear in section PS 5400 of the *CICA Handbook*. When establishing the value-for-money audit objectives and scope, a public sector auditor is required to identify all aspects of the entity that are significant and/or of high risk. Significant factors include financial magnitude, importance, economic, social and environmental impact, and interest expressed in the matters. We believe the entire Abbotsford hospital project to be significant, when considered beside these criteria. The project represents a radical departure in policy regarding the development, management and delivery of hospital infrastructure and health support services by private corporations, and as such carries the potential of significant increased risk to the public.

With respect to "risk," a public sector auditor is expected to pay particular attention if the entity "has diverse or inconsistent objectives," because "the risk increases that its activities or programs are not operating with due regard to value for money."[76] We submit that Partnerships BC does have diverse or inconsistent objectives, due to its *raison d'etre:* The agency must implement P3s yet is also expected to ensure value for money. For this reason, it is inappropriate to apply the "plausibility" test to the risk and discount rate valuations supplied by Partnerships BC.

Auditors are also required to ensure that sufficient and appropriate evidence is obtained to provide reasonable assurance that accounting estimates are reasonable. Subjective matters (e.g., management bias) and the quality of data must be examined. The HEU submits that particular attention must be paid to the issue of "management bias" at Partnerships BC.

Auditors must also assess whether fair market valuations are appropriate. Again, we believe that the "plausibility" standard of the Abbotsford hospital review does not sufficiently protect the taxpayers' interest in this matter.

[76] *CICA Handbook*, Public Sector Section 6410.16

Finally, even in terms of the review's limited scope, the Auditor General failed to adequately comply with its stated goals. Partnerships BC's *Achieving Value for Money* report is less than transparent:

- key reference material is either deleted or omitted;
- data describing both planned costs and payments cannot be re-created under forensic analysis; and
- crucial formulae necessary to evaluate these figures remain unexplained in both concept and practice. [77]

In short, public sector auditors have an essential role to play in assessing the Abbotsford hospital project, yet that role has not been fulfilled by the OAG's review.

4.4 Inappropriate faith in the review

Reports by accountants carry great weight and are generally regarded as credible. The profession strives for clarity about its functions and roles. For example, the *CICA Handbook* states:

> *"In review engagements, it is essential that the public accountant not lead the reader to conclude that an audit opinion is being expressed."*[78]

Unfortunately, a sizable gap exists between the limited scope of the Auditor General's review of the Abbotsford P3 project and how it was presented to and perceived by the public. Disregarding the review's disclaimers and qualifications, no less than the premier of the province stated: "The Auditor General said we saved $39 million on [the Abbotsford P3]."[79]

The premier was not alone. A lengthy *Vancouver Sun* article demonstrated (and disseminated) the popular view that the Auditor General had carefully evaluated and endorsed the Abbotsford hospital project. After observing that only one bid had been submitted, reporter Don Cayo wrote:

> *"The worst-case scenario is that P3s can't prove themselves a worthwhile alternative to traditional public-sector service delivery as long as the private bidding pool is too small, and the bidding pool remains stunted as long as there aren't many P3s.*
>
> *Does this mean trouble -- the odds are there'll be only one over-priced bid to take or leave -- for places like BC that pioneer the P3 concept in Canada?*

[77] Mackay Mynett. Refer to Appendix *B*.
[78] *CICA Handbook,* Section 5020.16
[79] *Abbotsford Times*, May 10, 2005

I don't think so. And I base that hopeful view on a reassuring assessment of the Abbotsford deal by Wayne Strelioff, BC's hard-nosed auditor-general.

Strelioff usually makes headlines for scolding the government after it has done something wrong. But in a rare move he has run his staff's fine-toothed comb through the complex value-for-money projections done by Partnerships BC, the government's P3 agency, at an early point where -- had it been necessary -- the deal could still be changed. And he has pronounced it sound."

And later:

"The comparison with probable costs if the public sector did the work shows the annual payments to the builder/operator will save only about $10 million on capital, repairs and operating costs over 30 years. But additional savings of three or four times that much will come from transferring risks to the private companies.

Yet without Strelioff's endorsement, who'd believe those numbers? And critics of government who hate P3s would no doubt have had some fun at the project's expense, thanks to an increase in the estimated capital cost from $211 million back in 2001 to $355 million today.

But the auditor-general's blessing certifies, among other things, that the higher estimate is justified by things like a planned increase in floor space of 10 per cent, changes in the equipment to be installed, improved energy efficiency, and inflation in a red-hot construction market."[80]

This misinterpretation of the Auditor General's "blessing" was widely proclaimed by media and government figures. It may be too late to fully correct this distorted view of the Abbotsford review and the *Achieving Value for Money* report. However, the OAG will do other reviews of other projects, including the controversial Canada Line transit project between Vancouver and Richmond (formerly called the RAV line). With the benefit of hindsight, we ask the Auditor General to take steps to prevent another misreading by the public. **To protect the public interest, we urge the Auditor General to take steps to remedy this "expectation gap" and fully inform the public about the limitations of a review.**

[80] Cayo, Don. *Vancouver Sun,* Wednesday, February 23, 2005, Page D5.

5. Looking Ahead, Getting It Right Now

The HEU is gravely concerned that the people of the Fraser Valley will not be well served by the Abbotsford P3 hospital project. But we are also worried that other P3 projects in British Columbia will be subjected to value-for-money comparisons using the problematic formulae used in the Abbotsford process.

Before any other P3 projects are launched in this province, the public deserves to have an independent analysis of:

- the project's business case;
- extra legal and transactional costs, including the ongoing costs of monitoring, and contract enforcement ;
- validity and assumptions in calculating the public sector comparator;
- allocation of risk and efficacy of risk transfer over the life of the contract;
- role and actions of third-party consultants retained by Partnerships BC;
- impact of lack of competitive pressure for 30-year contracts, particularly when only one consortium submits a final bid;
- extra costs and loss of quality control due to fragmentation of service delivery (i.e., separate and parallel management structures for clinical and support services);
- efficacy of self-reporting by private sector contractors;
- service quality risks (e.g., infection control) associated with the contracting-out of health support services;
- risks associated with assuming that current legislated collective agreements (under Bill 29) will remain in place for 30 years;
- potential diversion of health funding from other community health services in the Fraser Valley to pay for the Abbotsford project; and
- contingency plans for private sector failure/default, and the full financial and social costs of cancelling the project.

Examination of any of the above points could reveal flawed assumptions that erode or eliminate the claimed benefits of health care P3s.

The HEU opposes P3s for many reasons other than financial ones – for example, loss of public control of public services – and will continue to oppose them for those reasons. In this report, however, we focus primarily on financial issues. Due to cutbacks to the Auditor General, key factors in the Abbotsford P3 project have been left unexamined.

We believe that the mandate of the Office of the Auditor General requires it to step beyond the "plausibility" test and truly take a fine-toothed comb to the *Achieving Value for Money* report. A full and independent audit of the Abbotsford hospital project is required.

Appendix A: Sensitivity Analysis & Discount Rate

The following table illustrates the use of discount rates in comparing the present day cost of capital with deferred future payments. It shows a sensitivity analysis, or comparison, of the use of two differing rates and the resulting change in Net Present Value. The payments illustrated amount to $1000, paid at $100 per annum for the duration of a ten year period.

Table 1.
Comparison of Discount Rates

Annual Payment		Projected NPV @ 6% discount rate	Projected NPV @ 3.5% discount rate
Year One	$ 100.00	$94.34	$96.62
Year Two	$ 100.00	$183.34	$189.97
Year Three	$ 100.00	$267.30	$280.16
Year Four	$ 100.00	$346.51	$367.31
Year Five	$ 100.00	$421.24	$451.51
Year Six	$ 100.00	$491.73	$532.86
Year Seven	$ 100.00	$558.24	$611.45
Year Eight	$ 100.00	$620.98	$687.40
Year Nine	$ 100.00	$680.17	$760.77
Year Ten	$ 100.00	$736.01	$831.66

Total Payment $1,000.00

Net Present Value @ 6% discount rate $736.01

Net Present Value @ 3.5% discount rate $831.66

Appendix B: Report on the Sensitivity Analysis

March 22, 2005

Hospital Employees' Union of British Columbia
5000 North Fraser Way
Burnaby, BC V5J 5M3

Attention: Marcy Cohen

Dear Sirs:

Re: Abbotsford Hospital and Cancer Centre Project
Net Present Value Calculations

1.0 Introduction

1.1 You asked us to review the Net Present Value ("NPV") calculations set out on page 19 of the "Project Report: Achieving Value for Money, Abbotsford Regional Hospital and Cancer Centre Project" prepared by the British Columbia Ministry of Health Services, Partnerships British Columbia. The NPV calculations related to the final cost of the "Abbotsford Hospital and Cancer Centre Project Agreement" (excluding the RHD's capital contribution).

1.2 You also asked us to provide alternative calculations of the NPV of the final cost of the agreement using discount rates of 3.5%, 5%, and 6%.

2.0 Conclusion

2.1 The Net Present Value calculations set out on page 19 of the report, "Project Report: Achieving Value for Money, Abbotsford Regional Hospital and Cancer Centre Project", were as follows:

	NPV @ 5% Discount Rate	**NPV @ 6% Discount Rate**	**NPV @ 7% Discount Rate**
NPV of the final cost of the Project Agreement as at April 30, 2004	$450 million	$424 million	$404 million

2.2 Due to the lack of information available to us (refer to Section 5 and 6 for further details), we were unable to ascertain all of the parameters that were inherent in the NPV calculations set out in Partnerships British Columbia's report. As a result, we were unable to re-calculate the NPV of the final cost of the Project at a discount rate of 3.5% using the same parameters as used in the NPV calculations noted above (Note: we understand that the 3.5% discount rate you instructed us to use was

based on the real rate used by the UK Treasury as set out on page 18 of HM Treasury, "Quantitative Assessment User Guide", dated August 2004).

2.3 Based on information that is provided in the Partnerships BC report, we performed the following alternative net present value calculations that illustrate the sensitivity of discount rates used:

	NPV @ 3.5% Discount Rate	**NPV @ 5% Discount Rate**	**NPV @ 6% Discount Rate**
Alternative 1: NPV of the final cost of the Project Agreement at April 30, 2004, assuming an annual payment of $37.8 million (refer to Section 6)	$616 million	$490 million	$424 million
	(refer to Sch 1)	(refer to Sch 2)	(refer to Sch 3)
Alternative 2: NPV of the final cost of the Project Agreement at April 30, 2004, assuming an annual payment of $40.3 million (refer to Section 6)	$657 million	$522 million	$452 million
	(refer to Sch 4)	(refer to Sch 5)	(refer to Sch 6)

2.4 As shown above, using a discount rate of 3.5% has a very significant effect on the NPV calculations. In fact, under both alternative calculations, the NPV at April 30, 2004 using a discount rate of 3.5% is significantly higher than the public sector comparator of $463 million referred in the Partnerships British Columbia's report.

3.0 Scope of Review

3.1 When preparing this report, we reviewed the following information:

- Partnerships British Columbia's report, "Project Report: Achieving Value for Money Abbotsford Regional Hospital and Cancer Centre Project";
- Abbotsford Regional Hospital and Cancer Centre Project – Final Agreement dated February 22, 2005, Part F., Payment and Information Matters;
- Abbotsford Regional Hospital and Cancer Centre Project – Final Agreement dated February 22, 2005, Schedule 9 – Financial Close Information; and
- Abbotsford Regional Hospital and Cancer Centre Project – Final Agreement dated February 22, 2005, Schedule 23 – Payment Mechanism.

4.0 Definitions

4.1 We provide the following definitions:

- Net Present Value: The value, in today's dollars, of a series of cash flows over a future time period that have been discounted to the present using a chosen discount rate.

- Discount Rate: A rate of return used to convert a monetary sum, payable or receivable in the future, into present value.

5.0 Review of the NPV calculations set out in the "Project Report: Achieving Value for Money, Abbotsford Regional Hospital and Cancer Centre Project"

5.1 The NPV calculations set out on page 19 of the above noted report were as follows:

"Cost to the Public Sector

The final cost of the project agreement (excluding the RHD's capital contribution) can be expressed as a net present value (NPV), which expresses future amounts in today's dollars. In NPV terms, the agreement will cost the public sector approximately $424 million over 33 years, assuming there are no bonuses or penalties applied to the payments to AHA. This is about $39 million less than the estimated $463 million NPV cost of the public sector comparator (also excluding the RHD contribution), which is the hypothetical estimate of costs if the project were built, maintained and operated by the public sector. (Net present values calculated at April 30, 2004.)

The NPV figures above were developed using a discount rate, which represents the costs of capital over time, taking into account factors such as inflation and interest rates. A real (that is, excluding inflation) discount rate of six per cent was used, based upon international market practices and benchmarks at the time (for example a real rate of six per cent used in the U.K., real rates of six per cent to eight per cent in Australia, and a real rate of seven per cent in the U.S. for general public sector investment), and following consultation with BC Provincial Treasury. Sensitivity analysis of the six per cent discount rate showed that the NPV cost of the agreement would have been about $13 million less than that of the public sector comparator if a five per cent discount rate were used, and about $59 million less if a seven per cent rate were used."

5.2 Reference to the annual payments during the period of operation was on page 16 of the report as follows:

"The final total service payment in the first full year of operations will be $40.3 million, or $40.8 million including GST."

5.3 We also noted at page 21 of the Partnerships BC report a graph called "Components of Annual Service Payment in Government Fiscal Years (Constant 2008 Dollars). Although the graph indicated the general level of annual payment amounts, we could not identify the specific amounts for each year. We did note the following however with respect to the annual service payment amounts:

- From 2008 to approximately 2023, the annual amount was approximately $40 to $41 million;
- From 2023 to 2035 the annual amount appeared to range from approximately $41 million to $49 million due to fluctuations in repairs and replacement; and
- From 2035 to 2038, the annual amount appeared to range from approximately $40 million to $41 million.

5.4 Given the information provided in the report, we attempted to recalculate the NPV of $424 million using the following parameters:

- NPV date: April 30, 2004;
- Discount rate: 6%;
- Annual payment: $40.3 million;
- Payment commencement: May 2008; and
- Expiry of operating term of the agreement: May 2038.

[Note: We assumed each annual payment made at mid-year.]

5.5 Based on the above parameters we calculated the NPV to be $452 million (refer to Schedule 6). This was $28 million greater than the $424 million set out in Partnerships British Columbia's report.

[Note: Although the graph on page 21 of the Partnerships BC report indicated annual amounts to be approximately $40 million and higher (refer to paragraph 5.3), the specific amounts were not provided. If we were provided with the specific amounts and we recalculated the NPV using those specific amounts and the other parameters noted in paragraph 5.4 above, our NPV calculation would be higher than the $452 million that we calculated using the annual payment amount of $40.3 million.]

5.6 We calculated that in order to arrive at a NPV of $424 million the annual payment would have to be approximately $37.8 million (refer to Schedule 3) [Note: this assumes the annual payment would be the same each year and assumes all other parameters as noted in paragraph 5.4].

5.7 Given the above noted discrepancy, we attempted to obtain further information from the following parts of the Project Agreement:

- Part F: Payment and Information Matters;
- Schedule 9: Financial Close Information; and

- Schedule 23: Payment Mechanism.

5.8 Based on our review of the above, we confirmed that the payment commencement date was May 7, 2008 and the expiry date of the operating term was May 6, 2038. The information with respect to the annual service payments was set out in Schedule 23: Payment Mechanism. In Schedule 23-2, there were various formulas set out that defined how the amount of service payments was to be calculated. [Note: There were no specific service payment figures provided in Schedule 23]. However, due to missing information as noted in paragraph 5.10 below and the resultant incompleteness of the definitions of some formulas, we were unable to quantify the annual payments according the Project Agreement.

5.9 If the missing information was available, it may have enabled us to ascertain how the $424 million NPV was calculated in Partnerships British Columbia's report. We note that the Partnership British Columbia report did not provide any definitions or explanations related to the formulas noted below.

5.10 The missing information includes the following:

a) In Schedule 23-2, paragraph 4., "Calculation of the Annual Service Payment", subparagraph 4.1, the formula for the annual service payment is set out. Part of that formula includes "ASP_{n0}^{lc}", which is defined at 4.1 (c) as follows:

"ASP_{n0}^{lc} is the element of the Annual Service Payment in year n identified as the year n real lifecycle payment in the schedule of "Real Lifecycle Payments" as set out in Appendix H.1 of this Schedule 23."

We note that there were no figures provided at Appendix H.1. For each contract year 1 to 30 in Appendix H.1, "[*DELETION] was in the "$" column.

b) In Schedule 23-2, paragraph 3., "Periodic Service Payment", subparagraph 3.1, the formula for the periodic service payment is set out. Part of that formula includes "ASP_p^{mec}", which is defined at 3.1 (e):

"$ASP_p^{mec} = ASP_{p0}^{mec} \times EscalationIndex_p$

where:

ASP_{p0}^{mec} has the meaning given to it in Schedule 9 – Financial Close Information.

(i) $EscalationIndex_p$ means the indexation to be applied to the ASP_0^{mec} for the relevant Periodic Payment where $EscalationIndex_p$ is the greater of:

*[*DELETION]*

where:

…"

Firstly, there is a deletion of information regarding the escalation index. Secondly, we note that on Schedule 9 – Financial Close Information, the meaning of ASP_{p0}^{mec} is, *"[*DELETION] (Per Year) [*DELETION] (Per Period)."*

c) The formula for the periodic service payment also includes "ASP_p^{fec}", which is defined at 3.1 (d):

"ASP_p^{fec} is the element of the Periodic Service Payment calculated for the relevant Payment Period as the sum, over all relevant months, of the amount calculated for each month that contains days that are part of the relevant Payment Period as:

(i) the monthly dollar amount specified in Appendix H.2 – Schedule of Nominal Fixed Escalation Payments of this Schedule 23 for that month, multiplied by

(ii) …"

We note that at Appendix H.2, there were no figures provided.

d) The formula for the periodic service payment also includes "UP_p", which is defined at 3.1 (g):

"UP_p is the Utility Payment calculated in respect of the relevant Payment Period in accordance with the provisions set out in Schedule 23-8."

We note that the provisions in Schedule 23-8 contain further formulas for which we do not have any actual figures to quantify the utility payment amount.

5.11 We provide alternative calculations of the NPV as at April 30, 2004 in the following section.

6.0 Alternative Calculations of the NPV as at April 30, 2004

6.1 We performed the following alternative net present value calculations that illustrate the sensitivity of discount rates used.

Alternative 1

6.2 Based on the information set out in Partnerships British Columbia's report, we calculated that the annual payment would have to be $37,819,880 given the following other parameters set out in that report (refer to Schedule 3):

- Discount rate: 6%
- NPV: $424 million;
- Payment commencement: May 2008; and
- Expiry of operating term of the agreement: May 2038.

[Note: we assumed each annual payment was made at mid-year]

6.3 Using the annual payment amount of $37,819,880 and changing the discount rates to 3.5% and 5%, we calculated the NPV at April 30, 2004 to be $616 million (refer to Schedule 1) and $490 million (refer to Schedule 2), respectively.

Alternative 2

6.4 In Alternative 2, we assumed the annual payment amount of $40.3 million based on the amount identified in Partnerships British Columbia's report as the payment amount for the first full operating year. Using discount rates of 3.5%, 5%, and 6%, we calculated the NPV at April 30, 2004 to be $657 million (Schedule 4), $522 million (Schedule 5), and $452 million (Schedule 6), respectively.

6.5 As shown above, using the discount rate has a very significant effect on the NPV calculations. In fact, under both alternative calculations, the NPV at April 30, 2004 using a discount rate of 3.5% is significantly higher than the public sector comparator of $463 million referred in the Partnerships British Columbia's report.

7.0 Restrictions

7.1 We reserve the right to adjust our calculations in light of any additional information that we receive subsequent to the date of this report.

8.0 Professional Qualifications

8.1 The statement of professional qualifications of the writer is attached as Appendix A.

Yours very truly,

MACKAY MYNETT
Chartered Accountants

Robert D. Mackay, C.A., C.B.V.
604-697-5201

Appendix C: Additional Issues Beyond the Scope of This Report

The following issues require more in-depth analysis:

- the excessive secrecy associated with the Abbotsford project since its inception;
- the need for accountable and transparent processes by government;
- the full consequences of adopting a 30-year service contract in the rapidly changing health care field;
- the ability, in practice, of the commissioning authorities to alter the P3 contract to reflect changing clinical practice, or patient, staff and taxpayers' need;
- the full costs of contract revision;
- the full range of risks that are likely to revert to taxpayers as a result of the contract form;.
- the impact of international trade agreements, such as NAFTA, as they relate to publicly owned and publicly delivered health services;
- the ability of public sector accountants and auditors to verify the value-for –money assumptions used to justify the Abbotsford project;
- the role of third-party consultants retained by Partnerships BC; and
- alternative and less costly procurement methods.

Appendix D:
Canadian Institute of Chartered Accountants Guidelines (excerpt)

8100.06:

Reviews are distinguishable from audits in that the scope of a review is less than that of an audit and therefore the level of assurance provided is lower. A review consists primarily of an enquiry, analytical procedures and discussion related to information supplied to the public accountant by the enterprise with the limited objective of assessing whether the information being reported on is plausible within the framework of appropriate criteria. In this Section, the word “plausible” is used in the sense of appearing to be worthy of belief based on the information obtained by the public accountant in connection with the review.

Enquiry, analytical procedures and discussions are normally sufficient for the purposes of considering whether information supplied to the public accountant is plausible in the circumstances. However, these procedures are not sufficient to provide reasonable assurance that undetected error or fraud does not exist. A review emphasizes enquiries of management, the responses to which the public accountant is entitled to accept as long as such responses appear plausible. A review does not require the public accountant to seek supporting or independent evidence or to study and evaluate internal control. As a result, the public accountant’s review will not normally include procedures such as physical inspection, observation of client procedures, confirmation from external parties and examination of documents which are usually performed in an audit.