

# **THE PATHOLOGY OF PROFITABLE PARTNERSHIPS: DISPOSSESSION, MARKETIZATION, AND CANADIAN P3 HOSPITALS**

by

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## Abstract

Public-private partnerships (P3s) are increasingly used in jurisdictions across Canada to deliver public infrastructure and services. The need for new or redeveloped hospital infrastructure in particular has made this a leading avenue for P3 proliferation. The objective of this study is to analyze P3 policy and projects, principally in relation to the BC and Ontario provincial health sectors. The central arguments made are threefold: P3s are a unique form of accumulation by dispossession and public sector marketization; P3 projects are intrinsically unable to meet the promises made by proponents and carry several other negative social consequences beyond this; and P3 policy, though rooted in normative ideological assumptions and aspirations, is being normalized in BC and Ontario through the establishment of P3 enabling fields over the past decade. The concept of an 'enabling field' captures a constellation of new arrangements, notably capital planning procedures and legislative frameworks, supportive secondary reforms, and greater institutional support for privatization. Together these elements help routinize, institutionalize, and depoliticize P3 policy.

Canada's pioneering full spectrum P3 hospitals (where the private partner is charged with designing, building, operating, and financing the facility) are examined in detail: in BC, the Abbotsford Regional Hospital and Cancer Centre and the Gordon and Leslie Diamond Health Care Centre; and in Ontario, the Brampton Civic Hospital and the Royal Ottawa Hospital. These cases reveal the troubling results that policy normalization ignores: poor value for money and inadequate risk transfer, misleading claims of 'on time and on budget' delivery, an erosion of service quality and working conditions, and opaque partnership agreements that offer little by way of accountability and transparency. These findings challenge the assumptions and rhetoric of P3 proponents, and offer different examples of how dispossession and marketization manifest in the public health care system.

**Keywords:** Public-private partnership; P3 enabling field; accumulation by dispossession; marketization; neoliberalism; Canada

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## List of Acronyms

AFP	Alternative Financing and Procurement
AHA	Access Health Abbotsford
AHCC	Abbotsford Hospital and Cancer Centre
AHV	Access Health Vancouver
CAMF	Capital Asset Management Framework
CCOPS	Cabinet Committee on Privatization and SuperBuild
CUPE	Canadian Union of Public Employees
DBFO	design-build-finance-operate
FHA	Fraser Health Authority
HEU	Hospital Employees' Union
HSRC	Health Services Restructuring Commission
IHA	Interior Health Authority
IO	Infrastructure Ontario
IPFP	Infrastructure Planning, Financing, and Procurement Framework
LHIN	Local Health Integration Network
MOHLTC	Ministry of Health and Long-Term Care
NDP	New Democratic Party
NHA	Northern Health Authority
OHC	Ontario Health Coalition
OPSEU	Ontario Public Service Employees Union
P3	public-private partnership
PBC	Partnerships BC
PC	Progressive Conservative
PFI	private finance initiative
PSC	public sector comparator
REOI	request for expression of interest
RFP	request for proposals
RFQ	request for qualifications
RHA	regional health authority
RID	routinization, institutionalization, depoliticization
ROH	Royal Ottawa Hospital
ROHCG	Royal Ottawa Health Care Group

THICC	The Healthcare Infrastructure Company of Canada
VCHA	Vancouver Coastal Health Authority
VfM	value for money
VGH	Vancouver General Hospital
VIHA	Vancouver Island Health Authority
WOHC	William Osler Health Centre

## **Introduction. The pathology of for-profit partnerships: researching and writing about P3s**

As a medical or clinical term, 'pathology' refers to the study of the nature of diseases and the systemic changes they induce. Used here as a metaphor, this term captures the deleterious impact that privatization via public-private partnerships (P3s) can have on Canada's public health care system. While P3s are used in many sectors, ranging from highways to water treatment facilities, by late 2011 P3 hospitals accounted for roughly half to three quarters of all such projects in Ontario and BC respectively, the two Canadian provinces most enthusiastic for P3s.<sup>1</sup> P3 hospitals relative to traditional hospitals are also becoming increasingly common in these particular jurisdictions. Since the early 2000s *all* new large hospital projects (those costing in excess of \$50 million) have been developed using the P3 model in these provinces.<sup>2</sup> The contract bundling feature and length of these partnerships set them apart from more limited forms of contracting-out as most elements of a project become monopolized by a single for-profit provider (usually a consortium) for several decades. As a result, private partners now design, build, finance, and operate most new hospital projects' physical infrastructure and support services in BC and Ontario.

The proliferation of P3s raises several concerns. The dispossession of public sector employee rights and democratic control are key issues, and so too is the marketization that occurs when for-profit actors and market-based reasoning come to deeply influence public policy making. A P3-oriented public sector is induced through, and represented by, changes in health sector policy practice and discourse, occurring most prominently through the invention of P3 enabling fields. The concept of an 'enabling field' captures the constellation of new arrangements that now serve to normalize P3 use: new capital planning procedures and legislative frameworks, supportive secondary reforms, and greater institutional support for privatization. Together these elements help routinize, institutionalize, and depoliticize P3 policy, shifting the bias away from traditional public procurement and toward P3s. Developments such as these remain underpinned by ideological preference for privatization but policy reform helps

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<sup>1</sup> For up-to-date figures see Infrastructure Ontario n.d; Partnerships BC n.d.

<sup>2</sup> With the exception of the Peterborough Regional Health Centre in Ontario (PRHC) which was announced by the Ministry of Health and Long Term Care in 2000 and fully operational in 2008. PRHC was the last large (\$197 million) traditional hospital approved in that province prior to the wave of P3 projects first launched in the early 2000s. See chapters 4, 5, and 7 for more on the history of Ontario's P3 hospital program.

to transcend this normative basis by cementing P3s as the 'new traditional' in the health sector. In other words, P3 proliferation relies upon both normative and normalized neoliberal policy.

Being a unique form of privatization, P3s contribute to dispossession and marketization by enhancing the breadth and depth of capital accumulation and fostering greater public sector dependence upon the market. Whereas enabling fields draw attention toward the policy attributes of systemic P3-initiated change, dispossession and greater market rule also clearly manifest through particular hospital projects. Understanding the pathological nature of the P3 hospital therefore requires addressing both policy and project-specific dimensions of this phenomenon. The hospital P3s examined here reveal the troubling results that enabling field normalization attempts to ignore and/or suppress: poor value for money and inadequate risk transfer, misleading claims of 'on time and on budget' delivery, an erosion of service quality and working conditions, and opaque partnerships that offer little accountability and transparency for the public at-large.

The aim of this introductory chapter is to highlight the political economy backdrop that informs the arguments and contributions of this dissertation, and to summarize what the proliferation of P3s means for Canadian health care and public policy. The latter half describes the research and writing processes undertaken to complete this study, including its methodology and theoretical underpinnings. A summary of the sections and chapters that make up the dissertation appears at the end of this chapter; it establishes the steps that will be taken to substantiate the core arguments that run throughout the thesis.

## **Context**

Beneath the obvious focus on P3s, the health sector, and hospitals, at heart this study seeks to address a widespread, fundamental feature of change within contemporary society: the erosion of alternatives to capitalist markets and the narrowing of space that exists beyond the reach of capital. As an outcome of the capitalist division of labour, the modern state is ontologically connected to private for-profit markets and ultimately acts as the guarantor of private property and enforcer of market social relations. Yet for a brief time during the Keynesian/postwar era (in Canada at least) the expansion of the public sector and creation of a welfare state came to moderate some of the more offensive and destructive features of capitalism by providing a social wage, actively intervening in the economy, and reducing market dependence (Armstrong 1977; McBride 2005; Wolfe 1977). Of course the reality of the Keynesian period cannot be adequately captured by broad generalizations, and Keynesianism

should never be mistaken for socialism – the welfare state supported capital accumulation and at least in part “was designed by governments that wished to preserve the power of the ruling class” (Finkel 1977, 345) – but the postwar political economy stands in stark contrast to eras both antecedent and successive.

For the first time in Canadian history a sophisticated public sector came to provide key goods and services at low or no direct cost to the public. In most instances public provision through Crown corporations or welfare state activities filled gaps that for-profit actors were unwilling or unable to occupy, in other rarer instances this involved supplanting capitalist markets and expropriating private assets (Whiteside 2012). By contrast, with the notable exception of primary education, prior to the 1930s public services remained scant and state intervention often favoured joint ventures with capital or bankrolling private investors through corporate welfare (Gordon 1981; Tupper and Doern 1981). Further, along with the welfare state came relatively secure, well paying public sector jobs (later enhanced through strong public sector unions), increasing the bargaining power of labour overall and socializing some of the burdens associated with social reproduction (shifting this away from women and households).

With onset of the neoliberal era in the 1980s, and even more so as of late, we are witnessing the reassertion of what Guest (1980) calls the ‘residual’ state – where social security (broadly defined) is provided privately by for-profit vendors, the family, and charities. A key part of this process is the (re)commodification of public services and infrastructure, turning these spaces into sites of profit-making in novel yet customary ways. In line with trends common to all eras of capitalist development, primitive accumulation (Marx 1977; Harvey 2003a) today involves the commodification of social forms and transformation of common or public property into private property – making theft, plunder, and pillage as significant now as ever. However, there are also new dimensions to this dynamic. The investment potential offered by spaces once kept relatively separate from capital is now being tapped through the introduction of market mechanisms. Hence the goods and services that are *still* provided by the public sector have now themselves become a site of capitalist profit making and the dispossession of rights won by labour (and activists more broadly) through collective bargaining and the welfare state. Given that the state structure, as Mahon (1977, 169-170) summarizes, is the political manifestation of class conflict, it should not be seen as the victim of capitalist market expansion, but rather as its expression.

Never an abstract concept, the expanding rule of capital is animated through specific instances (projects), affecting individual services and staff. Understanding how privatization occurs and its implications can thus benefit from a sector-specific focus. Canada’s public health

care system remains one of the country's few progressive, collectively-oriented, relatively generous areas of public policy; and it is ever encircled by the regressive, individualist, and austere political economy of the neoliberal era. The necessity of health care services make them an ideal target for dispossession, but this simultaneously helps to preserve strong public support for one of the few robust elements of the tattered welfare state. We must therefore be attentive to the mundane and less obvious aspects of dispossession within this sector, and how depoliticization is an important component of health care privatization.

The core of the medicare system – funding for universal health insurance (covering doctor's visits and treatment in hospital) – remains public, most nurses continue to be public sector employees, and doctors' fees are paid for by government, but other key components are now being gradually eroded. This has occurred in myriad ways including through service delisting (narrowing the range of services covered by medicare), shifting care into the home (where medicare coverage often does not extend), introducing budget cuts and freezes (manufacturing a 'sustainability' crisis), and allowing for-profit clinics to provide some surgical procedures (helping to foster two tier health care and siphoning off doctors and nurses). The internal erosion of the public health care system also proceeds through more straightforward forms of privatization: the use of P3s for hospital infrastructure and support services, and contracting-out public sector jobs to for-profit companies. The great irony here is that the internal erosion of the public health care system began at nearly the same time as the 1984 *Canada Health Act* was introduced into law. This piece of legislation forms the bedrock of the current federal commitment to nation-wide health care and enshrines principles such as reasonable access, universality, and comprehensiveness – all of which is greatly challenged by privatization, delisting, and for-profit clinics.

The depoliticization of public health care is occurring in two ways. First, social needs are made to conform to market dictates and public sector responsibilities are met through for-profit providers. Privatization is a clear example of this form of depoliticization given that it shifts areas of social concern away from the public sector and into the realm of capitalist accumulation. Referring to privatization as 'depoliticization' should not be taken to suggest that it is an apolitical process, instead it points to the elimination/reduction of public sector (and democratic) control, decision-making, and authority over important facets of society. Privatization will always remain *inherently* political given that the creation of exclusive rights of private property and the commodification of labour deeply affects the production, allocation, distribution, and consumption of goods and services; and thus power and wellbeing throughout society. Like Wood says of Marx's account of the social dimensions of power within capitalism



– a mode of production is a “relationship of power” (1981, 78) and therefore capitalist private property represents “the ultimate ‘privatization’ of politics” (ibid, 92).

A second form of depoliticization described in this dissertation relates to the transfer of decision-making within the bureaucracy from health authorities (both regional/local and provincial) to arm’s-length commercialized Crown corporations designed with the express purpose of facilitating privatization (P3 units). Along with this latter form comes the reorientation of public sector decision-making through new capital planning routines and protocols that favour P3s (important components of P3 enabling fields). Wider social goals such as those pertaining to health outcomes, democratic control, transparency, accountability, and service quality are often compromised along the way as change of this sort encourages or focuses on market outcomes (including market-based conceptions of value for money and risk), partnering with unaccountable private actors, commercial confidentiality, market discipline, and the quantity/speed of services provided. The use of Crown corporations to help promote privatization and its depoliticization is also a novel development within the public sector.

Privatization is therefore a process of significant social change. Profitable investment opportunities are expanded, services are turned into commodities, the state is restructured, labour is dispossessed, the ‘public interest’ is re-conceptualized, and bureaucratic decision-making is re-oriented. Privatization is also a moment. The origins of any one instance in this transformation can be pinpointed through the policies, frameworks, and decisions made within specific jurisdictions. Understanding the P3 phenomenon thus requires examining its dialectical attributes: the process and the moment. It also requires distinguishing rhetoric from reality: the justifications offered and inherent biases and assumptions made, compared to the actual operation of P3 projects. As Evans (2008) reminds us, often ‘*The world is not the way they tell you it is*’.

## **Objectives & contributions**

The three principal objectives of this study are as follows: i) to describe and analyze the political economy context in which P3s have emerged and the ways in which the P3 phenomenon contributes to the evolution of neoliberalization; ii) to critically evaluate the track record and implications of P3s (particularly P3 hospital projects); iii) to identify the role(s) played by the public sector in supporting, accommodating, and encouraging partnerships with for-profit private partners. By meeting these goals, this study contributes to a range of literatures related

to privatization, namely theoretical literature on dispossession and marketization, empirical literature on P3 projects (in particular, Canada's pioneering P3 hospitals), and policy literature on P3 implementation (specifically through its identification and description of provincial P3 enabling fields).

Addressing these objectives requires assessing the political economy of privatization. Political economy is not only an acknowledgement that politics and economics are interrelated; it is also a lens through which social phenomena may be analyzed. As Robert Cox (1996, 87) succinctly describes, "theory is always *for* someone and *for* some purpose." The particular political economy lens used in this dissertation is described in chapter 1. This chapter advocates for an understanding of both 'market politics' and 'politics of the market'. Examined from an eclectic historical materialist perspective (drawing on Marx (1947), Harvey (2001; 2003a; 2003b; 2006), and Panitch (1977), to name a few), politics of the market captures the socio-political change associated with the cyclical nature of capital accumulation. Market politics, on the other hand, draws attention toward the ways in which public policy change, though influenced by market dynamics, can be driven by internal contradictions as well (as argued by Leys (2001), Peck and Tickell (2002), and Keil (2009), among others).

The emergence of the P3 model in Canada in the mid-1990s is understood here to fit within the juncture identified earlier – it is both an expression of longstanding capitalist tendencies toward dispossession, and a uniquely modern variant of public sector privatization. The lease arrangements that form a P3 allow for ongoing dispossession within the state apparatus, differing from more familiar forms of privatization that sever public sector engagement and create exclusive rights of private ownership. Both the wider and project-specific arguments made throughout this dissertation remain intertwined: the story of the P3 hospital is a microcosm of privatization writ large, and privatization itself stands as a signature of capitalist development.

Marketization is another important theoretical concept relevant to neoliberal-era privatization. Analyzed in chapter 1, marketization is a widely used, though often ill defined concept. Here it is argued that there are two ways to apply the term to the use of P3s: the expansion of *market rule* that flows from private partner decision- and profit-making and the adoption of *market-like rules* by the public sector as a way of enabling P3 use.

Market rule is achieved through the dispossession of rights and customs previously enjoyed by citizens, public sector workers, stakeholders (e.g., patients, communities), and the public sector itself. Established through general discussions (chapters 2 and 3) and four specific Canadian P3 hospital case studies (chapters 6 and 7), there are a range of ways in which

market rule and dispossession affect P3 hospitals. The most obvious and immediate transformation is the decades-long privatization of work historically conducted by public employees (e.g., hospital cleaning, food services, laundry, maintenance, and physical plant upkeep) which can lead to more precarious employment. Given that between 70 and 90 percent of total health care costs, depending on the service, are derived through labour costs (Armstrong and Armstrong 2008, 125), profit for private employers is earned mainly through reductions in wages and benefits, and changes in working conditions. Not only does this negatively affect staff but reduced labour costs can also mean cut corners, with clear implications for health services and patients. For instance, when staff are provided with less training it can lead to lower quality or less rigorous cleaning, in turn affecting infection control and hygiene.

Hospitals account for the largest share of total health care spending in Canada (roughly one third) (CIHI 2012) and therefore governments may be tempted to introduce privatization as a way to reduce public expenditures. Yet greater profit making for the private partners and contractors does not necessarily translate into lower costs for taxpayers, especially when hospital infrastructure is privately financed. P3s are often used by government to avoid upfront capital expenses and as a way of shifting costs and risks away from the public sector – however higher interest rates, hidden fees, inadequate or misleading risk transfer, and higher private partner overhead costs all add up, producing more expensive infrastructure and services over the long run. Higher cost P3 infrastructure also places greater pressure on the community and third sector resources required to fund the ‘local share’ component of these projects.

Finally, the dispossession of rights and customs surrounding public sector decision-making (including democratic transparency and oversight) also occurs when P3 private providers – often large multinational corporations – come to manage, organize, and control some degree of future planning with respect to hospital services and infrastructure. Greater market rule presents a number of contradictions for the current and future management of public hospitals such as reduced capacity for future innovation (e.g., the application of new technology and spatial design techniques) and disintegrated hospital service organization and planning. P3s create an internal bifurcation of authority when private partners manage support services and public partners manage clinical services.

Market-like rules, the other major component of marketization with P3s, reorient public sector decision-making by adopting the logic and reasoning of capital. Market-based notions of risk and value for money re-conceptualize the ‘public interest’ and become the basis upon which P3 proliferation is encouraged. The term used here to describe the key policies involved in this

process is a 'P3 enabling field'. An original contribution made by this study is its identification of the presence of P3 enabling fields in Ontario and BC, and the classification and analysis of their component parts: enabling legislation and capital planning frameworks (BC's *Community Charter Act*, *Health Sector Partnerships Agreement Act*, and Capital Asset Management Framework; Ontario's *Municipal Act*, Infrastructure Planning, Financing, and Procurement Framework, and Alternative Financing and Procurement model); supportive secondary reforms (BC's restructured Regional Health Authorities, and the creation of Local Health Integration Networks in Ontario); and new forms of institutional support achieved via the activities of P3 units (Partnerships BC and Infrastructure Ontario).

Contradictions and problems produced by dispossession leave the P3 model vulnerable to crises of faith on the part of policy makers (particularly in light of longstanding public opposition to privatization in sensitive areas like health care) and to crises induced by greater market dependence (e.g., financial market volatility). The adoption of market-like rules through P3 enabling fields cannot ultimately eliminate the pitfalls associated with P3 projects, but it does stabilize the model in tough times, makes P3 projects easier to implement, regularizes the process, and creates a bias toward privatization – hence they 'enable' privatization by stealth. These initiatives furthermore constitute a 'field' given that they now inform decision-making across the bureaucracy and public sector. An exception to this wide-reaching influence is the co-existence of sector-specific P3 programs, involving reforms unique to health systems management such as the restructuring of Regional Health Authorities and creation of Local Health Integration Networks.

The establishment of P3 enabling fields, especially P3 units and new capital planning procedures, recalls Mahon's (1977) description of a bureaucracy's 'unequal structure of representation'. Not only do enabling fields privilege policies developed by Ministries of Finance and Infrastructure, but they force other social concerns (e.g., health and health care) to be addressed through the prism of a P3 screen – P3s must now be first considered for all large capital projects.

Whereas P3s are often presented by proponents as being strictly a new form of public infrastructure procurement, the theoretical and policy analysis of P3 hospitals offered here indicates that their emergence and unfolding is an important component of neoliberal restructuring by enhancing market dependence and widening/deepening the sphere of capital accumulation. A related contribution of this dissertation is, as alluded to above, its analysis of the implications that these developments hold for the public sector. It is argued here that enabling fields create a new 'common sense' that alters public sector decision-making and

procurement processes leading to covert yet enduring support for privatization. In other words, P3 enabling fields are highly transformative, not merely substitutes for older protocols or ways to fill in gaps that previously existed with earlier modes of P3 development. The nature of this transformation can be best described as involving three processes: routinization, institutionalization, and depoliticization (RID). RID helps to regularize this form of privatization and ensures that any changes made to P3 programs affect how P3s proceed, not whether they proceed. Ultimately, through these processes P3s become the 'new traditional' way in which public infrastructure is designed, built, financed, and operated.

## **Research methods**

Post-positivism is an epistemological foundation of this study as interpretation, not a neutral and distanced stance, is integral to understanding how privatization (P3 policy and projects) unfolds in provincial health care systems. Given the focus on the dialectical features of this phenomenon – the process and the moment – this study incorporates both synchronic and diachronic interpretations. A synchronic (or static) understanding is one that “contemplat[es] the coherence of a social relationship within its own terms” and thus “evaluate[s] how a relationship, an institution, or a process operates in narrow or day-to-day terms” (Sinclair 1996, 8). This strategy is used mainly in reference to particular instances of privatization, such as a P3 hospital or item of enabling legislation. On the other hand, process, context, and change remain indispensable to understanding the implications of privatization and thus diachronic interpretation is also employed given its strength in “seek[ing] out contradictions and conflicts inherent in a social structure and contemplate[ing] the characteristics of emerging social forces” (ibid). Like processes and moments, diachronic and synchronic understandings are complementary – particularly for the advancement of heterodox political economy theory.

The policy techniques, practices, and institutions that support P3 development, the track record and legacy of P3 hospital projects, and the historical, economic, and social forces that contribute to the flourishing of the P3 model have been studied through triangulation by incorporating process tracing, content and discourse analysis, and key-informant interviews. Triangulation is commonly employed across the social sciences and within many methodological orientations since it makes use of multiple data-gathering techniques in order to establish, confirm, and refine interpretation (Berg 2007, 6). Data collection for this study involved a mix of primary and secondary sources.

Critical literature reviews, interdisciplinary in nature, drew on scholarly sources and gray literature; and policy analyses were informed by government policy briefs, statements, guidelines, and other relevant sources (e.g., Hansard transcripts, official audits, and value for money reports published by P3 units and private sector consultants). Scholarly and gray sources were used to establish the track record and legacy of P3s (generally and within the health sector), focusing on the illusory nature of cost savings, risk transfer, and value for money; and how P3 hospitals stifle innovation, create an internal bifurcation of authority within hospital management, and unduly burden the resources of the third sector and local community (chapters 2 and 3). Government sources (e.g., official budgets, service and performance agreements, policy frameworks, and other documents released by Ministries such as Finance, Infrastructure, and Health) were particularly useful in establishing the argument that BC and Ontario have constructed 'P3 enabling fields' (chapter 4) with the effect of routinizing, institutionalizing, and depoliticizing dispossession and marketization via P3s (chapter 5).

Four P3 hospital case studies were selected for this research: in BC, the Abbotsford Regional Hospital and Cancer Centre and the Gordon and Leslie Diamond Health Care Centre; and in Ontario, the Brampton Civic Hospital and the Royal Ottawa Hospital. These four were initially chosen because they corresponded to the total number of operational design-build-finance-operate (DBFO) P3 hospitals in Canada when this research began in 2009. It was essential that the hospitals were operational since this would yield the maximum amount of usable information with regard to the project agreement, completion time, and final cost of the project, whether best-practice standards were met, aspects of labour relations during the negotiation period and into the operational stage of the P3, and whether initial concerns did in fact materialize.

Since beginning this research, additional P3 hospitals have opened and many more have been launched, although nearly all of these remain confined to BC and Ontario. Instead of posing a problem for this study, the evolution of P3 policy and project development presented an opportunity to reframe the significance of these four case studies. Rather than being Canada's only four operational DBFO hospitals, they stand as pioneering P3 projects in the provincial health sector. As is discussed in chapters 6 and 7, these pioneers helped to guide the development of health sector P3 programs in BC and Ontario. In addition, since they emerged prior to the sophistication of these programs (before P3s were routinized, institutionalized, and depoliticized), their procurement and operational phases more clearly reveal the underlying reality of privatization in health care – its ideological roots and the flaws inherent to P3 rationale. In keeping with the post-positivist methodological orientation of this

study, these cases are not being used to represent *all* varieties of P3 hospital. They are used instead to question and analyze the assumptions and rhetoric of P3 proponents, and should be thought of as different examples of how dispossession and marketization manifest in the public health care system.

Secondary sources were initially consulted in order to produce a rough sketch of each hospital project. Value for money reports published by Partnerships BC and Infrastructure Ontario were informative as much for the data contained within them as for what they did not reveal. These reports provide only 'bottom line' information and thus do not disclose the level of detail required for the public to independently assess value for money. Given that a core aim of this study is to critically analyze the claims made by P3 proponents (Partnerships BC and Infrastructure Ontario being chief institutional champions of the P3 model in each respective province), far more additional research was required. Reports by Auditors General remain scant although indispensable where available (for the Diamond Centre and Brampton Civic Hospital), as were transcripts from Select Standing Committee meetings on topics relevant to P3 policy and projects. Owing to the relative lack of transparency and official reporting, in many instances the gray literature published by unions and public health care advocacy organizations remains a principal source of financial and technical data, particularly when authored by forensic accountants (e.g., Parks and Terhart 2009). Newspapers articles were also useful in establishing timelines and identifying local issues and concerns. There are comparatively few scholarly sources currently available on P3 hospitals in Canada – and hence another contribution of this study is that it adds to that body of literature – although these were incorporated where relevant.

The scarcity of secondary material available on each case made formal and informal key-informant interviews a necessary component of this research. Interviews were used to confirm findings and fill in gaps, to seek answers tailored to this study, as well as to identify issues that may have otherwise been missed. Sampling for this original research made use of the non-probability snowball technique where interviewees were initially chosen for their expertise and/or firsthand experience with P3 projects, and additional contacts were added from there using the recommendations of those initially interviewed.

The interview format ranged from formal, semi-structured interviews to informal personal communications. Personal communications were held with experts on P3s and/or health care (John Loxley, University of Manitoba; Colleen Fuller, Canadian Doctors for Medicare; Mike Old, Hospital Employees' Union; and Pat Armstrong, York University). Formal, semi-structured key-informant interviews were held with various types of research participants. Some were chosen

for their expertise on P3s and for their insight into the impact of privatization on health care support staff and unions (Hugh Mackenzie, Canadian Centre for Policy Alternatives; Doug Allan, Ontario Council of Hospital Unions; Nancy Pridham, Ontario Public Service Employees Union; Keith Reynolds, Canadian Union of Public Employees; Rick Jansen, Ontario Public Service Employees Union; Robbin Knox, Hospital Employees' Union); whereas other research participants were selected for their upper level decision-making involvement within public partner health authorities in BC (Fraser Health Authority and Vancouver Coastal Health Authority) and public hospital corporations in Ontario (William Osler Health Centre and The Royal Ottawa Health Care Group), and private partner service providers (Carillion Canada and Sodexo Canada). The names and positions of the seven interviewees employed by public and private partners have been kept confidential in accordance with their wishes and with research ethics guidelines. Formal and informal interviews were conducted throughout 2012 in person (in Winnipeg, Toronto, and Vancouver), as well as over the phone and via email.

Interview questions were adapted for each type of interview. For P3/privatization experts, the questions were of a general nature and related mainly to policy and project evolution. For instance this involved evaluating the differences between forms of privatization (e.g., contracting-out vs. P3s), P3 programs in Canada (BC vs. Ontario), and identifying changes or commonalities over time (i.e., the P3 hospitals studied here compared with those more recently developed). Interviews conducted with those working for public and private partners as well as the unions affected by the P3 projects analyzed in this study involved more specific questions tailored to each particular hospital project. This included obtaining information on the development and operational phase of each project (e.g., experience with contracting-out prior to the use of P3s, labour relations and working conditions, the performance of private service providers, and how public and private partners address ongoing difficulties and disputes).

Through this mix of primary and secondary sources, the focus of case study analysis in chapters 6 and 7 corresponds to the projects themselves as well as to how they relate to the evolution of P3 policy. Each P3 hospital project is discussed in terms of the degree to which its performance matches with the promises made by proponents (relating to risk transfer and value for money, savings, and on-time and on-budget delivery). However, attention is also paid to aspects that are seldom discussed by privatization enthusiasts: the implications for labour and service delivery, and the incorporation of private for-profit decision-making into the heart of hospital and health service decision-making.



The central arguments, findings, and themes of each chapter are summarized in the section that follows.

## **Chapter summary**

The central arguments made here are threefold: P3s are a unique form of neoliberal accumulation by dispossession and public sector marketization; P3 projects are intrinsically unable to meet the promises made by proponents and carry several other negative social consequences beyond this; and P3 policy, though rooted in normative ideological assumptions and aspirations, is now increasingly normalized in jurisdictions that have established P3 enabling fields over the past decade (BC and Ontario). Normalization proceeds through the routinization, institutionalization, and depoliticization of P3 use within the public health care system. These arguments are substantiated through seven chapters divided into two sections.

Section one examines the political economy of privatization and P3s in Canada. The focus narrows to the health sector in the final chapter of this section.

Chapter 1 (*Market politics and politics of the market*) introduces and examines key concepts used throughout this dissertation: neoliberalism (including its normative and normalized dimensions), marketization (the expansion of market rule and market-like rules within the public sector), crisis (of capital, of/in neoliberalism), and dispossession (the impetus behind, and many faces of, privatization). It also looks at how the state has rolled-back, rolled-out, and rolled-with marketized regulatory reforms over the neoliberal period. These themes are linked to privatization and P3 policy. The unique features of P3s as privatization are also discussed.

Chapter 2 (*Partnering for profit*) examines the theory, track record, and assumptions informing P3 policy and projects. Two large sections make up the chapter: the features, promises, and reality of P3 policy and projects; and how P3s were affected by the 2008 global financial crisis. Key terms and concepts and their normative underpinnings are also elucidated: risk transfer, off-book financing, cost savings, value for money, and P3 evaluation methodology.

Chapter 3 (*Unhealthy policy*) discusses the historical establishment and evolution of the public health care system in Canada, including its internal erosion across the neoliberal era. The principal items examined are fiscal austerity at the federal level and loss of national oversight, provincial policy restructuring and the introduction of marketization at the provincial and local level, as well as the impact of health care privatization on social reproduction (patients and staff). The latter half of the chapter looks at the specific drawbacks of P3 hospitals: how

they stifle innovation, create an internal bifurcation of authority, and unduly burden the resources and efforts of the third sector (e.g., charitable organizations) and local forms of governance (e.g., regional districts and public hospital corporations).

Section two analyzes P3 hospital policies and projects in BC and Ontario, making use of the concepts explored in the previous section, in particular: neoliberalization (normative and normalized dimensions of routinization, institutionalization, and depoliticization), marketization (the spread of market rule and market-like rules), and dispossession (the impetus behind P3s). It is concerned with specifying how the theory and trends described in the previous section apply to specific provincial health sector P3 projects and policies, giving it a narrower focus overall.

Chapter 4 (*Normalizing dispossession*) delves into the netherworld of market-oriented policy restructuring. It highlights the movement away from developing individual P3 projects to instead creating P3 programs within provincial health sectors, which has pushed P3s into being the 'new traditional' way of delivering hospitals in BC and Ontario. This shift has been encouraged through the creation of P3 enabling fields, the main items of which are identified and discussed.

Chapter 5 (*Normalizing neoliberalization*) follows up on the analysis provided in chapter 4 by examining how enabling fields routinize, institutionalize, and depoliticize P3 development. Three primary enabling field components are then further explored: capital planning procedures, health authority restructuring, and the creation of P3 units.

Chapters 6 and 7 (*Launching transformations*) provide case study examples of P3 hospitals. They focus on the trailblazers of the Canadian market: BC and Ontario's pioneering DBFO P3 hospitals – the Abbotsford and Diamond Centre projects in BC, and the Brampton and Royal Ottawa projects in Ontario. Cases are examined for their performance and legacy: the historical and political circumstances under which they were created, their economic and financial consequences, the shape of the new governance model in health care, and how social reproduction (health and health care workers) has been affected within P3 hospitals. However, given that P3 hospital proliferation continues, the latter portion of each chapter looks at how more recent P3 hospitals and policies were affected by the legacy of those that came first.

The conclusion (*Stabilizing dispossession*) summarizes the P3 hospital track record, as seen through the cases examined in chapters 6 and 7. It then looks at how, in light of these serious problems, health sector program stabilization occurred; as well as how P3 policy was stabilized after the 2008 global financial crisis – and what this might mean for neoliberal intensification overall. The discussion is capped off with a description of alternatives, and the

limits to alternatives (particularly in light of the constraints imposed by P3 enabling fields), to the P3 model in health care.

**SECTION 1. Examining the political economy of privatization and P3s in Canada**

## **Chapter 1. Market politics and politics of the market: dispossession, crises, and neoliberal state restructuring**

Privatization is a multi-faceted phenomenon. Not only does it take many forms, it also alters the role of the state and expands the purview of the market. Understanding privatization therefore requires examining both its policy attributes and how it relates to changes (and crises) within the capitalist system. This chapter seeks to address the public and private components of privatization by situating the policy within its wider context. This analysis follows in the heterodox (historical materialist) political economy tradition of recognizing that the capitalist state plays a strong and indispensable role in supporting and creating the appropriate conditions for profitability, but it also acknowledges that public policy options are varied and not mechanistically derivative of capitalist imperatives. The tension that exists between understanding public policy changes on their own terms and in light of the wider context of capital accumulation will be approached through the twin concepts of ‘market politics’ and ‘politics of the market’.

‘Politics of the market’ refers to socio-political change associated with the cyclical nature of capital accumulation. ‘Politics’ in this broader sense result not only from government activities as changes within capitalist markets hold important social and policy implications as well.<sup>3</sup> The postwar Fordist regime of accumulation provides a clear example of this dynamic. Fordist-era accumulation was centred upon mass production and consumption, rising productivity and income, and profit-making linked to full capacity utilization and greater investments in mass production (Jessop and Sum 2006, 60). Fordism thus held profound social, political, and economic implications – influencing institutions, norms, and organizational forms such as the system of collective bargaining, social reproduction, the scope of the welfare state, and banking and financial arrangements. Neoliberal era accumulation, to be examined more closely in this chapter, instead features dynamics such as accumulation by dispossession and financialization, which hold their own unique implications for the state, public policy, and society more generally.

Economic turbulence such as recession, financial crises, and declining rates of profitability can be similarly addressed through the politics of the market. The growing

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<sup>3</sup> The term ‘market,’ it also should be noted, is being used here to specifically refer to private for-profit markets derived through the capitalist mode of production, based on private property and the capitalist division of labour. Markets distributing goods and services through other modes of production (e.g., feudal) have existed in the past and will continue to exist in the future under alternative modes of production (e.g., socialist). Thus ‘the market’ should not be conceptualized in either ahistorical or transhistorical terms. Similarly, referring to ‘the state’ is expedient but ought to be understood as indicating a particular form of state – that is to say, a capitalist state. Other qualifiers and attributes are equally important as well (e.g., ‘the neoliberal state’).

exhaustion of the Fordist regime of accumulation was dealt with in part through spatio-temporal change within capitalist markets (e.g., outsourcing and the development of just-in-time flexibilization). However, market forces are but one aspect of crisis-induced social restructuring and the institutional support provided by the state remains crucial. State support can take many forms, not all of which encourage ever-greater market expansion. For instance, as Fine and Harris (1976, 102) describe, when a serious crisis emerges renewed accumulation is only partially accomplished by capital; it is also initiated through, and supported by, forms of state intervention such as nationalization, financial assistance, and greater supervision of industry. State intervention in times of crisis can therefore involve a significant reorientation of public policy, urging the need for a simultaneous analysis of market politics.

The concept of 'market politics' used here has been adapted from Leys' (2001) description of market-driven politics, which he argues arise when economic forces come to shape and constrain domestic policy choices. Rather than viewing economic forces as wholly determinative, this chapter instead emphasizes policy choice and evolution within the context of market constraint.<sup>4</sup> Thus state restructuring can be thought of as strategic and historically specific (often involving adjustments induced through internal contradictions) rather than being strictly dictated by the market.

The range of policy options available to decision-makers becomes most obvious when state intervention is viewed from an historical perspective. This chapter deals mainly with evolution over the neoliberal era (roughly 1980-today) although some contrast with the previous era of the Keynesian welfare state will be provided. One predominant feature of neoliberal policy has been its emphasis on marketization: shifting what were previously public sector responsibilities into the realm of the for-profit private sector, and the subjection of policy practices and bureaucratic decision making to market-like rules. The former expands market rule over an ever-wider array of social concerns and fosters greater market-dependence within the public sector; and the latter reorients public sector decision-making and incorporates market-based reasoning into the formulation and execution of public policy.

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<sup>4</sup> An additional difference between 'market politics' and 'market-driven politics' include Leys' (2001, 2008) assertion that neoliberal globalization has forged a novel relationship between politics and markets. For example, he states that market-driven politics describes the "way national politics and global market forces are *now* connected" (2008, 26, emphasis added). Instead this chapter argues that market forces (global and local) have, to one extent or another, always influenced capitalist state policy. Furthermore, Leys casts the economic and the political as antagonistic when he suggests that "we have to recognize how far the balance of power between governments and corporations has shifted" (2008, 76). Here market politics and politics of the market are considered non-rival and intrinsically interconnected.

Just as the capitalist system is inherently unstable, the neoliberal policy techniques and practices that promote market rule and market-like rules are also riddled with contradictions. Witnessed over the past thirty years, the failure of neoliberal era market politics to generate sustained economic growth and widespread prosperity has led to variations within the policy mix (some incremental, some sudden) in tandem with economic turbulence over this same period – yet for all its failures, neoliberalism has evolved rather than being abandoned. As described by Peck and Tickell (2002), in the late 1970s/early 1980s the neoliberal era was ushered in through a rolling-back of the Keynesian welfare state but by the 1990s new practices and prescriptions began to mark a phase of neoliberal roll-out. Despite the challenges presented by the 2008 global financial crisis and the discrediting of certain core tenets of the paradigm (Fine and Hall 2012, 50), neoliberal market politics remain normalized, having attained the mantle of a pragmatic or ‘common sense’ way of governing. Keil (2009) calls this the ‘rolling-with’ phase of neoliberalism given that even when policies fail, the model ultimately triumphs once substantial engagement with alternatives ceases to occur.

The interrelated concepts of ‘politics of the market’ and ‘market politics’ are used in this chapter to thematically introduce what follows in subsequent chapters: the multifaceted dynamics of dispossession, marketization, and neoliberal restructuring; as well as the relationship that exists between crises of capital and policy change. After these concepts and connections have been established, the focus of the chapter narrows to the public-private partnership (P3) phenomenon. This includes reflecting on why, given their particular contribution to dispossession and marketization, P3s are a unique form of privatization.

## **Market politics and politics of the market**

For Marx (1947), the historical emergence of the capitalist state marks the simultaneous depoliticization of market activities as formal political decision-making becomes dominated by government and the state apparatus more broadly.<sup>5</sup> As Sayer (1985, 233) describes it:

On the one hand, the state is constituted as (at least ideally) the arena of general, public concerns, understood straightforwardly as the interest of all. Individuals become *citizens* of the polity, enjoying (again if only in theory) equal political and legal *rights*. On the other hand, this is *ipso facto* a process of *de*-politicisation of civil society, in the sense

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<sup>5</sup> Depoliticization via privatization shifts certain areas of power and decision-making away from the public sphere and (back) into the private for-profit realm. Thus referring to ‘depoliticization’ today in many ways evokes the antonym of ‘depoliticization’ as used by Marx. See chapter 5 for more on contemporary forms of depoliticization.

that (formally at any rate) individuals' particular, material circumstances do not carry with them different political or legal statuses. All are equally citizens of the state, all are equal before the law. Formation of the political state and de-politicisation of civil society are two sides of the same coin.

Generally speaking, this bifurcation of 'public' (state) and 'private' (market/civil society) social forms remains with us today but these realms are best thought of as containing unique social expressions of power rather than being insulated facets of society.<sup>6</sup> Both the state and market are products of the capitalist division of labour, uniting them on an ontological level.<sup>7</sup> The state, public policy, market dynamics, and the balance of class forces are therefore intrinsically linked. Moments of systemic crisis are particularly revealing as they expose these interconnections in ways not readily apparent during economic upswings or conditions of generalized prosperity.

### **Crises, fixes, and accumulation by dispossession**

In contrast to neoclassical economic theory that views capitalist markets as "failure-free" (Pitelis 1992, 14) – relegating moments of crisis to random and exogenous events such sudden supply shocks (e.g., changes in the price of oil), government failure (as the monetarist school would argue, see Friedman 1962), or even to microeconomic concerns such as incomplete information (Pitelis 1992) – within the heterodox political economy tradition the cyclical and crisis-prone nature of capitalism is often the primary focus of analysis.<sup>8</sup> There are several leading heterodox perspectives on the underlying causes of capitalist crises, none of which can be adequately examined here.<sup>9</sup> These include long wave theories such as those propounded by regulation theorists (e.g., Aglietta 1998; Boyer and Saillard 1995) and by the social structure of accumulation approach (e.g., McDonough 1999; O'Hara 1998; 2006). However, the real strength of these long wave theories lies not in their focus on crisis but instead on stabilization: how the ups and downs of capitalism are smoothed out for particular periods of time.<sup>10</sup> While each approach is different, they all tend to emphasize the successful, albeit temporary, arrangements that lead to generalized prosperity and economic predictability through the

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<sup>6</sup> Ellen Meiksins Wood (1981) also provides an insightful discussion of the separation and differentiation of the 'economic' and 'political' spheres within the capitalist system.

<sup>7</sup> For an iconoclastic critique of the Marxian political vs. economic duality see Nitzan and Bichler 2009, Chapter 2.

<sup>8</sup> Keynesian theory also emphasizes cycles of boom and bust.

<sup>9</sup> See McBride and Whiteside 2011a Chapter 2 for a more complete summary.

<sup>10</sup> Cycles can last for various lengths of time. Those most commonly referred to are known as 'Kondratieff cycles' which run roughly 40-60 years in length but others can be several decades to over a century long (O'Hara 2006, 13).



support for capital accumulation, investment, and consumption that comes from extra-economic institutions (Kotz 1994, 57).

Alternatively, Marxist overaccumulation theorists, most notably David Harvey (e.g., 2001; 2003a; 2003b), point to the features of the capitalist system that produce crises and lead to endemic instability. For overaccumulation theory, periods of crises are not unique or necessarily driven by the failure of extra-economic institutions but rather by the very functioning of the capitalist mode of production and the contradictions it engenders. Harvey describes three central contradictions that produce these periodic crises: those that arise within the capitalist class as individual capitalists act in a competitive profit-seeking manner; the antagonisms between labour and capital that create class struggle over the wage/profit split; and the contradictions that arise when strife occurs between the capitalist production system and non- or pre-capitalist sectors (Harvey 2001, 79-80). These conflicts can lead to crises of overaccumulation, which are “particular manifestations of excess capital ‘held up’ in all of the states it assumes in the course of circulation” (Harvey 2006, 195). Surplus capital is thus the root cause of widespread systemic crises. Overaccumulation can take many forms of appearance, including: a glut of commodities on the market, idle productive capacity, and surpluses of money capital lacking outlets for productive and profitable investment (ibid).

Moments of ‘crisis’ therefore do not signify a collapse of the system but instead initiate the replacement of (some) problematic features of one mode by shifting to what Harvey calls a ‘new plane’ of accumulation that structures new, more successful arrangements (ibid, 241). This new plane will typically involve the following elements: the penetration of capital into new spheres of activity (by reorganizing pre-existing forms of activity along capitalist lines), the creation of new social wants and needs, and a geographic expansion into new regions (ibid, 241-2). In addition to geographic expansion and spatial reorganization, Harvey adds the concept of temporal displacement to account for long-term investments in physical and social infrastructure, which he then terms ‘spatio-temporal fixes’ (2001, 312-344; 2003b, 64-68). He describes how this process absorbs surplus in the following way: “temporal displacement [encourages] investment in long-term capital projects or social expenditures that defer the re-entry of current excess capital values into circulation well into the future; and spatial displacement... open[s] up new markets, new production capacities and new resources, [and new] social and labour possibilities elsewhere” (ibid 2003b, 64). Temporal displacement is most often associated with the use of credit markets to defer debt repayment, a process that has assumed new heights of importance with neoliberal financialization.

The use of the term 'fix', therefore, is "a metaphor for solutions to capitalist crises", which extends beyond economic restructuring to include social, political, and institutional support mechanisms (ibid, 65). The transformation of a crisis into a new plane of accumulation is crucially dependent on the state. Given that capitalist society is class divided, and that these divisions directly contribute to crises, "a separate structure to specifically maintain, monitor, and restore equilibrium" is a necessary feature of successful long-term accumulation (Barrow 2002, 25). The state takes up this task by "ensur[ing] the reproduction and the political cohesion of capitalist societies" (Thomas 2002, 80). More specifically, the analytical framework established by O'Connor (1973) and advanced by Panitch (1977) identifies important accumulation, legitimation, and coercion roles played by the capitalist state. How these policies manifest can vary from state to state in each historical era. From roughly the mid-1940s to today, Canada has had two distinct fixes, one associated with the Keynesian welfare state (KWS), and the other with the more recent emergence of neoliberalism. Both arose out of a crisis of overaccumulation.

The accumulation regime established during the postwar era was unusually successful while it lasted, for as McCormick suggests, this was "the most sustained and profitable period of economic growth in the history of world capitalism" (McCormick 1989, 99). Beneficial and self-reinforcing attributes of the Keynesian fix include its Fordist high growth and consumption model which was centred on a relatively generous market and social wage.<sup>11</sup> However, by the mid-1970s growing problems with the postwar fix were becoming evident around the world. High rates of growth, productivity, employment and wages, and profitability were all salient characteristics of the decades following the Second World War but by the late-1960s global capitalism had entered into an economic downturn (Kiely 2007, 62). For example, between 1965 and 1973 the rate of profit in the US fell by 40.9 percent in the manufacturing sector, and by 29.3 percent in the private business sector generally (Chernomas and Sepehri 2002, 1). This downturn in profitability in the US was of special concern for Canada given its 'branch-plant' status (Panitch 1981, 284). By 1975, overaccumulation in the manufacturing sector in Canada had clearly set in, taking the form of "high unemployment of labor and capacity, slow growth of output and limited accumulation of capital" (Webber and Rigby 1986, 34). Thus began a restructuring campaign promoting the belief that the Keynesian class compromise embodied in the KWS was now a fetter on profitability, ultimately leading to the initiation of several significant policy changes in the early 1980s.

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<sup>11</sup> For more detail, see McBride and Whiteside 2011a, Chapter 3.

The adoption of monetarism early on in the neoliberal era initiated a sharp break from the previous method of demand management and its accompanying high-growth model. This new policy, aimed at controlling inflation at the expense of full employment and encouraging investment rather than consumption, began in Canada when real interest rates were increased from their negative or low levels in the 1970s to 6 percent in the 1980s, peaked at 9 percent in 1990, and remained around 4-6 percent in the 1990s (McBride 2005, 100). Whereas creditors benefit from high interest rates, debtors, including large government debtors, can quickly find themselves strapped for cash when interest rates rise so dramatically. In Canada this translated into an increase in gross public debt as a percentage of budgetary revenues from 12.7 percent in 1970-71 to 34.1 percent by 1989-90, putting an enormous strain on the ability to pay for the KWS at a time when regressive taxation policies were first being adopted (McBride 1992, 99-100).

Monetarism therefore worsened the burgeoning recession and created the very conditions needed to justify the widespread introduction of neoliberalism. Although it has become commonplace to suggest that neoliberal policies were a solution to the faltering KWS, in practice these policy changes have served to undermine the ability of the welfare state to function properly. Rather than accepting the standard description of neoliberalism as the solution to the problems of Keynesian economic policy, instead neoliberal tactics had the result of exacerbating the economic slump and eliminating viable options for repair of the KWS.

Another hallmark of the neoliberal era has been the widespread adoption of accumulation by dispossession. Whereas Marx's *Capital* focused on valorization through expanded reproduction, Harvey insists that the processes of 'original accumulation' identified by Marx are ongoing features of the system, and not relics of a pre-capitalist or proto-capitalist period (Harvey 2003a, 144). For Harvey, dispossession remains continually important as it devalues assets and/or strips away rights so as to create an 'outside' that can then be incorporated into the circuits of capital accumulation at low, or no, cost (ibid, 149). In this fashion, new spaces for capital accumulation are opened up and overaccumulated capital can be valorized. Crises can therefore be resolved at least in part through accumulation by dispossession.

Although dispossession is by no means unique to the current era, it is especially prevalent with neoliberalism. This includes the creation of new mechanisms to enclose the commons (e.g. privatization), the creation of new markets (e.g. trading in carbon credits), and

devaluation through currency speculation (ibid, 145-8).<sup>12</sup> Considered together, neoliberalism and its penchant for dispossession are meaningful ways to explain not only the waves of public asset divestiture in the 1980s, but also the more common forms of privatization today: contracting-out and the use of P3s. Despite manifesting in different policy forms, all types of privatization are equally part of a neoliberal spatio-temporal fix for two reasons. First, they all provide for spatial displacement by enhancing the breadth and depth of profitable private accumulation. Second, temporal displacement is achieved by opening up investment in long-term capital projects and social services to surplus capital rather than the previous pattern of 'crowding out' private investment in these areas. Privately financed P3s in particular allow for both spatial and temporal displacement through accumulation by dispossession.

As is the case for the capitalist system more generally, the neoliberal fix holds many problems and contradictions. Dispossession may create new markets for investment and financialization may temporarily defer crises through an expansion of credit markets, but both have proven unable to generate the sustained growth and prosperity required for an upswing to occur. With respect to dispossession, Arrighi et al. (2010, 411) argue that over the long run it "undermines the conditions for successful development," and Harvey (2003a, 154-6) agrees that it can end up disrupting or destroying paths to expanded reproduction. One reason for this relates to the deleterious impact that privatization can have on wages and working conditions, dampening effective demand and hence profitability. Financialization, another important component of the neoliberal fix, also contains its share of contradictions (Fine and Hall 2012). The expansion and proliferation of financial markets has enabled significant wealth and affluence for some, but easy access to credit in concert with stagnant or declining real wages and a decades-long global economic slump (McNally 2011) also promotes unsustainable levels of debt fueled investment and consumption, the catastrophic results of which were made clear with the 2008 financial crisis (McBride and Whiteside 2011a, 2011b).

Before turning to the policy transformations that have occurred over the neoliberal era in an effort to accommodate, defer, and repress contradictions of this sort, it is worth reemphasizing that the capitalist state, and hence public policy, is a reflection of the balance of class forces over time. The onset of neoliberalism is not the product of blind economic necessity; its privileged position requires constant maintenance and renewal. Similarly, the

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<sup>12</sup> This theory is not without its detractors, the most common critique being that it is too expansive and/or not precise enough (Brenner 2006; Fine 2006; Ashman and Callinicos 2006). Brenner (2006, 100), for example, calls this a "virtual grab bag of processes" since it encompasses, amongst other things: the concentration of capital, transfers of assets amongst capitalists, the intensification of labour exploitation, and the modern day enclosure of the commons (privatization).

Keynesian fix set the tone for how to revive a morbid economy after the Great Depression of the 1930s, but the establishment of the welfare state itself was never predestined – it took strong public demand and much struggle over the years for it to bloom. In addition, dispossession does not necessarily happen overnight nor is its entrenchment as a policy norm always a splashy, high profile affair. Rather, as Cohen (1997, 49) shows, it can also be gradually implemented through “a steady erosion of programs and institutions ... achieved by introducing a thousand little budget cuts, tax changes, and hard-to-explain technical manipulations to existing legislation.” Subsequent chapters (4 and 5) delve into the policy and legislative changes, small and large, which enable dispossession via P3s within Canada’s public health care system.

### **Transformations within neoliberalism**

Neoliberalism is a political project that aims to expand private markets and thus the realm of market social relations. Market expansion is achieved in a number of ways, state restructuring and policy transformation being central among them. Neoliberal public policy typically draws on some combination of the following: budgetary austerity, the implementation of regressive taxation, de/re-regulation, privatization, liberalization and the adoption of free trade agreements. However, the exact nature of neoliberal reform has evolved over the past few decades, as internal contradictions have necessitated policy learning and adjustment. Work done by Peck and Tickell (2002) on the ‘roll-back’ and ‘roll-out’ stages of this process is particularly informative. They describe three phases: first, during the 1970s, neoliberalism was mainly an intellectual project and a critique of the orthodoxy at the time – Keynesian economics. Second, global stagflation and a massive run up of public debt were used to promote a change in policy orientation that led to a paradigm shift in the 1980s under ideologically-motivated governments such as the Reagan, Thatcher, and Mulroney administrations.<sup>13</sup> This phase in the 1980s is dubbed ‘roll-back’ neoliberalization in reference to the destruction of the Keynesian architecture through monetarism, massive budget and social spending cuts, regressive taxation, privatization (asset divestiture), and deregulation – all of which became reigning policies of the day.

By the mid-1990s further reforms, those which were internal to the public sector and bureaucracy and more pragmatic and technocratic (less overtly ‘political’) in nature, were used

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<sup>13</sup> Although it could be argued that neoliberal reforms underpin the ‘crisis’ of the Keynesian welfare state.

to cement the paradigm shift. For Peck and Tickell (2002) this is the 'roll-out', prescriptive phase of the neoliberal project and it helped to insulate the new 'common sense'. Roll-out policies include: social program reform (rather than simply program cuts), tax expenditures as the new welfare state (rather than removing all support), establishing partnerships with the private sector (rather than full-scale privatization), and re-regulation (rather than deregulation).

The 'roll-back' and 'roll-out' distinction demonstrates the ways in which the neoliberal project has evolved over the years, the emergence of P3s in the 1990s on the heels of full-scale privatization being a prime example.<sup>14</sup> Once many profitable Crown corporations were sold off by the mid-1990s, privatization initiatives switched from overt asset sales to strategies that have been labeled 'privatization by stealth' (CUPE 2003). P3s and contracting-out government services have since become the premier forms of privatization in areas that are potentially unprofitable or too politically sensitive to privatize (e.g., infrastructure and support services relating to hospitals, highways, water treatment facilities, and schools).

Keil (2009) argues that a new phase of the neoliberal project has more recently emerged: rolling with an unstable, but normalized market order, which he thus dubs 'roll-with-it' neoliberalization. This concept captures the normalization of neoliberal norms, mindsets, 'codes of conduct', practices, social formations, and ways of governing that are modeled on the enterprise and the norm of competition (Keil 2009). Rolling-with neoliberalism can also involve normalization through Foucauldian governmentality techniques such as budgetary discipline, performance management, and the power of audit to discipline state managers (Dardot and Laval 2009, cited in *ibid*). From a slightly different perspective, Peck (2010) proposes the concept of 'rolling neoliberalization' or 'failing forward' which accounts for the dominance and deepening of neoliberalism despite its ongoing contestation.

Altogether, these accounts suggest that despite the neoliberal legacy of financial market instability, deep rooted contradictions, and outright failure to improve the livelihood of the average citizen over the past three decades, it is, if nothing else, a highly adaptable paradigm. An important part of its success as a governance model over the past decade has been the normalization of its policy techniques, practices, and norms (Hay 2004). This provides neoliberalism with stability and longevity despite its many failures. Yet across all phases, be they overtly normative or increasingly normalized, marketization remains a feature common to

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<sup>14</sup> Federal privatization initiatives, ranked according to sales proceeds, include: CNR (1995, \$2.1 billion); Petro-Canada (1991, \$1.7 billion); NavCanada (1996, \$1.5 billion); and Air Canada (1988, \$474 million) (McBride 2005, 103). And provincially: Alberta Government Telephones (1990, \$1.7 billion); Manitoba Telephone Systems (1996, \$860 million); Cameco (1991, \$855 million); and Nova Scotia Power Corporation, the largest private equity transactions in Canadian history at the time (1992, \$816 million) (*ibid*, 104).

the neoliberal era. The extension of market rule and market dependence occurs in myriad ways – privatization being the leading avenue of marketization.

## **Marketization, dispossession, and P3s**

Marketization is a term with several different meanings. Often it is used in reference to specific new public management prescriptions (e.g., competitive tendering) aimed at ‘reinventing government’ through market mechanisms that turn the public sector into the purchaser rather than provider of services (Boyne 1998; Hodge 2000; Hood 1991; Kettl 2005; Osborne and Gaebler 1992). Alternatively, the term can also be used in a more general sense, referring to larger trends of market-led social and economic restructuring (Jessop 2002; Peck 2010) or to the reduction of deep rooted historical, political or social dilemmas to issues with relatively simple market-based solutions (e.g., the need for greater self-reliance, consumer choice, market consumption, and/or entrepreneurial encouragement) (Prahalad 2005; for a wider discussion and critique see Ferguson 1995). These different meanings may be equally useful overall but in order to capture the dynamics of privatization policy in particular, marketization ought to be seen as taking two related but distinct forms. It involves both the extension of market rule and the adoption of market-like rules by the public sector. These two are bound up with processes of dispossession.

As mentioned, accumulation by dispossession leads to market expansion in a number of ways, namely through the creation of new opportunities for profit making and by redistributing assets, thereby enhancing the breadth and depth of capitalist accumulation (Harvey 2003a). However, Ashman and Callinicos (2006) clarify that market expansion via privatization is not a homogenous process as it can involve processes of commodification, recommodification, and/or state restructuring. Commodification turns assets that were not previously commodities into private property that can be bought and sold in capitalist markets; recommodification converts what was once produced privately but subsequently taken over by the state back into a commodity; and restructuring creates a reliance upon private for-profit provision (ibid, 121-123). Achieving these outcomes (state restructuring in particular) frequently occurs through the adoption of market-like rules in the public sector that incorporate the logic, rationale, and decision-making calculus of private for-profit investors into the crafting of public policy (as mentioned above with respect to neoliberal normalization). With the P3 phenomenon both variants of marketization are present.

## Market rule

Similar to other forms of privatization (e.g., selling state assets), P3s create new markets for capital through re/commodification. Whereas traditional public works projects (physical and social infrastructure) are wholly owned and controlled by the public sector, with contracts awarded to a private company for a limited and specified role (such as the construction portion) (Hodge and Greve 2005, 64), P3s establish binding long-term contracts that allow for the private for-profit provision of public goods and services. This is reflected in Cohn's definition of P3s as "instruments for meeting the obligations of the state that are transformed so as to involve private property ownership as a key element in the operation of that instrument" (Cohn 2004, 2). Therefore, although public assets are not directly divested, P3 contracts nonetheless carve out avenues for profitable private sector investment by contractually guaranteeing future revenue streams in areas that would otherwise prove potentially unprofitable, or too politically sensitive to privatize.

P3s are most often structured as lease agreements and thus, unlike full-scale privatization, the state retains formal ownership of the newly created asset. However, as MacPherson (1978, 7) aptly describes, a lease "is not a thing but rights to the use of a thing for a limited period of time on certain conditions" and therefore *rights* to the newly created asset are actually held by the private partner for the duration of the project agreement (typically 30 years).<sup>15</sup> The profit motive permeates all elements of the project and its various phases of development, and market social relations are expanded throughout the lifetime of the P3. In addition, P3-induced state restructuring intensifies the dependence of the public sector upon the

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<sup>15</sup> P3s used to deliver public sector infrastructure (e.g., hospitals) involve many components: agreements related to land, financing, infrastructure (design, construction), equipment procurement, and the operation and management of public services. While each P3 agreement is unique, trends in the provinces that most often establish P3 hospitals – Ontario and BC (see chapters 4-7 for more detail) – display a complicated public/private division amongst project tasks. For instance: i) the land upon which P3 hospitals are built is not fully privatized but leased; ii) private financing is used for construction purposes but not for hospital equipment (this is a task most often taken up by local communities and is thus tends to rely upon the third sector, see chapter 3); iii) design is private and subject to commercial confidentiality and proprietary knowledge laws although public input and approval must be sought at key stages of development (see chapter 6); iv) clinical services are publicly funded and managed whereas non-clinical services in P3 hospitals are publicly funded but privately managed. The range of non-clinical care services subject to privatization has also fluctuated over time and by project; and even with P3 hospitals that do not bundle non-clinical services within the project agreement these may be subject to contracting-out by the public health authority. Given that control, authority, and assets are shared, P3s may represent 'privatization by stealth' (CUPE 2003) but they are partnerships nonetheless. The tension produced by being simultaneously a partnership and a form of privatization is addressed in chapters 6 and 7 which discuss the management of specific Canadian P3 hospitals.



market by awarding authority and decision-making over the formulation and execution of vital areas of public policy to private for-profit investors.

The specific implications of dispossession via P3s can vary. Most obviously it involves the decades-long privatization of work historically conducted by public sector employees (see chapters 3, 6, 7). This leads to a deterioration of wages and working conditions and thus, as Huws (2012, 64) argues, to the expropriation of rights previously won by labour. Not only does this affect the staff working for P3 private operators, but it also erodes the bargaining position of the labour movement overall given that the public sector tends to be the principal source of union strength in a given jurisdiction. It can therefore hold negative implications for workers in general to the extent that past struggles for universal public services are undermined in the process (ibid, 64-5).<sup>16</sup>

Less obvious is the financialization of public sector activities that constitutes a relatively unique feature of P3-related dispossession.<sup>17</sup> Harvey (2003a, 147) explains that financialization has become an important avenue for accumulation by dispossession given its predatory and crisis-prone nature (e.g., allowing for ponzi schemes, asset destruction through inflation, and pension fund raiding). Privately financed P3s add to this phenomenon in three important ways.

First, under the auspices of 'risk transfer' private partners assume responsibility for hypothetical project risks such as cost overruns and delays in exchange for lucrative investment opportunities (see chapter 2). Though each project is unique, investors often expect real rates of return in the 15-25 percent range (Gaffney et al. 1999, 116; Hodge 2004, 162), making P3 arrangements an attractive investment opportunity for finance capital.

Second, if a P3 is refinanced once it has entered the relatively low risk operational phase of the project, the private partner is often able to secure cheaper forms of debt (e.g., bond financing rather than bank debt, see Loxley 2010, 68) which can further increase the profitability of this arrangement.<sup>18</sup> Equity sales can also be quite lucrative. In the UK, for example Whitfield

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<sup>16</sup> A word of caution is required here. With most P3s in Canada the government becomes the purchaser of services and infrastructure, not the public, and thus the universal nature of public services may not be undermined per se. In this circumstance, as is the case with P3 hospitals, services remain universally accessible by the public but their management, organization, and some degree of future planning becomes dominated by large (often multinational) corporations driven by the profit motive, not community or competing public interests. This aspect is similar to contracting-out although the longer time horizon and contract bundling features of P3s add a greater degree of permanence.

<sup>17</sup> Not all P3 arrangements incorporate private financing. However, it is the essence of the UK's pioneering Private Finance Initiative (PFI) and the arrangement most common to Canadian P3s ever since their emergence in the 1990s.

<sup>18</sup> Other examples of P3 refinancing include: changes made to the loan repayment schedule and to the lending margin, switching to/from a fixed rate of interest, and early repayment of shareholder debt. All were undertaken in the case of the Fazakerley Prison Services Limited PFI project in the UK which

(2011) reports that 240 P3 equity transactions have taken place since 1992, valued at £10.0bn, with average profit rates coming in at 50.6 percent.

Third, there is also a dimension of self-dispossession that occurs when the institutional investor that finances a P3 is a public sector pension fund. The Ontario Municipal Employees Retirement System (OMERS), Ontario Teachers' Pension Plan, and Labourers Pension Fund of Central and Eastern Canada, for example, have been involved in several Canadian P3s in the past (Loxley 2010), including the Ontario P3 hospitals examined here (see chapter 7).

Entwining workers' savings (pensions) with vehicles of privatization creates a material reliance upon P3s, often involving the very same public sector workers or unions whose interests are simultaneously undermined by privatization. With this latter feature we see that short run benefits can create long run contradictions for those working for P3 private providers.

## **Market-like rules**

The state restructuring that takes place to facilitate dispossession involves not only expanding market rule and dependence but also the adoption of market-like rules within the public sector. The reorientation of the public sector is therefore another important component of marketization, and again the P3 phenomenon stands out in this regard.

In Canadian jurisdictions most enthusiastic for P3s (BC and Ontario), P3 proliferation is encouraged through changes within government made to capital planning procedures and bureaucratic decision-making (including new legislation), and new forms of institutional support for privatization. This constellation of new arrangements can be thought of as a 'P3 enabling field' (discussed throughout chapter 4). These provincial enabling fields normalize P3 use through the routinization, institutionalization, and depoliticization of this policy (the subject of chapter 5). Routinizing P3 implementation involves the creation of infrastructure planning protocols and routines that deeply embed the language and calculus of the private for-profit sector into the heart of public policy making. Institutionalizing support for P3s has been advanced through the creation of new capital planning procedures and public authorities, both of which create an air of permanency for this policy. Finally, depoliticization through provincial

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increased returns to shareholders by 61 percent (£10.7 million) over the original projected level when the project agreement was struck (UK Comptroller and Auditor General 2000, 1). Depending on the regulatory context, often windfall profits such as these are not shared with the public partner, and the consent of the public partner may not be legally required. Loxley (2010, 69) argues that refinancing schemes affect value for money estimates conducted prior to P3 selection and "may make it difficult to ascertain risk transfer and who exactly is bearing risk and at what cost, in the evaluation phase of a P3". See chapter 2 for more detail on value for money and risk transfer.

P3 enabling fields helps to obscure the normative basis of P3 use by making it appear as though privatization is merely a pragmatic decision. Depoliticization also occurs through the actual shift from public to private authority, making it both a strategy and a reality. The transformation of public policy through the market-like rules of P3 enabling fields is a novel development despite the fact that partnerships between government and for-profit companies have, to one extent or another, been present for centuries.

By marketizing public sector decision-making processes, P3s become a unique form of privatization.<sup>19</sup> In contrast, with the sale of state owned enterprises, the responsibility of the state to provide that good or service is severed (Grimsey and Lewis 2004, 55). Contracting-out hospital support services, on the other hand, is far more limited and particular, often of a comparatively short term nature (e.g., 5 years), and the needs of the public sector are identified and planned for in-house even if they are executed by for-profit operators. The outcome of a P3 may still entail the provision of public (i.e., universal) services, but the process of developing and operating a P3 involves dispossession, commodification, and multiple forms of marketization.

## **Concluding remarks**

The relationship between crises of capital and the attendant alteration of public policy can neither be ignored nor can the specific nature of policy change be assumed. Although the overriding perspective informing the discussion in this chapter eschews the ontological division between public and private proposed by liberal analyses, it has also attempted to avoid an overly rigid materialist interpretation of policy change. Instead, a heterodox political economy approach to understanding the dynamics of 'market politics' and 'politics of the market' more adequately captures the interrelations between these two social expressions of power. The principal intersection between the two is to be found in the nexus of crises of capital, spatio-temporal fixes involving accumulation by dispossession, and the marketization of state policy and decision-making processes.

Dispossession and marketization are particularly important concepts for the chapters that follow given that privatization bridges both types of neoliberal transformation, and equally affects the public and private for-profit social realms. P3s are certainly not the only type of

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<sup>19</sup> Yet, as Wall and Connolly (2009, 711) point out, the issue of whether P3s are a form of public sector privatization has been subject to debate in the literature over the past decade or so (e.g., Rikowski 2003; Whitfield 2005, 2006; Hatcher 2006).

privatization but they are distinct and thus offer unique insights. With for-profit infrastructure and service agreements, dispossession occurs *within* the state, offering strong guarantees for profitable investment without severing public obligations (thus insulating the private partner from risk); and marketization involves not only the expansion of market rule but also market logics and norms through the adoption of market-like rules that reorient public-sector decision making and routinize, institutionalization, and depoliticize dispossession.

This discussion of neoliberal accumulation dynamics as well as the policies and practices that promote dispossession and marketization is intended to serve as background and context for the analysis that follows in subsequent chapters: chapter 2 which examines the rhetoric and reality of P3 policy/projects; chapter 3 which looks at the specific health care-related aspects of privatization and P3 hospitals; chapters 4 and 5 which describe the enabling fields and routinization, institutionalization, and depoliticization that accompany P3 programs in BC and Ontario; and chapters 6 and 7 which provide detailed case study examples of the themes described in each previous chapter.

## **Chapter 2. Partnering for profit: the discourse and practice of public-private partnerships**

Public-private partnerships (P3s) can be used in all areas of public infrastructure and service provision (e.g., hospitals, water and sewage facilities, bridges and highways). In Canada there have been nearly 200 P3s established across the country since the mid-1990s (McKenna 2012). Infrastructure P3s involve the private sector in a variety of ways, with the most common form being the design-build-finance-operate (DBFO) model.<sup>20</sup> P3s are not merely new procurement options for public infrastructure; they reflect larger changes in capital accumulation, ideology, bureaucratic processes, and public policy. As explained in the previous chapter, the wider political economy context of neoliberalism, dispossession, and marketization has been crucial for P3 emergence. These connections are illustrated through the track record and assumptions informing P3s.

Despite their growing popularity, P3 arrangements are seldom able to reduce public sector costs given the historically more expensive nature of private financing and the presence of the profit motive. Risk transfer, another supposed benefit of this policy, is also illusory, more often based on normative assumptions than actual results. Finally, several methodological biases inherent to the processes currently used to analyze value for money cast doubt upon the purportedly neutral selection of P3s over traditional forms of public procurement.

Problems with the P3 model, in relation to cost and risk in particular, were only further compounded during the recent global financial crisis as private financing became more expensive and difficult to secure, leading to several project delays and cancellations across the country. In BC, for example, construction of the Port Mann bridge was delayed in 2009 when the private finance partner was unable to secure the \$700 million required to finance the P3; and, around that same time, the high price of private financing led the government to take on most of the loan risk with the Fort St. John Hospital P3 project. With the onset of a new round of fiscal austerity in 2011, one might reasonably expect that this policy would have been scrapped in favour of lower cost public procurement. Instead, as of 2010, the P3 model began flourishing once again. In Canada this is due in large part to strong government support (especially the federal government and the provinces of BC and Ontario). Renewed proliferation is particularly

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<sup>20</sup> DBFO projects involve lease arrangements where the private partner is responsible for the design, construction, finance, and operation of an asset; and feature long-term contracts (typically 25 to 30 years). Other P3 models include build-own-operate-transfer (BOOT), and design-build-operate (DBO) (see Hodge and Greve 2005, 64).

problematic given that these arrangements link important public services to highly volatile global financial markets and poorer value for money leads to higher costs over the long run.

This chapter provides a broad overview of the P3 phenomenon in Canada. The first section analyzes the features, promises, and reality of P3 policy and projects; and the second section discusses how P3s were affected by the global financial crisis. Key terms and concepts and their normative underpinnings are elucidated throughout, most notably: cost savings, off-book financing, risk transfer, value for money, and P3 evaluation methodology.

## **Justifying public-private partnerships: the illusory nature of cost savings, risk transfer, and value for money**

The standard argument in support of a P3 is that it can more effectively deliver services and infrastructure when compared with traditional public methods, as it uniquely harnesses the efficiencies, innovative capacities, and (financial) resources of the private sector (Akintoye et al. 2003, 4). Greater market dependence for the public sector is promoted largely through New Public Management (NPM) ideals that aim to transform the government and its agencies into the procurer of services rather than the provider (Edwards and Shaoul 2003, 397). With P3s in particular there is an assumption (rooted in the public choice school of thought and neoclassical economics) that partnering with the private sector will avoid the problems associated with an inherently inefficient public administration. This translates into P3s being presented as a net gain for the taxpayer: they are purportedly able to deliver value for money through lower costs over the lifetime of the project by transferring risk to the private partner who, it is believed, will operate in a more innovative, efficient, and financially prudent fashion (ibid, 397-8). The three sections that follow detail the issues associated with P3 cost savings and risk transfer arguments, and the problematic nature of value for money methodology.

### **Cost savings**

The cost savings argument is derived mainly through the neoclassical assumption that market competition (in this case for the P3 contract) combined with the profit-maximizing behaviour unique to the private sector will lead to lower overall project costs. Furthermore, given that P3 contracts have time-sensitive stipulations, it is argued that the private partner will have a built-in incentive to produce efficiencies in order to achieve a profit (Murphy 2008). Knowledge specialization, along with greater scale and scope of activities is also said to provide

private sector actors with more experience and ability to generate cost savings (especially compared to small municipal governments). As a result, the cost advantages offered by partnering relate to its unique ability to bring more cost-efficient operations and better project management skills to the project, along with an emphasis on using the most cost-effective technologies and lower wage costs (Vining and Boardman 2008, 14).

There are a number of problems with these assumptions. First, even in the case of private sector cost superiority, savings are not likely to be passed on to the public but rather absorbed by the private partner in the form of higher profit (*ibid*, 15). Furthermore, cost savings arguments do not take into account social concerns produced by reducing labour costs (i.e., lower wages, more precarious working conditions) and through a relaxation of standards (e.g., hiring and training, environmental, and construction standards).

P3s also tend to be more expensive than traditional projects. These increased costs typically relate to the higher interest rates paid by the private sector, but can also result from higher than bid construction costs, as well as the administrative and legal fees that accompany P3s.<sup>21</sup> Vining and Boardman (2008, 11) have labeled the plethora of additional hidden costs associated with P3s as ‘transaction costs’. These include: contracting and negotiation costs, and formal contract agreement costs such as monitoring, renegotiation, and termination.

In the UK, where P3s first began and where P3 markets remain the most sophisticated of any, recent reports analyzing the results of three decades of P3 policy foreshadow worrisome implications for Canada’s increasingly widespread P3 use. Fawcett (2012) sums up the UK experience when he writes that “the record isn’t great” and that “using private money for public investment hasn’t been an unqualified success.” More specifically, Graham Winch of Manchester Business School reports that “the value-for-money case for PPP in the public sector has yet to be proven. The benefits gained from the availability of ‘extra’ finance, the transfer of risk from public to private sector, and improvements in decision-making processes are too nebulous to provide any certainty that they outweigh all the known problems” (quoted in Armitstead 2012; see also Ball et al. 2001; Shaoul 2010).

In Canada, case study evidence points to similar results (Loxley 2010; Mehra 2005). For example, in 2012 Siemiatycki found that for 28 P3 projects developed in Ontario over the past decade the average cost was 16 percent higher than it would have been with traditional public tendering (McKenna 2012). Chapter 6 and 7 detail the cost creep and hidden fees associated with Canada’s initial four DBFO P3 hospitals.

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<sup>21</sup> See chapters 6 and 7 for these costs in relation to the first four DBFO P3 hospitals in Canada.

Cost savings arguments are not only based on economic rationale but on political dynamics as well. For instance, cost-related justifications are often framed in terms of the political preference to avoid government debt through the use of private financing. Thus it is argued that scarce government funds are best allocated elsewhere when large capital projects can be funded through the indebtedness of private firms (Rouillard 2006, 8). In Canada this rationale is in part ideological (i.e., the perception that public debt is a sign of mismanagement) and in part practical given the massive cuts in federal social spending experienced in the 1980s and 1990s (McBride 2005, 106-10). P3s are therefore presented as a way to deliver new infrastructure during a time of fiscal austerity.

However the reality is that P3s cannot actually reduce the financial obligations of the state – they are only able to mask the cost of a project through the use of a cash, rather than accrual, accounting system. Prior to 2009, Canadian P3s were often recorded as operating leases rather than capital expenses, allowing governments to benefit from “off-book” infrastructure spending by accounting for a new project as an annual lease payment to a private contractor rather than as an upfront capital expense like with traditional infrastructure (Murphy 2008, 101). Off-book financing allowed politicians to make good on election promises or win political points with the electorate by committing to public infrastructure projects whilst simultaneously deferring full repayment far into the future. With most P3 deals lasting roughly three decades, costs are stretched beyond the election cycle and even beyond the length of most public sector careers. Accounting for P3 projects as lease payments is also expedient given the presence of balanced budget legislation which has constrained public spending in provinces and territories across the country since the 1990s. Further, dealing with balanced budget legislation through off-book financing avoids the application of often unpopular user fees to infrastructure such as highways and bridges.

Ultimately the justifications for, and benefits derived from, off-book financing are illusory. The use of private financing is never able to reduce public sector liabilities given that costs associated with public infrastructure and services must ultimately be repaid by the taxpayer. In some cases, project agreements even require that the state buy back the infrastructure once the project agreement expires (Auerbach et al. 2003, 5).

In 2009 this budgetary loophole was tightened with the adoption of new public sector accounting principles in Canada (known as GAAP or generally accepted accounting principles), essentially eliminating the ‘build now, pay later’ rationale. From a global perspective, national variations in P3 accounting systems and principles remain; although there are signs of



increasing harmonization (under the International Public Sector Accounting Standards Board, for example) (see Heald and Georgiou 2010).

## **Risk transfer**

In light of the higher costs associated with private financing, multiple transaction costs accumulated over the lifespan of a P3, and profit-oriented motivation of the private partner, tangible savings for the public remain elusive. Thus the other major justification for P3s, and the one most commonly adopted by proponents today,<sup>22</sup> is based on the notion of achieving value for money (VfM) by transferring project risks from the public to the private partner. Better VfM is not necessarily synonymous with lower project costs, making it a more opaque and technocratic justification for privatization. For example, Ontario's Value for Money methodology manual (Infrastructure Ontario 2007a) indicates that base project costs, financing costs and ancillary costs (legal and other transactions costs) are all lower for traditional procurement and thus P3 VfM superiority is derived exclusively through risk transfer.

Value for money reports produced for recently operational P3 hospitals in Ontario indicate just how significant risk transfer is to claims of P3 VfM superiority. With the Centre for Addiction and Mental Health P3, P3 base project costs are valued at \$354.8 million compared to only \$235.1 million for the traditional procurement model; risk transfer makes up the entire 'savings' that is achieved with a P3 (Infrastructure Ontario 2010, 6). With the Sunnybrook Health Science Centre P3, base costs are estimated at \$142 million (P3) vs. \$129 million (traditional); when the value of risk transfer is estimated the P3 comes in at \$14.1 million under the traditional option (Infrastructure Ontario 2007b, 14). And with the North Bay Regional Health Centre P3 base costs are estimated at \$551.7 million (P3) as opposed to \$404.6 million (traditional); factoring in risk transfer produces a VfM superiority of \$56.7 million in favour of the P3 (Infrastructure Ontario 2007c, 11).

Risk, in the context of a capital project, is held to be a situation of potential loss of investment resulting from operating in an uncertain business environment (Grimsey and Lewis 2004, 148-52). The most common risks attributed to P3 projects include: site (tenure, access, suitability), design and construction (delays, weather, cost overruns), operation and maintenance (cost overruns), and financial risks (interest rates, inflation). What the P3 model attempts to do, from a public policy perspective, is transfer to the private partner as many of

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<sup>22</sup> Cost savings arguments were far more popular in the early days of P3s in Canada (Loxley 2010).

these risks as would be feasible, minimizing the exposure of the public partner and creating a built-in incentive for the private partner to generate project efficiencies and lower overall costs. For instance, it is common for P3 contracts to stipulate that payments to the private partner will only begin once the project is operational, and continued payment is based on meeting a performance criteria (Hodge and Greve 2005, 52).<sup>23</sup> Thus P3 justification rests on the normative claim that optimal risk transfer will produce the best VfM, and that the P3 model is uniquely able to achieve this.

Freedland (1998, 307) argues that at heart risk transfer arguments contain the inherent assumption that “a commercial bearing or insurance of public burdens is a beneficial thing in and of itself.” The reasoning here is highly circular: P3 projects are justified (rhetorically and mathematically) exclusively through the normative logic of the P3 model itself, ignoring the option of transferring risk through traditional contracts (Ontario Auditor General 2008; Quebec Auditor General 2009). This level of self-referentiality fits squarely within the ‘rolling-with’ variant of normalized neoliberalism described in the previous chapter.

An emphasis on risk transfer also relies upon the belief that failure, mis-estimation and suboptimal performance are commonplace occurrences with public infrastructure and service provision even when these beliefs may be completely unsubstantiated. For example, P3s are now used for most large public infrastructure projects in Ontario but, as confirmed by the former President and CEO of Infrastructure Ontario, there has yet to be any systematic analysis of the track record of risk and performance associated with traditional public procurement in that province (Ontario Standing Committee on Government Agencies 2008, 1130).<sup>24</sup> Left unchecked, the underlying normative assumption that public procurement is inherently riskier incentivizes P3 use as a way of protecting against purportedly common risks – despite it being far from certain which (if any) particular risks bedevil public infrastructure projects. Assuming that public management is less efficient and effective also provides the rationale needed to blame the public sector should P3s perform worse than expected, justifying the appropriation of project development techniques from the private sector and increasing public sector dependence upon market actors for their P3 knowledge and expertise.

Stripped of all rhetoric and self-promoting jargon, risk transfer through a P3 amounts to three things: privileging certain risks, ignoring others, and creating new risks along the way.

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<sup>23</sup> However, optimal risk transfer with P3s occurs not when all risks are transferred to the private partner but when taken up by “whoever is best able to manage it,” and in so doing VfM is achieved (Freedland 1998, 306). Offloading all risks to the private partner is thus neither desirable nor an appropriate justification for using a P3.

<sup>24</sup> Similarly, early P3 performance was also not gauged by policy makers prior to the proliferation of P3s in the province of British Columbia.

The risks controlled (transferred) through a P3 are those that private partners can profit from or, in other words, those that the state can marketize and monetize by turning public goods and services into exchangeable commodities through competitive bidding and for-profit delivery. At the same time, risk assignment is based on the probability of particular outcomes, and thus it ignores future possibilities that cannot be stated statistically (Froud 2003, 570). Uncertain costs (unknown or unacknowledged risks) are not transferred and always remain with the state (ibid, 581). The rigidity of the P3 contract precludes any subsequent transfer of uncompensated risks onto the shoulders of the private partner once the project agreement is signed.

It follows, therefore, that the risks (and uncertainties) that are not incorporated into VfM assessments are those that would discourage the use of P3s. Project risks are narrowly equated with market-derived conceptions of the public interest which do not take into consideration concerns such as the contradiction that exists between profit-making and commercial confidentiality on the one hand, and democratic oversight and local control on the other. Collective risks associated with service quality deterioration or more precarious working conditions are similarly excluded.

Along with the simultaneous privileging and suppression of particular risks is the creation of risk and uncertainty through P3 use. As will be more thoroughly discussed in chapter 3, multi-decade long contracts in the health sector lock public service decision making into “a particular pattern of service provision whereby changes must be negotiated with the provider and paid for” (Froud 2003, 580). This lock-in may stifle innovation and flexibility since the health sector requires that infrastructure be able to meet and adapt to future service needs and changes in policy and technology. The internal bifurcation of authority within P3 hospitals that results from private partners managing some services and public partners managing others also creates problems for the organization of staff and integration of decision-making – both of which are important for effective and efficient health service provision in hospital.

Even considered on its own terms, justification for risk allocation is often opaque. For example, with the Fredericton-Moncton Highway Project P3, the Auditor General of New Brunswick affirmed that the Request for Proposals issued by the Province clearly allocated most project risks to the private partner (development, design and construction risks; operation and maintenance risks; demand risks; and finance risks), and noted that this would provide for a significant transfer of risk above and beyond traditional forms of project procurement (New Brunswick Auditor General 1999, 68). However, when the Auditor General attempted to investigate the basis on which these risks were transferred and assigned to the project partners (in order to establish value for money), he was “unable to develop any substantive evidence

supporting risk transfer decisions” (ibid, 85). Certainly the mere presence of a private for-profit partner alone is not enough to ensure these risks were advantageously transferred.

Scrutinizing Infrastructure Ontario’s (IO) methodology, Loxley (2012, 19) points to the equally nebulous nature of risk transfer in Ontario. In his words:

The risk analysis of IO is based on a report from a private consultant (Infrastructure Ontario, 2007) which comes up with a risk transfer matrix showing that the province would retain risk equal to 43.6% of base construction costs under a traditional model and only 16.7% of base construction costs under a Build-Finance model. These, it argues would vary from project to project and it appears that the projects mentioned assume greater risk transfer than the average suggested by the consultants (over 3:1 versus the 2.6:1 implied in the model). The problem with the consultants’ report is that there is no source, reference or justification given for any one of its numbers. None of the individual projects does any better as absolutely no support is presented, except the consultants’ report, for the risk transfer figures given. If these crucial risk transfer numbers have any foundation empirically, it is not clear what it is or where it comes from.

Furthermore, in their study of P3s from the UK, Ireland, the Netherlands, Australia, and Denmark, Vining and Boardman (2008, 14) find that risk transfer as a central justification for P3s is inadequate as a P3 does not actually reduce risk, it merely reassigns it. As they suggest, given that governments can spread risks over a larger number of projects, it does not always follow that simply transferring all risks to the private partner leads to enhanced VfM (ibid). Not taking advantage of the potential for cost savings through risk pooling (i.e., publicly financing a large number of projects) can amount to a huge loss for the citizen and taxpayer. In his study of Alberta P3 schools, Hugh Mackenzie (2007, iv) found that “for every two schools financed using the P3 model, an additional school could be built if they were all financed using conventional public sector financing.”

A final consideration, and perhaps the most damning for the risk transfer argument, is that in order for the public partner to offload some or all of these risks, compensation for the acceptance of risk must be offered. This compensation translates into the anticipated profit margin of the private partner. Unless the private partner is inexperienced with P3s, this risk will be reflected in the price of the bids submitted to a request for proposals. As mentioned in chapter 1, taking responsibility for project risks can be a very lucrative arrangement, and shareholders involved with privately financed P3s tend to expect real rates of return on investment of at least 15-25 percent per year (Gaffney et al. 1999, 116; Hodge 2004, 162). Justifying the use of a P3 on the basis of risk transfer alone is therefore untenable since qualified private partners will either avoid bidding on contracts that offload too much risk, or this risk will be monetized in the form of higher-cost bids in line with the anticipated profit margin

sought by investors (Cohn 2004, 8). Thus the monetization of risk through the bidding process cancels out risk transfer as “risk becomes just one component of the project’s cost structure and is therefore passed completely onto the state in the consortium’s bid” (Rouillard 2006, 5).

### **Value for money methodology**

In order to ascertain whether a P3 is likely to be more or less costly than a traditional project, best practice dictates that a public sector comparator (PSC) be generated in order to determine VfM. The PSC provides the mechanism through which a P3 can be compared to a traditional form of project delivery. Financial and quantifiable non-financial benefits are compared in both cases, and the option with the lowest net present cost is typically chosen. There are, however, many controversial aspects to the VfM process, beyond those already mentioned above with respect to cost savings and risk transfer.

First, an amount (known as a ‘risk adjustment’) is added to the PSC to cover risks like construction overruns and operational difficulties, under the presumption that with a P3 the private partner will be contractually obligated to cover these risks. Broadbent et al. (2003, 427) report that for P3s in the UK, nearly 50 percent of the total risk adjustment (the amount added to the PSC) is related to design and construction risk valuation. However, as previously mentioned, the Auditors General of Ontario (2008) and Quebec (2009) argue that there is no reason to assume that risks relating to construction and design (amongst other things) cannot be adequately managed through a traditional design-build contract. Incorporating the assumption that a PSC would not be able to transfer this risk into VfM methodology is therefore a highly questionable practice.

Second, on top of the amount added to the PSC to cover risk, a discount rate is applied which can significantly impact VfM calculations. Discounting is used to compare the two forms of cash – money spent today versus payments which are spread over many decades, and is based on the private sector principle that money spent today costs more since it had the potential to earn interest if spent gradually (Gaffney et al. 1999). It is held that discounting is necessary for VfM determinations as the cost of conventional projects are typically born upfront, during the initial stages (the design and construction phase), whereas a P3 spreads costs over the entire project (Broadbent et al. 2003, 428). Through the application of a discount rate, net present costs can be calculated for both the P3 and PSC and the lowest cost is taken to represent best VfM.

Aside from the fact that private sector techniques used to maximize shareholder value may not be wholly appropriate for determining public policy, the most controversial aspect of this practice is the discount rate chosen. The rate is so sensitive that it can easily skew the VfM calculation in favour of the P3 (Shaffer 2006; Gaffney et al 1999; Parks and Terhart 2009). The higher the discount rate applied, the more attractive the P3 will appear since money spent today becomes more costly. A few examples from BC make this clear.

When calculating VfM for the Diamond Centre hospital P3 in Vancouver, Partnerships BC used a discount rate of 7.12 percent. To illustrate its sensitivity, Parks and Terhart (2009, 9) calculate that if a 4.12 percent discount rate had been applied, the P3 would have represented a net present value cost of \$15.2 million over and above that of the PSC. However, if a 9.12 percent discount rate had been applied, the P3 would appear to produce a net present value savings of \$29.6 million. With no discounting applied to the VfM assessment, the difference in nominal dollars is \$114 million in favour of the PSC (ibid, 10). Similarly, with the Sea-to-Sky highway P3, Partnerships BC applied a discount rate of 7.5 percent, however at 5 percent (the government's borrowing rate at the time) the P3 costs almost \$220 million more than the PSC (Shaffer 2006, 6). As Loxley (2012; 2010) indicates, even though there is no globally agreed upon discount rate, rates used to calculate VfM in Ontario and BC are well above the UK's best practice rate of 3.5 percent, often by 1-3 percent respectively. This practice makes it appear as though a P3 offers better value even in cases where cost savings fail to materialize. International evidence produces similar results (e.g., Hodge and Duffield 2010).

The VfM appraisal process is also problematic because discounting is applied on top of the additional risk valuation added to the PSC. Gaffney et al. (1999) argue that in effect this double counts the cost of risk to the disadvantage of the PSC. Furthermore, returning to a previously discussed issue, P3 contracts provide market-based protections against *some* risks but they also ignore uncertain future scenarios and create new risks of their own. As Lyons (1996) reminds us, all contracts are inevitably incomplete and cannot possibly insure against every contingency in the future. However, "equivalent treatment of (existing) and created [P3] risks would require that the exposure to new risk be quantified and added to the private sector's bid as a potential cost that would not be incurred under conventional procurement and operation" (Froud 2003, 580). This practice is not followed with current VfM analyses, a methodological omission that clearly favours the P3 option.

Given the many problems associated with the use of P3s – misleading claims of risk transfer, accounting techniques used to make partnerships appear less costly, high transaction costs and ignored social costs, and systematic bias in the evaluation methodology – the obvious

question becomes: why the continued proliferation of P3s? The answer offered here is that P3s are (and can only be) justified, whether overtly or implicitly, through an appeal to neoliberal ideals that favour dispossession and marketization and attempt to normalize this inherently normative policy. Even in cases where P3s may come in on time and on budget this cannot significantly offset the other transaction costs involved, the introduction of future policy inflexibility, and loss of full public control over vital infrastructure and services. In addition to these longstanding concerns, more recent problems have also emerged as a result of the 2008 global financial crisis.

## **Public-private partnerships and the 2008 global financial crisis**

Despite growing enthusiasm for P3s since the early 2000s, fortunes began to turn for this form of privatization with the onset of the recent global financial crisis. Most P3s are heavily reliant upon international bond markets for their financing and the credit crunch that occurred in the wake of the crisis created a huge barrier to private financing. 2008 proved to be the worst year on record for P3s worldwide, with far fewer coming to financial close than had been the trend in recent years. Government support was soon tailored to rescuing P3s and by 2010 their use began to rebound, thanks in part to financial market improvement but also to the support of steadfast state policy. This next section briefly chronicles these events: from collapsed and abandoned deals to their rescue by public policy makers. Government support took two principal forms: i) an encouragement of new projects despite serious problems with the private finance portion of P3s; and, ii) the creation of P3 units and P3-targeted financing schemes to rescue projects and promote new P3s.

### **Collapsed and abandoned P3 deals**

The private finance portion of DBFOs has long been criticized as a key factor in the comparatively higher costs of P3s (e.g., Hellowell and Pollock 2007; Loxley 2010; Loxley 1999a, 1999b). This results from the interest rate differential that typically exists between private sector and public sector borrowers. Governments in Canada generally receive better credit ratings, and thus pay lower interest rates, than the private sector since they uniquely hold the power of general taxation to guarantee that all debts will be honoured. This longstanding issue of higher priced P3 projects was made even worse by the recent global financial crisis as costs

associated with the private finance portion of newly initiated partnerships were ratcheted up significantly.

Prior to 2007 government borrowers in Canada were able to secure interest rates that were, on average, 2 percent lower than those charged to private borrowers, but between 2007 and 2009 this increased to an average of 3 or 4 percent – making P3s nearly 70 percent more expensive than publicly funded infrastructure when measured in present value terms (Mackenzie 2009, 2).<sup>25</sup> Transaction costs also increased as the timeframe for negotiations was lengthened due to financial market instability (Drapak 2009). This combination significantly impacted the value for money offered by a P3.

Along with increased costs came the implications of the credit crunch and changes in financial market dynamics. When the option to secure monoline wrapped bonds disappeared during the subprime meltdown, the main source of private financing used by P3s was suddenly eliminated.<sup>26</sup> Together these developments posed serious challenges for newly initiated projects (those that were in the bidding and construction stages) and led to a series of delays, renegotiations, and collapsed deals in 2008/9.

In Canada the effects of the financial crisis began to show in mid-2008 and most projects that reached financial close at this time were smaller in scope and required only short term financing (CCPPP 2009, 1). Several high profile and high cost deals were affected. With the Port Mann Bridge P3, one of the private partners (Macquarie Infrastructure Group) was unable to come up with the requisite \$700 million and as a result the Province of British Columbia was forced to renegotiate the agreement in order to keep the project going (Hunter 2009). This renegotiation occurred just weeks before construction was scheduled to begin. With the Fort St. John Hospital P3 project, also in BC, financial market instability meant that a new private partner was needed to bailout the original private equity provider contracted to finance the \$268 million hospital (Mackenzie 2009, 11). Although the BC provincial government remained committed to actively pursuing P3 projects throughout the crisis, stimulus fund spending

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<sup>25</sup> Although it must be noted that credit has been cheap ever since. In response to the economic recession in 2009-10 and lack of recovery in the years that followed, prime rates in Canada have hovered around 1-3 percent, changing the dynamics of public vs. private financing at least temporarily. While private financing may be generally more expensive, the specific interest rate spreads between government and private partner borrowers must be considered on a case-by-case basis. It is highly unlikely that prime rates will remain this low for much longer.

<sup>26</sup> A monoline wrapped bond refers to when companies take out insurance against the risk that they will default on their debt ('monoline'), and by using a high quality insurance group ('wrapped') debtors are able to secure very high credit ratings, leading to lower interest rates (see Tett 2007 for further detail).



targeted speedier traditional infrastructure projects and decision-makers suspended the requirement that P3s be first considered for all large infrastructure projects (ibid, 10).<sup>27</sup>

Other pro-P3 provinces faced similar problems. In Ontario, for example, the Niagara Health Systems P3 project, originally scheduled to begin construction in spring 2009, was delayed for several months when the private financing portion fell through (Mackenzie 2009, 12). A new private financing partner then stepped in. Rather than abandon P3 policy altogether, the province temporarily moved away from partnerships arrangements that relied on private financing.

Other international comparisons produce similar results. In the UK, 2008 and 2009 were the lowest volume years on record since 1998 when the PFI heyday began. During the height of the financial crisis the average number of P3 projects to reach financial close had been cut in half, with only 34 and 35 projects closing, in 2008 and 2009 respectively (Timmins 2010). Worldwide the volume of P3 deals was stagnant in 2008 and by mid-2009 25 percent of all P3 deals had been cancelled (Drapak 2009).

Increases in the cost of borrowing meant that interest rate spreads in newly industrialized and developing countries (where global P3 growth had previously been most prominent just prior to the crisis) increased to levels not seen since the Asian Financial Crisis in 1997 (Berger et al. 2009, 5). Operational P3s in these emerging market countries faced problems with refinancing similar to those experienced in Canada. However, unlike in Canada, the global economic downturn in 2009 greatly affected newly-proposed P3s since revenue for projects in developing countries tends to rely on direct user fees (e.g., tolls). The recession thus cut into the revenue streams relied upon by P3 investors, narrowing the range of prospective bidders. Exchange rate fluctuations also caused many developing countries' projects to be cancelled (ibid, 7). A study conducted by the World Bank's Public-Private Infrastructure Advisory Facility between 2008 and 2009 reported that roughly one third of the developing countries polled experienced delays with P3 projects, with South Asia and transitional economies in Europe and Central Asia accounting for the majority (ibid, 13). All of this has led industry experts to conclude that "none would suggest that the PPP market is likely to return to the ideal conditions in previous years" (CCPPP 2009, 1). The historical low point in the global P3 market (late 1990s/early 2000s) may be the new 'normal' in terms of the volume of annual P3 deals (Leigland and Russell 2009, 4).

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<sup>27</sup> The requirement that P3s must be first considered for all large infrastructure projects has since been re-imposed.

Under the assumption that projects could be refinanced periodically at projected rates, many existing P3s have secured financing for a shorter term than the life of the project. Mackenzie (2009) suggests that the rationale underpinning privately financed P3s therefore had a built-in expectation that the credit-fueled bubble would continue indefinitely. There was little prudence demonstrated despite P3 proponents often justifying partnerships on the basis of fiscal austerity, and promoters did not factor in the possibility of a looming financial crisis. Fiscal recklessness such as this led Scotland's Finance Minister John Swinney to label the use of private financing associated with P3s "one of the worst excesses of the age of financial irresponsibility" (Fraser 2009). The global financial crisis and its immediate aftermath also led several Canadian policy makers to publicly question their use. For instance, Quebec Health Minister Yves Bolduc stated in 2009 that "P3s were not a religion" for his party (CUPE 2009). The Treasury Board President, Minister of Transport, and Minister of Municipal Affairs also cast doubt on the future of P3s in that province, and several proposed P3s were scrapped in favour of public procurement (ibid).

### **P3 rescue: government promotion and support**

Despite serious problems with P3 markets in 2008-9, several Canadian provinces continued to initiate new P3s throughout the crisis. BC and Ontario in particular remained committed, announcing new infrastructure projects in areas relating to health care, transportation, incarceration, water treatment, and other important sectors throughout the crisis and recession (see Partnerships BC, n.d.; Infrastructure Ontario, n.d.).

One way in which this was accomplished in BC was through the alteration of certain private financing accounting rules. Given the sudden increase in private sector borrowing costs relative to government borrowing, in 2009 Partnerships BC began to use a 'wide equity' financing model, temporarily suspending the requirement that a private partner provide both equity and bank financing (Partnerships BC 2009). Thus for the Fort St. John Hospital P3 the government took on the loan risk and the private partner (ISL Health) was allowed to increase their equity share (from 10 percent to 14 percent) (Reynolds 2012b). This significantly reduced the burden of financial risk transfer for the private partner as the Northern Health Authority came to assume most of the cost of construction. Although the wide equity model did save taxpayers from some of the additional costs associated with private financing during the crisis, a portion of the project's financing still came from more expensive private debt. Coupled with the lack of

significant risk transfer, this raises the obvious question of why a P3 arrangement was needed at all for this project.

Support for individual projects was also accompanied by longer term initiatives such as the creation of P3 units – specialized government agencies charged with promoting and assisting with P3 development (helping with project financing and by offering technical and legal guidance). At the federal level in Canada, PPP Canada Inc. now takes up this task. Created in late 2007 as a federal Crown corporation, PPP Canada promotes, assesses and evaluates, and provides expertise and assistance with the development of partnerships across the country (and at the municipal level in particular). Once the P3 market deteriorated sharply in 2008, PPP Canada also engaged in ‘extensive discussions’ in 2008/9 with the provinces/territories, private sector stakeholders and other federal organizations to gauge the nature and extent of public sector support needed to ensure that new projects were started, and that recently initiated projects reached financial close. Through these efforts PPP Canada determined that its priority would be to help ease the “significant roadblock” to P3 projects posed by the financial crisis (PPP Canada 2009). In furtherance of its mandate to “develop the Canadian market for public-private partnerships,” it received funding commitments from the federal government of \$2.8 billion per annum for 2011-2013 (ibid). PPP Canada also teamed up with Export Development Canada to provide surety, bonding support, and co-lending to enable troubled P3 projects to proceed (ibid). Budget 2013 renewed these funding commitments once more, this time by \$1.25 billion (described in chapter 3.3 *The New Building Canada Plan*, see Government of Canada 2013). In contrast, fiscal austerity made a comeback at the federal level in Budget 2012 which introduced cuts totaling \$5.2 billion (Government of Canada 2012).

Other countries have enacted similar forms of political support for P3s. In the UK the Treasury created its PFI Lending Initiative in 2009 in order to provide financing for projects that would have otherwise been terminated due to a shortfall in private sector lending (CCPPP 2009, 6). In December 2009 the Chancellor of the Exchequer also announced in a pre-budget report the creation of Infrastructure UK (IUK) which “would take on the role to advise the Government on strategic long-term infrastructure planning, prioritization, financing and delivery across sectors from energy and waste, to water, telecommunications and transport” (Farquharson and Encinas 2010, 7). This brought together the Treasury’s P3 policy makers, the country’s P3 unit (Partnerships UK), and the new lending initiative as a way of integrating P3 policy into long run infrastructure planning. France incorporated financial support for P3 initiatives into its 2008 stimulus plan (ibid, 8). In contrast, the 2009 Canadian stimulus package suspended the 2007

requirement that P3s be considered first for large infrastructure projects (CLC 2009, 3-4), but this P3 screen was re-imposed in 2011.

The active promotion of P3s during and after the 2008 crisis does more than merely allow P3 policy to move forward, it also encouraged a re-establishment of neoliberal rule through dispossession and marketization (a topic returned to in the concluding chapter). Further, the embracing of private finance to fund public services and infrastructure recreates the conditions that initially triggered the global financial crisis. Examples of this include the off balance sheet accounting practices that are made easier and more attractive by the P3 model and the securitization and offshoring of private funds which are re-circulated into important areas of social welfare and public policy (with risks ultimately backed by the taxpayer). The commercial confidentiality that accompanies all P3 agreements also encourages low levels of corporate accountability and they allow for profit-seeking behaviour using market refinancing and equity sales – practices which are largely beyond public control once a project agreement is in place (see Reynolds 2011; Sandborn 2008; Whitfield 2009).

## **Concluding remarks**

P3s are a form of privatization that holds unique characteristics, distinguishing partnerships from full-scale asset divestiture and from more limited forms of contracting-out. An important part of the P3 process is the normalization of normative discourse and market-derived techniques, reframing notions of public infrastructure and service provision. Through a market-based conceptualization of risk, risk transfer, value for money, and cost savings, the traditional fully-public option is evaluated against the P3 model in a way that is conceptually and methodologically biased in favour of privatization. The traditional method is no longer considered on its own terms and measured against its own strengths; nor is the P3 option subject to the values and outcomes of public procurement and collective decision-making. Risks created by P3s are not considered in value for money assessments, and neither are the risks that market-based transactions are unable to address. Self-referentiality of this sort is not only an academic concern as it brings specific problems to the health care sector – stifling innovation, locking-in particular policies when flexibility is far more desirable, draining resources through the introduction of profit, threatening trade agreement exemptions, disintegrating service provision and hospital management, and subjecting public services and infrastructure to financial crises and market volatility. These issues, along with the nature of commodification in health care, will be taken up in chapter 3.

## **Chapter 3. Unhealthy policy: health, health care and the impact of privatization**

Public-private partnerships (P3s) with the for-profit private sector first emerged in Canada in the mid-1990s and have been steadily growing in popularity ever since. More recently, proliferation since the mid-2000s has been sustained largely through infrastructure projects developed within provincial health sectors. In Ontario and British Columbia (BC) for example, the Canadian provinces most enthusiastic about P3s, by 2011 roughly 75 percent and 50 percent respectively of all such projects were health-care related (e.g., hospitals, clinical facilities, health care centres) (see Infrastructure Ontario n.d.; Partnerships BC n.d.).<sup>28</sup> With large hospital re/development in particular P3s are now the principal way in which these infrastructure projects and their accompanying support services are delivered. Even though the rise of P3s is a global phenomenon that is in no way unique to Canada or the health sector, jurisdictional specificity when evaluating this policy matters. Not only are P3s themselves symptomatic of larger trends, but hospital P3s reveal how wider neoliberal processes operate at the ground level (in the form of particular projects) and how this unfolds within a specific sector (health care).

Chapter 1 argued that P3s are a novel form of accumulation by dispossession which allows for privatization to take place within especially sensitive areas of public policy that would not otherwise be suitable candidates for more overt privatization initiatives. Within a public health care system, and one so widely cherished as the Canadian medicare system, P3s thus offer the advantage of opening up an untapped pool of potential investment sites, but this is accomplished in a relatively depoliticized, technocratic fashion.

This chapter will extend the analysis initiated in previous chapters by examining the theoretical and empirical implications of P3 policy and projects, however here the focus will be on Canadian hospitals and health sector privatization. The nature of this discussion is threefold. First, the context in which P3 hospitals are able to flourish will be summarized: the internal erosion of medicare through fiscal austerity, the downloading of responsibility to the provinces simultaneous to the reduction in federal oversight, and the marketization of health systems through neoliberal restructuring. This section also provides a brief introduction to the historical creation and evolution of public health care in Canada, illustrating the ways in which its underlying values are at odds with the major trends of the neoliberal era. Second, the

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<sup>28</sup> However it must be noted that the proportion of P3 hospitals to total P3s fluctuates over time and the P3 model has been expanding into new sectors.

implications of health care privatization will be examined; including the impact that it has on health, social reproduction, and health services. Third, the problems and concerns unique to P3 hospital projects and policy will be discussed by specifying how they stifle innovation, create an internal bifurcation of authority, and unduly burden third sector and local community efforts to finance their share of capital and equipment costs.

## **The creation, evolution, and internal erosion of public health care in Canada**

### **History**

The Canadian public health care system is the outcome of many years of negotiation and compromise, making medicare a perpetual work-in-progress with few moments of stasis in its relatively short existence. Public concern over Canadian health policy was jumpstarted in the late nineteenth century after a series of serious epidemics, including influenza and tuberculosis, but the situation would turn grave once the economic and health impacts of the Great Depression were felt. Conditions at that time had become so severe as to call into question the entire 'residual' system of social security that existed prior to 1940 which relied on the family and the private sector (including the charitable sector) as a "first line of defense" (Guest 1980, 1). While this residual system of social security had always proven inadequate for the most marginalized, the high level of unemployment and destitution that followed the stock market crash in 1929 meant that relief for the poor and the sick fell to the municipalities that were on the verge of bankruptcy themselves, and unemployment 'insurance' was provided through nineteenth century style work camps or left up to soup kitchens and private charities (Fuller 1998, 20). As a reflection of poor population health experienced at this time, 44 percent of the young army recruits during the Second World War were rejected due to illness, matched by a similar percentage of unhealthy people working the production lines during the War (ibid, 27). These rejection rates, along with dismal infant mortality rates, rates of death as a result of communicable disease, and a high incidence of ill health among children, led Canadians to "seek and demand alternatives" (ibid, 28).

Despite the desires of the public, and some in the private sector (recognizing that socializing the costs of health care would prove beneficial for not just the working class but for capital as well), it would take some two decades for these demands to be fully met. The shift

toward Keynesian policy began in Canada with the 1935 introduction of legislation to cushion the blow of the Depression, namely with the passage of the *Employment and Social Insurance Act*, the *Minimum Wages Act*, and the *Limitations of Hours of Work Act* (Cameron 2006, 58). Further interventions included the creation of Crown Corporations in order to provide necessary goods and services not offered by the private sector (Clarkson 2002; Whiteside 2012). The inauguration of medicare was much slower going due to the constitutional stipulation that “provinces were to establish, maintain, and manage hospitals, asylums, charities and eleemosynary [charitable] institutions” (Fuller 1998, 13). Thus a national health care program would have to arise within the restrictive context of *British North America Act*, resulting in much inter-provincial division on the issue.<sup>29</sup> In addition, the interests of powerful private for-profit insurance companies, coupled with doctor-led resistance through bodies such as the Canadian Medical Association, created firm resistance to the initiation of a comprehensive national health care plan. Ultimately, through a series of legislative steps beginning in the 1950s, opposition to medicare was overshadowed by unwavering public pressure and the support of a political economy climate favouring government intervention (the Keynesian fix, discussed in chapter 1).

First, the *Hospital Insurance and Diagnostic Services Act*, initiated in 1957, fully insured inpatient hospital services through a federal-provincial cost sharing agreement in which the federal government agreed to split 50 percent of the hospital costs with the provinces through a grant-in-aid formula (Auer et al. 1995, 5). Next, in 1966 the *Medical Care Act* was instituted to insure doctors’ services, with all costs met by general tax revenue. Finally, on July 1, 1968 the Medical Care Insurance program went into effect, which combined the two into one cost-sharing formula covering all “necessary” hospital and medical services (ibid, 6). This legislation imposed five cost-sharing conditions: universal coverage (all Canadian residents were covered), accessibility (no hindrance through a means test or extra charges), portability (all Canadians should receive services anywhere in Canada), comprehensiveness (all ‘medically necessary’ hospital and physicians’ services were covered), and public administration (each provincial plan was to be administered on a non-profit basis without the involvement of the private sector) (Vogt 1999, 185). By 1971, just before the transition to neoliberalism, all provinces had universal health care.

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<sup>29</sup> For example, the Dominion-Provincial Conference of 1945 was the first national conference that discussed the implementation of a national health care system, and talks would collapse in 1946 when the four prairie provinces clashed with the other six, led by Ontario, on issues relating to jurisdiction, tax collection, money, and cost sharing (Fuller 1998, 30).

## **Paving the way for privatization: federal spending austerity & downloading oversight**

The federal-provincial cost sharing that was a key feature of the viability of medicare would only last until 1977, when the federal government implemented the Federal-Provincial Fiscal Arrangements and Established Programs Act (EPF). The EPF replaced the fifty-fifty cost split between the provinces and the federal government in the area of health and post-secondary education. The Act also rolled federal transfers for health and education into a new block-funding formula whereby contributions would be partly cash and partly tax points transferred to the provinces (McBride 2005, 107).

The effects of this policy were twofold. First, the block-funding policy served to decentralize funds and therefore devolve political power to the provinces (ibid). Second, under the EPF increases in federal funding were tied to growth of GNP rather than the previous mode of tying federal funding to increases in real costs (ibid). Thus the initiation of the EPF in 1977 represents a significant departure from the previous funding structure both in terms of the value of the amount transferred and in terms of the ability for the federal government to enforce national standards since the provinces were given more power over the allocation of funds.

With the federal capacity for oversight reduced and health care transfers declining, from 1977 onward a significant amount of provincial variation emerged, with some provinces beginning to permit 'extra billing' and the imposition of user fees by both doctors and hospitals (Vogt 1999, 186). Given the obvious contradictions that this posed for meeting the basic principles of the public health care system, namely universality and accessibility, several public inquiries were initiated, including the Health Services Review of 1980, which "revealed strong support throughout Canada for a system of universal health care without extra user charges" (ibid). The federal government responded to these and other similar findings with the 1984 *Canada Health Act*. The Act restated the five principles of health insurance, and allowed the federal government to withhold transfers to a province should extra billing or user fees be permitted (Auer et al. 1995, 9).

The promise of the Act would be short lived, however. One year later, in 1985, the release of the Macdonald Commission report symbolized the onset of a shift towards neoliberalism in Canada. Although not all recommendations were implemented, some pertinent areas include the following: the use of monetary tools to manage the economy as opposed to the Keynesian style of managing supply and demand, expenditure cutbacks, a devolution of power for the delivery of services, market liberalization, trade liberalization, and a rejection of



Canada's historical commitment to an interventionist state in favour of more entrepreneurial forms of governance (Cameron 2006, 66-7; McBride 2005, 61; Clarkson 2002, 29).

The adoption of these neoliberal principles had a dramatic effect on federal health care funding in Canada. Following the release of the Macdonald report, the federal government imposed ceilings on EPF payments in 1986, 1990-91, 1991-92, and a freeze on health care expenditures from 1992 to 1995 (McBride 2005, 107). Federal spending on health care would further deteriorate when the 1995 budget announced that EPF would be merged with the Canada Assistance Plan (CAP, the fund for social assistance and welfare) into a new block fund, to be called the Canada Health and Social Transfer (CHST) (Browne 2000, 21). The CHST was developed "almost entirely by the Department of Finance without broad consultation either with the public or other departments," and it had a serious impact on the fiscal affairs of the provinces (Vogt 1999, 193). Compared with what they would have received under the former CAP and EPF programs, the CHST dramatically reduced transfer payments, with 1996-98 cash transfers to the provinces alone declining by 33 percent (\$6 billion) (ibid).

Meanwhile, as federal spending was being brought in line with neoliberal dictates, health care costs were mounting. There are several different ways of measuring the cost of health care, two of the most common being in nominal or real dollars and as a share of GDP. When measured in nominal dollars, between 1980 and 1990 Canada's total health care costs rose by \$40 billion, from \$22.7 billion to \$62.2 billion; with hospital costs contributing to 50 percent of the total increase, physician services and pharmaceuticals to 20 percent, and residential care to 10 percent (Auer et al. 1995, 82). Nominal dollars, however, are not price adjusted. When we account for inflation by using real dollars we see that economy-wide inflation produced roughly 50 percent of the 1980-90 increase in health care costs and another 20 percent was related to health care-specific wage and price inflation (ibid, 82-3). Further, while the overall upward trend in the cost of health care has continued over the past thirty years (Evans 2007), when measured as a share of GDP we see that the underlying driver of 'sustainability' concerns is the decline in national income growth beginning early in the neoliberal era. In 1971 health care costs amounted to 7.1 percent of GDP, and after the 1982 recession this became 8.1 percent. By 1992, just at the onset of the next neoliberal-era recession, it reached 10.0 percent of GDP. Rather than allowing these costs to take up a greater proportion of federal government expenditures, the CHST was introduced.<sup>30</sup> Predictably, spending cutbacks during a time of

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<sup>30</sup> A third consideration is health spending as a proportion of government expenditures. Increases in health spending as a share of provincial budgets appear to have been quite dramatic from 1995/6 to 2005/6 – rising from 35 percent to 42 percent over this timeframe. However, as Evans (2007) shows, this change is also principally the result of neoliberal policies: provincial tax cuts and austerity applied to other

rising costs bore results similar to those of the EPF: a health care system starved of funds compromised quality health care, and an even larger block-funding scheme further diminished the capacity of the federal government to ensure that the five principles of public health care were being maintained across Canada.

Growing public concern over long waiting lists and understaffed/overcrowded facilities, and some within the capitalist class taking issue with the erosion of the 'competitive advantage' of Canada, would urge a rise in health care spending once again.<sup>31</sup> Thus, by 2001 spending had increased to almost \$60 billion, well above its 1992 level of \$52 billion (Rachlis et al. 2001, 6). Yet despite this increase, expenditures on hospitals remained well below their 1992 level, and jobs eliminated (primarily nursing staff) were not restored (ibid). Furthermore, many analysts were beginning to recognize that health care funding was not the only issue, as poor management and organization were also to blame (Rachlis 2004, 22). This theme was emphasized in the Romanow and Kirby Reports of 2002, both suggesting that innovation in service delivery would be needed to resolve the problems of medicare (see Romanow 2002; Kirby 2002).

Despite medicare requiring strong stewardship, the exact nature of this innovation has been largely left up to the provinces. In jurisdictions such as in Ontario and BC, dispossession and marketization have been chosen rather than searching for alternatives that match the spirit of the *Canada Health Act*. Provincial autonomy was only further enhanced in 2004 when the federal government committed to transfer an additional \$41 billion over 10 years to the provinces without any conditions attached (Armstrong and Armstrong 2008, 24).<sup>32</sup> Thus, whereas fiscal austerity manufactured a health care crisis in the 1990s, the recent spending

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areas of public spending. Thus health care spending in the 1990s came to occupy a larger share of a shrinking pie.

<sup>31</sup> Medicare in Canada has meant the reduction of costs for companies such the Big Three automakers in the US (Ford, GM, Chrysler). In 2006 they were spending more than \$10 billion on health care benefits in the US that they did not need to pay in Canada (see Caron 2008, 9). This, and similar examples from other industries, has led many commentators in the private sector (e.g., Richard Nesbitt, CEO Toronto Stock Exchange Group; and A. Charles Baillie, former Chairman and CEO, TD Bank, honorary chair of the Canadian Council of Chief Executives) to advocate in favour of maintaining a system of public health care in Canada.

<sup>32</sup> In 2004 health and social transfers were separated once more through the creation of the Canada Health Transfer (CHT) and the Canada Social Transfer (CST). At this time, Paul Martin launched a 10-year 'Plan to Strengthen Health Care' (sometimes referred to as the Health Accord) where the federal government agreed to annual increases in federal spending transfers of 6 percent. This commitment raised the federal spending contribution by 20 percent – a significant improvement after the deep cuts implemented in the 1990s, though substantially less than the 50 percent originally provided prior to the EPF. The Health Accord expires in 2013-4 and, as Bhatia (2011, 81) puts it, "this will become a big deal politically over next few years". The federal government now appears set to reduce the increases in the amount it transfers to the provinces for public health care (Galloway 2012).

increases concurrent with dispossession illustrate that privatization cannot be blamed on a lack of funds.

## **Provincial health systems restructuring through marketization**

Changes made to the medicare system over the neoliberal period have not only been initiated at the federal level, but also by the provinces – an important development given that this level of government is constitutionally empowered to manage and oversee the delivery of health services in Canada. In BC and Ontario there has been significant health systems restructuring over the past decade, with reforms taking a clearly marketized inflection. As previously discussed in chapter 1, marketization involves the expansion of market-like rules and market rule. Market-like rules have been introduced in several ways: through changes in the organization of public health systems management (regional health authority (RHA) restructuring in BC, local health integration network (LHIN) creation in Ontario), and through new spending rules and funding schemes (applied to RHAs in BC and hospital boards in Ontario).

The specifics of public health systems management changes in these provinces are examined in chapters 4 and 5, suffice it to say here that RHAs and hospital boards must comply with performance agreements which stipulate that budget cuts imposed by the province cannot be dealt with through deficits at the local level, forcing hospital restructuring and amalgamations, service cuts (e.g., cancelling elective surgeries), fee hikes (where applicable, e.g., parking lot rates,<sup>33</sup> the costs of private hospital rooms), and cuts to labour costs (e.g., freezes on hiring and overtime, layoffs) (BC Ministry of Health Planning 2002; BC Ministry of Health Services 2002; BC Ministry of Skills and Development and Labour 2002; Camfield 2006; CBC 2009; Cohen and Cohen 2004; McMartin 2002; Murphy 2007; OHC 2008b). RHAs and hospitals are thus reoriented toward the bottom line, often at the expense of health care provision and a consideration of wider social needs. The boards of RHAs and hospitals have also been corporatized, as leaders are now largely selected for their business backgrounds rather than experience in the health sector (Murphy 2007).

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<sup>33</sup> In a *Canadian Medical Association Journal* editorial high parking fees associated with urban hospitals have been flagged as being a hidden user fee which contradicts the 1984 *Canada Health Act* ban on user fees and assurance of equal access and free care at the point of delivery (Kale 2012). In the 2013 Budget, the federal government removed the exemption from GST/HST historically provided to hospital parking lot fees (Government of Canada 2013).

Funding schemes for hospital operating costs have also changed, which is another important way in which market-like rules are introduced and internal markets for public hospital services are created. BC and Ontario have recently (in 2010 and 2009 respectively) made two changes worth noting in this regard. As of 2010, BC began to move away from line item based hospital funding<sup>34</sup> to an 'activity based' model in dozens of hospitals across the province, affecting roughly 20 percent of hospital funding overall (Cohen et al. 2012, 6). Cast as a 'patient-focused' model able to reduce surgical wait times and improve access to emergency services (BC Ministry of Health 2010), under an activity based model financing for procedures becomes linked to the volume of activity and payments are made by procedure or by patient. Funds are distributed using metrics such as efficiency, throughput, and lowest price rather than other non-marketized considerations like ensuring that patients are receiving the highest quality care possible and equity of access across the population (Canadian Doctors for Medicare 2008). Patients with the most complex care needs are particularly disadvantaged by this funding model (Cohen et al. 2012).

In 2009 Ontario began to change its funding model as well, taking steps to move away from global budgets (lump sum amounts) through the introduction of 'pay for results' and 'pay for performance' schemes that provide extra funding to hospitals on the basis of, and tie hospital board member compensation to, performance measures (Ontario Ministry of Health 2009; McFarland 2010). They also began to focus on population-based funding whereby money would be diverted to areas with faster growing or more elderly populations. Concerns similar to those associated with activity-based funding arise: regional disparities (urban vs. rural) can skew access to care, and quality of care is not adequately assessed when 'performance' is reoriented toward market-like efficiency measurements and cost reductions (Howlett 2010).

Doug Allan warns that the move toward a performance based payment model in Ontario hurts P3 hospitals' funding given their higher costs (2012, Phone Interview, July 18). This is confirmed by another interviewee (Public Partner Manager 4 2012, Phone Interview, November 12) who reports that the twenty-five year life cycle costs associated with the DBFO Brampton Civic Hospital P3 has produced a higher cost per case, thereby making the hospital look less efficient compared to traditional hospitals or more limited design-build P3s. Furthermore, again in reference to the Brampton Civic Hospital, this public partner manager (ibid) explains that with brand new P3 hospitals there is a high equipment depreciation expense which also makes them

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<sup>34</sup> Line item funding "involves negotiating amounts for specific line items in a budget. The sum of all line items equals the total hospital budget" (Canadian Doctors for Medicare 2008, 3). In practice this has operated like global lump sum funding since health care providers received a set budget each year (Cohen et al. 2012).

appear less efficient on a cost per case basis. This can negatively affect the performance based funding that the hospital receives from the Ministry.

Reforms made to health service provision and funding are intertwined with the expansion of market rule. When care is shifted out of hospital and into the community/home where public insurance does not often (adequately) cover services and pharmaceuticals, marketization occurs. Market dependence is also enhanced through the increasing public sector reliance upon for-profit surgical clinics that perform routine, low risk procedures. Often presented as a way of relieving stresses placed on the public system (e.g., BCMA 2012), shifting medically necessary surgery into private for-profit clinics actually does more long term harm to the public system than any good that can come from a temporary reduction in wait times. In a cross-Canada study of for-profit diagnostic, surgical and 'boutique' physician clinics, Mehra (2008, 7) finds that there is, "a demonstrable reduction in capacity of public non-profit hospitals as a direct result of staff poaching by nearby for-profit clinics" and thus "there is little evidence to support the contention that for-profit ownership bears any relation to reducing wait times" (ibid, 8). Not only do for-profit clinics draw highly-qualified staff away from local hospitals but they also take the lightest care patients, leaving the most expensive and difficult to treat patients in the public system which now has a diminished capacity to deal with them (a practice known as 'cream-skimming'). For-profit clinics have also been allowed to charge for procedures that are covered under medicare (known as 'double-billing') (ibid). However a recent ruling in BC indicates that a more proactive stance against double-billing might be on the horizon (e.g., see Oliver 2012).

Other ways in which market rule is expanding within the public health care system (e.g., through privatization and labour reorganization) will be addressed shortly. Taken together, these factors contribute to a larger pattern of shifting blame, occluding accountability, reorienting the public sector, and embedding the profit motive within the provision of public health services.

### **Public vs. private health care insurance and delivery**

Despite its relatively recent emergence, corporate profit making within the public health care system holds the potential for serious long run consequences. Introducing for-profit investment into the heart of medicare, as occurs through for-profit clinics and P3 hospitals,

threatens not only the nature and quality of care but may compromise its Annex 1<sup>35</sup> exemption from the North American Free Trade Agreement (NAFTA), a feature that currently protects medicare from investors' rights guaranteed through international trade law. The threat posed by P3 hospitals is disputed by the Canadian Council for Public-Private Partnerships (2003b)<sup>36</sup> but there has already been one privatization-related NAFTA challenge. In July 2008 American investor Marvin J. Howard, along with Centurion Health Corporation and the Howard Family Trust, filed a Notice of Intent under NAFTA Chapter 11 seeking US\$160 million in damages on the grounds that by not allowing his American firm to provide for-profit surgical services, BC violated NAFTA's barriers to entry and expropriation clauses (Vis-Dunbar 2008, 3). To substantiate the claim, Centurion posited that there exists "serious inconsistencies" between the *Canada Health Act* and Canadian provincial health care programs (Permanent Court of Arbitration 2010, 2). Ultimately the arbitration proceedings were terminated in 2010 in advance of any judgment by the NAFTA Court of Arbitration on the grounds that the claimant did not pay the requisite monetary deposit agreed to in 2009. Rather than standing as a victory for public health care, the evaporation of this court case instead points to the importance of governance transformations in health care and the potential for neoliberal trade treaties to lock in reforms (see Gill 2003).

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<sup>35</sup> The North American Free Trade Agreement's (NAFTA) Annex 1 allows for variation in public policy, stipulating that any 'non-conforming' measures (i.e., the ability to exclude private for profit investment in public health care) that were in place prior to January 1, 1994 are exempt from key NAFTA rules and investor-state challenges. However, once privatization is introduced, Parties lose the ability to rely on Annex 1 protections. The most significant exemption currently enjoyed by the public health care system is protection from NAFTA Chapter 11 ('Investment') which accords a range of rights to private investors from the NAFTA Parties, and allows them to seek private remedies through binding investor-state dispute settlement procedures. These rules and investor protections apply to all foreign investment throughout the health care sector. Particularly important rights accorded to foreign investors include: protection from nationalization, expropriation of assets without proper compensation (including not only wholesale expropriation but also creeping or gradual forms such as "measures that effectively strip an owner of the ability to manage but without actually changing the ownership or title" see Horlick et al. 2002, 21 for how this relates to the electricity sector in Canada), national treatment, minimum international standards of treatment for all investors, and prohibitions against the establishment of certain operating parameters.

<sup>36</sup> The CCPPP takes an optimistic view of the protection of investors' rights through NAFTA's Chapter 11, stating that "Chapter 11 merely seeks to assure Canada's NAFTA partners that they will not be treated more harshly or differently because of their status as foreigners. Canada can still raise or change its environmental, health and safety and other social standards as long as the new standards are applied equally and without discrimination" (2003b, 55). More specific to P3 hospitals, the CCPPP points out that NAFTA rules do not apply to government procurement (ibid, 56). However in 2010 the Canada-US Agreement on Government Procurement included a commitment by US and Canadian governments to "explore the scope for a long term government procurement agreement ... to deepen, on a reciprocal basis, procurement commitments beyond those in the WTO GPA and NAFTA" (DFAIT 2012). Expanded commitments relating to government procurement in concert with the threat that profit making in the public health sector poses to the Annex 1 exemption make privatization largely a one-way street.

Policy changes in this delicate sector are therefore of relevance not only to those in provinces with P3s and other forms of privatization but to Canadians more broadly. There remains a great deal of debate over what specific implications NAFTA may hold, and similarly what effect the World Trade Organization's (WTO) General Agreement on Trade in Services may someday have on the public health care system. Both trade agreements promote liberalization and hinder the ability of governments to reverse privatization, yet the issue remains opaque unless and until a dispute is brought successfully before a tribunal – at which point it is “quite possible that some services Canada sees as covered by a reservation or exception will not be considered in the same way by our trading partners or by a panel arbitrating a dispute” (Ouellet 2002, 17). Thus, as Fierlbeck (2011, 101) puts it, “as long as Canadian health care stays firmly in the public sector, the rules of the marketplace will have no bearing on it. Once Canada begins to permit health care services (such as insurance) to be offered in the private sector, anti-competition [trade agreement] rules can be applied.” Should Canada lose its medicare-specific NAFTA and WTO exemptions, or if the internal erosion of medicare leads to two-tier health care, comparisons of public and private insurance and delivery (examined below) indicate that there will be grave results: higher cost, less efficient financing of the system, and poorer and inadequate delivery of care leading to greater mortality risks.

In 1964 the Hall Commission, a body tasked with examining the various options available for constructing a system of national health care, found that private insurance systems were not very efficient, with roughly 28 percent of premiums going to overhead costs (see Royal Commission on Health Services 1964a; 1964b). Additional costs generated by private insurance that are minimized or not present with universal insurance include the need to assess patients, enroll them if they qualify, collect their premiums, and repay physicians/patients – all of which adds significant paperwork, hidden costs, and inefficiencies through system wide duplications. The extraction of profit on top of these overhead costs, along with the need for the federal government to subsidize or cover the costs of insuring the ‘non-insurable’ (those who were too sick or poor to afford private insurance), led the Hall Commission to recommend the single payer system of universal health care coverage that we have today. The US, also looking to reform their health system at the roughly the same time, took a different path and efforts to establish a national, comprehensive system of health insurance were only partially successful – with Medicare being provided for the elderly and Medicaid for the very poor (Hacker 1998; Maioni 1998).

Over time the Canadian system has retained a greater degree of efficiency, cost control, and administrative simplicity than the US system.<sup>37</sup> Woolhandler et al. (2003), for example, report that per capita Canada spends only one third of what the US spends on health insurance administration and this gap appears to be ever growing; and the multiple insurer system is intrinsically costlier than a single payer system due to the higher overhead costs of the latter (as a result of claims' processing duplication and smaller insured groups), and because with the Canadian single payer system hospitals can be paid a lump sum global budget which is not possible under a multiple insurer system. Beyond the financial and administrative implications, universal coverage also brings equity-related benefits not experienced in the US such as coverage for all, not just those who are healthy and wealthy. Of course inequalities can be found in nearly any nation-wide system, and in Canada higher income groups and healthier people pay more and receive proportionally less than those who are poorer and of ill health (Evans 2007).

On top of the issues associated with private insurance, private health care delivery leads to additional concerns. For instance, Woolhandler and Himmelstein (2004) show that in the US for-profit specialty hospitals focus on money making procedures (e.g., providing cardiac and orthopedic care) whereas money-losing programs (e.g., geriatric care, emergency departments) are shifted to not-for-profit hospitals leading to a duplication of services (inefficiencies), greater burdens for not-for profits, and more money being siphoned off by for-profits. Furthermore, the reorganization required to commodify health services creates its own inefficiencies since the various components of the system are no longer managed by a single organization. It therefore becomes harder to integrate services once multiple organizations are providing health care, leading to coordination problems and additional overhead costs (e.g., an expansion of accounting systems, greater monitoring costs).

The emphasis on profit maximization is also a concern. As Woolhandler and Himmelstein (2004) demonstrate, private for-profit hospitals are profit maximizers, not cost minimizers: payments for care in private-for-profit hospitals exceed costs in not-for-profit hospitals by 19 percent. Profit seeking also leads to greater risk of death: on the basis of an extensive literature review, Devereaux et al. (2002) conclude that private-for profit hospitals have higher hospital mortality rates given that they employ fewer highly skilled personnel per bed.

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<sup>37</sup> Canada has been relatively effective at controlling costs in comparison with the US which spent nearly 18 percent of GDP on health in 2012. In that same year, Canada spent just over 11 percent of GDP, making it comparable to France or Germany but slightly above the average for spending among major OECD countries (9.5 percent) (see OECD 2012).



## The impact of privatization on health and health care

### Health and health care

Not only is health care challenged by privatization but health itself can be negatively affected by capitalist accumulation.<sup>38</sup> In other words, capitalism poses problems for health and wellbeing regardless of whether accumulation by dispossession is present. Colin Leys (2010) summarizes this contradiction in the following manner: capitalism produces and relies upon inequalities, yet leading research into the social determinants of health strongly indicates that there is a connection between poverty and ill health (physical, developmental, social), with health indicators varying by income group. Income and ill health are thus inversely related to one another and this means that those who are in greatest need of health care coverage are those who, if forced to fully rely on the market, are least likely to be able to secure adequate coverage. As one newspaper article put it, 'wealth equals health' (CBC 2012). In turn this can hurt capital accumulation if the overall health of workers becomes threatened. Thus by socializing the costs of health care through public insurance (which is the essence of Canada's medicare system), public health care not only improves health and wellbeing but also indirectly supports capital accumulation. The importance of this relationship is borne out historically given that, as previously mentioned, one of the most important factors leading to the development of medicare in Canada was the ill health experienced by factory workers and army recruits in the 1940s (Fuller 1998, 27).<sup>39</sup>

However, as Leys (2010, 15) also reminds us, health care "is an ideological construct almost as much as a material reality." The principles of public health care in Canada, namely universality and accessibility, remain in place (for a description see Armstrong and Armstrong 2008, 30-31) but the era of neoliberal rule has meant that attempts to achieve these goals are

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<sup>38</sup> Beginning in the late 19<sup>th</sup> century, and occurring around the same time as the emergence of the contemporary capitalist system, the 'mortality revolution' ushered in an era of widespread and long lasting increases in longevity and overall public health in the global North. However, despite this historical coincidence, the link between wellness and capitalism is tenuous at best given that the breakthroughs in science and technology which are typically credited for the mortality revolution were often state funded and innovations related to sanitation and public health care were widely resisted by capital (as employers and taxpayers) (see Leys 2010, 1-6).

<sup>39</sup> And thus insofar as P3s erode economic advantages offered by public health care systems, they will also pose a contradiction for both individual health and for capital. The notion that P3s can help as well as hinder capital dovetails with Arrighi et al.'s (2010, 411) argument that over the long run accumulation by dispossession "generally undermines the conditions for successful development."

now subsumed within a policy discourse of efficiency, sustainability, and risk transfer to the private sector; as well as the material reality of fiscal austerity and cost control. This exacerbates the tension that already exists between capitalism, health, and health care by widening inequality.<sup>40</sup>

## **Hospital service privatization and social reproduction**

Closely linked to the conflict that exists between health and capitalism, social reproduction is also threatened by the profitability imperative. Problems posed for social reproduction, a concept which “encompasses daily life and long term reproduction, both of the means of production and the labor power to make them work” (Katz 2001, 711),<sup>41</sup> were mediated to a certain extent by the development of a public health care system in Canada. Public health care meant not only universal access to medically necessary health services (delinking receipt of services from an ability to pay for them), but also greater job security and better pay for health care workers – the majority of whom are women (see Cohen and Cohen 2006, 124). State provision of health care insurance can also reduce the burden of unpaid work done in the home, although it is estimated that roughly 70 percent of all care work in Canada is still provided in this fashion (Armstrong and Armstrong 2010, 163). Dispossession erodes this public support for social reproduction as it redistributes burdens (e.g., shifting care and financial burdens onto the individual or household), reinforces inequalities (e.g., related to gender and income), and reconfigures the dynamics of public and private authority (e.g., expanding the role and purview of the market).

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<sup>40</sup> See McBride and Whiteside (2011b) for a discussion of rising income disparity and wealth concentration in Canada during the neoliberal era.

<sup>41</sup> Bezanson and Luxton (2006, 3, emphasis added) provide a more elaborated discussion when they write, “the concept of social reproduction refers to the processes involved in maintaining and reproducing people, specifically the labouring population, and their labour power on a daily and generational basis... It involves the provision of food, clothing, shelter, basic safety, and health care, along with the development and transmission of knowledge, social values, and cultural practices and the construction of individual and collective identities... Embedded in a feminist political economy framework, social reproduction offers a basis for understanding how various institutions (such as the state, the market, the family/household, and the third sector) interact and balance power so that the work involved in the daily and generational production and maintenance of people is completed. *Social reproduction is dynamic in that most of the work involved in it can be taken up by various actors and institutions*”. Dynamism is an important emphasis here as the practice of health care provision within the home, the community, by the private for-profit sector, and/or by the state is a social construct and historically particular hence the importance of understanding how privatization via P3 hospitals affects social reproduction and redistributes burdens and power.

When discussing authority and influence in the Canadian health care system it is important to acknowledge that private actors have always been a feature of the system, including within the public medicare system. Doctors, for example, have typically been private providers of health care services, making their own decisions as to what is medically necessary, where their private practices are located, and they face little oversight of their expenditures (Armstrong and Armstrong 2008, 36). Similarly, hospitals in Canada have historically been run privately, though on a not-for-profit basis (e.g., by community or religious organizations). What is new, and thus constitutes a significant shift in decision-making and authority, is the introduction of the profit motive into the long term planning, operation, and management of non-clinical services in public hospitals through P3s and contracting-out. In terms of social reproduction, this has an impact on both health outcomes and labour.

Cutting corners in order to reduce costs and increase profitability through hospital support service privatization creates difficulties for service integration and planning (Shrybman 2007b), and has been directly linked to illness and death. For example, in 2009 BC's Nanaimo Regional General Hospital developed the antibacterial resistant super bug *C. difficile*, causing dozens to fall ill and five deaths in 2009. Though infection control is a concern in all hospitals, the BC Centre for Disease Control reports that due to understaffing and improper training by the private contractor, the privatized cleaning support staff made several crucial errors in their sanitization attempts which greatly exacerbated later attempts at infection control (Leyne 2009). This supports Cohen and Cohen's (2006, 138) contention that "because of the special requirements and dangers inherent in a hospital setting, this type of cleaning requires a level of knowledge and skill that is acquired through years of on-the-job experience as well as special training. Such training is not typically offered by the private sector."

A related issue with hospital support service privatization is the deleterious effect that this can have on the women and visible minorities who predominantly provide these services. This includes lower wages, less secure employment and predictable shifts, and an introduction of neo-Taylorist labour disciplining and monitoring techniques (see Armstrong and Armstrong 2010; Cohen and Cohen 2006). Furthermore, support services provided in hospital (such as dietary, cleaning, and linen services) have been re-conceptualized under the P3 model, and through contracting-out, as being akin to hotel services rather than unique health care-specific services. This is problematic given that these services are in fact a fundamental aspect of health care provision. Support staff "ensure the cleanliness of rooms, furnishings, and equipment that are vital to infection control; they prepare and deliver meals; they dispose of garbage and bio-hazardous material; they do the laundry for patients and staff," and thus crucial

areas of health care are affected such as hygiene, nutrition, infection control, and patient care (Stinson et al. 2005, 34). Patients and staff training tend to suffer as a result.

## **P3 hospitals**

To reiterate and expand upon some of the key points presented in previous chapters, dispossession via P3s operates on several levels. For labour, dispossession is experienced directly through the decades-long privatization of work historically conducted by public sector employees. This aspect is similar to contracting-out although the longer time horizon and contract bundling features of P3s add a greater degree of permanence. Huws (2012) calls the commodification of public services ‘secondary primitive accumulation’ since it expropriates rights previously won by labour and holds negative implications for health care workers and their work (the specifics of which will be discussed shortly).

The financialization of public sector activities is also a concern and constitutes a relatively unique feature of P3-related dispossession.<sup>42</sup> Under the auspices of ‘risk transfer’ private partners assume responsibility for hypothetical project risks such as cost overruns and delays in exchange for lucrative investment opportunities. Risk transfer, however, is illusory not only because it is fully paid for by the public partner rather than simply ‘transferred’ to the private partner, but also because calculations of risk in P3 value for money assessments use biased methodology. As reported by the Institute for Public Policy Research in Britain: “none of [the PFI hospital projects on which data exist] show significant value-for-money savings when set against the Public Sector Comparator. In the case of most NHS hospital PFI schemes the small projected savings could easily disappear if some assumptions relating to risk, or the discount rate, were altered” (as quoted in Farnsworth 2006, 833).

On top of the many pitfalls associated with the P3 model presented here and in previous chapters are three unique concerns specific to P3 hospitals: how they stifle innovation, create an internal bifurcation of authority, and unduly burden efforts of the third sector and resources of the local community.<sup>43</sup>

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<sup>42</sup> Not all P3 arrangements incorporate private financing. However, it is the essence of the UK’s pioneering Private Finance Initiative and the arrangement most common to Canadian P3s ever since their emergence in the mid-1990s.

<sup>43</sup> CUPE (2011, 28) suggests that P3 hospitals also reduce access to health care services since they “have cut the total hospital bed count in some areas of Canada” and “many P3 hospitals are too far away from many patients”. However, given that hospital location and capacity are decisions made by the public sector prior to P3 selection, they are not necessarily attributable to the P3 model itself and thus will not be examined here.

The first concern relates to the mismatch between the fixed, contract-based mode of physical infrastructure planning and the long run need for flexibility. Design innovation with hospitals relates specifically to the physical adaptability of the building, as it must meet today's needs whilst also accommodating future economic and social requirements as well as medical advances (Barlow and Koberle-Gaiser 2008). In 2001 the UK's Department of Health (2001) reiterated the importance of health infrastructure design innovation (conceptualized as adaptability) as a way of improving care at the same time as the PFI model had begun to proliferate within that sector. Several years later, case study evidence of PFI hospitals in the UK compiled by Barlow and Koberle-Gaiser (2008, 1392) led to the finding that "the PFI model is unable to promote the level of innovation in the design of hospital built assets needed to optimize their lifetime clinical efficiency".

Though the challenge of adaptability may be equally present with traditional hospitals, the nature of P3 contracts creates additional hurdles given the nature of its project agreement arrangements: the length of the contract is both too long and too short to generate innovative solutions from a risk-based perspective. A critique applicable to all P3s, but particularly appropriate in the case of hospital projects, is the long term, inflexible nature of the market-based contracts. This locks policy, design, and service planning in for several decades whereas innovations in technology, public policy, another other related fields can have much shorter lifecycles – making project agreements far too long within the health sector.

On the other hand, P3 contracts are also too short to truly transfer many important risks to the private partner. With average P3 hospital contract lengths of roughly thirty years, the P3 model can transfer some immediate risks associated with construction and maintenance but the private consortia need only consider the medium run design of a hospital, not the long term and uncertain risks. Functional obsolescence, changing policies, and unidentified future health care needs falls onto the shoulders of the public sector which holds ultimate responsibility for hospitals in perpetuity (Pollock et al. 2002). Further, Leiringer (2006) finds that as a way of minimizing the costs associated with construction risk, P3 private partners have an incentive to use tried and true design and construction techniques, not the most forward thinking and innovative ones. Thus design is conducted by profit-oriented risk adverse partners with little motivating them to plan for uncertain changes that would likely occur outside of the parameters of the project agreement.

Hospital design from the perspective of private architectural and construction firms also represents a repository of knowledge and expertise, raising a related irony: rather than improving efficiency and fostering innovation, the competitive nature of P3 tendering

discourages the very features it is purported to engender. When expertise in long run infrastructure planning and design was held mainly in-house, efficiencies and innovations were generated through retained knowledge within the public sector. Privatizing this knowledge and subjecting it to (albeit limited) market competition individualizes hospitals from a design perspective, eliminating inter-project learning. Intra-project learning is also stifled as health service planning becomes disintegrated from the design and operation of physical infrastructure. Since hospital project agreements in Canada do not cover clinical services, there is little incentive on the part of the private partner to plan and design for the improvement of clinical care (Barlow and Koberle-Gaiser 2008).

Another concern specific to P3 hospitals relates to the contradiction that exists between the privatized mode of support service delivery and the need for clinical and non-clinical service integration within global hospital planning. Sometimes referred to as an 'internal bifurcation of authority' (Shrybman 2007b; Mehra 2005), this feature of P3 hospitals is produced when authority and oversight over hospital services is no longer held exclusively by public health authorities but shared with P3 private partners.<sup>44</sup>

Problems associated with an internal bifurcation of authority include disintegrated planning procedures, and hindrances placed upon communication and collaboration within the hospital. The duplication of administrative layers and authority structures can also create problems related to uncertainty and inflexibility should labour disputes arise (see chapter 7 for how this occurred with the Royal Ottawa Hospital P3). This feature introduces private for-profit decision-making into the heart of medicare in Canada: hospital management and health service planning. Not only is decision-making profit oriented but hospitals' boards (Ontario) and regional health authorities (BC) working with P3 operators are no longer in charge of monitoring support service contractors. With the P3 model, subcontracted service providers become the responsibility of the private partner, making P3 support service privatization distinct from contracting-out within traditional hospitals. Shrybman feels that the private financing and management of support services could facilitate the flourishing of two tier health care given that P3 hospitals allow private investors to "integrate, within the public hospital setting, a parallel and privately funded health services regime" (2007b, 198).

With multi-decade project agreements, the higher costs associated with P3s are locked in over the long run which can put pressure on public health systems' managers to make cuts in

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<sup>44</sup> Depending on the project agreement. Note that in Ontario soft support services (e.g., housekeeping, dietary, and laundry services) are not currently subject to P3 agreements though they may be contracted out by hospital boards.

other areas in order to keep up with P3 payments. In the case of the Brampton Civic Hospital P3 (discussed in chapter 7), the province has assumed responsibility for the capital costs but not for the service contract – this falls onto the hospital board, as do the tough decisions and tradeoffs that must be made in times of fiscal austerity. Given that severing the service component from the overall project agreement is subject to formalized contract dispute procedures, it would be prohibitively expensive for a local public authority to contemplate this scenario – even in the case of poor performance.<sup>45</sup>

Through a series of Freedom of Information requests in 2011, it has been revealed that NHS Trusts in the UK are now locked into long term PFI deals where they are “forced to pay ‘hyper-inflated’ charges for basic services” such as “£242 to put a padlock on a garden gate at a trust in North Staffordshire, £466 to replace a light fitting and £75 for an air freshener in Cumbria and £15,000 to ‘install a laundry door following feasibility study’ at a trust in Salisbury” (Hope 2012). Being locked into more costly, long running PFI deals also led to the June 2012 bankruptcy of South London Healthcare NHS Trust; and soon after it was revealed that an additional 22 NHS Trusts faced ‘unsustainable’ financial conditions as a result of expensive PFI hospitals (Alleyne 2012). Serious financial problems of this sort have yet to surface in Canada, although in light of performance agreements that prohibit regional health authorities from running deficits (e.g., in BC), it is clear that P3 payments will take priority over other service needs in Canada as well.<sup>46</sup>

The third concern specific to P3 hospitals in Canada relates to the additional burden that this model places on third sector and municipal or community-based efforts and resources. Common to BC and Ontario is the stipulation that a portion of the infrastructure and equipment costs of all new hospitals (whether P3 or not) be paid through the contributions of local communities, known as the ‘local share’. In Ontario the local share is the responsibility of public

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<sup>45</sup> P3 proponents often applaud the protections offered by project agreements that include performance-based payment schemes. With private partners subject to penalties and deductions, it is argued, the public is insulated from unnecessary cost and risk. However, in practice P3 agreements are not always as robust as they appear. As discussed in chapter 6, with the Diamond Centre P3 in BC, despite claims to the contrary, payment deductions cannot be imposed and the public partner cannot compel the private operator to seek out new subcontractors – even when a problem relates to an issue as serious as hospital infection control. Further, also discussed in chapter 6, often public partners prefer to resolve disputes through negotiation and compromise rather than imposing financial penalties on private partners.

<sup>46</sup> The BC provincial government had previously come up with year-end bailouts of RHAs that were in danger of running a deficit. However in 2009 BC Health Minister Kevin Falcon announced that these top ups would no longer take place, forcing health authorities to cut hundreds of millions of dollars, achieved through service caps and cuts, slashing jobs, and higher user fees where applicable (CBC 2009). As evidenced through the recent firing of BC’s Cowichan Valley district 79 school board (where school boards face similar constraints), there is little reason to believe that provincial officials will not continue to strongly enforce the balance budget imperative with RHAs as well (Nuttall 2012).

hospital corporations and the charitable organizations that participate in funding drives; in BC this is the responsibility of regional health authorities, regional hospital districts, hospital foundations, and auxiliaries.<sup>47</sup> Historically the local share has varied quite significantly in Ontario, oscillating from between zero to 50 percent of the cost associated with hospital equipment and furnishings (Ontario Standing Committee on Public Accounts 2009). In BC the local share component has been more stable, and is often upwards of 40 percent (Bish and Clemens 2008, 73).

Since the local share is a proportion of total costs rather than a fixed or risk-adjusted amount, as hospital costs grow so too does the burden placed upon third sector and community contributions. In the case of the Brampton Civic Hospital P3 (examined in chapter 7), additional costs became so great that the William Osler Health Centre (WOHC, the public hospital corporation) was unable to generate the local share of construction and equipment procurement and installation (Ontario Auditor General 2008, 118). The Ministry of Health was then forced to grant WOHC credits for the difference between what the public design-build costs would have been and the P3 bid, amounting to \$164 million (ibid). The Ministry has since revised its policy around local share contributions and this now stands at 10 percent of the construction costs and 100 percent of the equipment costs (ibid, 124). In BC, the Fraser Valley Regional Hospital District contributed \$72.3 million to the \$355 million Abbotsford P3 (FVRD n.d.), or roughly 20 percent of the capital cost.<sup>48</sup> Total capital costs associated with this P3 escalated by over 50 percent between 2001 and 2008 and thus so too did the local share (see chapter 6 for more detail on cost creep).

The relationship between P3s and the charitable/not-for-profit agents that contribute to the local share component of these hospitals differs slightly from the one more typically identified in the literature on the third sector and neoliberal restructuring. For example, in Evans and Shields on Canada (2000; 1998) and Van Gramberg and Bassett (2005) on Australia we read of the ways in which public sector roll-back creates a greater reliance upon, and commercialization of, the third sector. In the Canadian health care sector the situation is somewhat different given the relative insulation of medicare from neoliberal roll-back, at least in

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<sup>47</sup> Hospital foundations and auxiliaries are registered charities run by volunteers which finance equipment used in hospitals. Hospital foundations also help fund some clinical costs, research institutes, manage donation and investment income, and often run health and wellness campaigns.

<sup>48</sup> The Fraser Valley Regional Hospital District falls under the purview of the Fraser Valley Regional District. Regional Districts in BC are not separate levels of government but instead are “federations of the municipalities and electoral areas that exist within their boundaries” (BC Ministry of Community Services 2005, 9). Their major revenue sources are: property value taxes, parcel taxes, and fees and charges (ibid, 8).



comparison with other areas of welfare state policy.<sup>49</sup> Medically necessary services remain publicly funded and provided, and smaller hospital projects are rarely delivered using private financing; similarly, hospital foundations, charities, and auxiliaries have retained their longstanding (pre-neoliberal) commitment to providing hospital equipment and funding certain other capital costs. Thus, with respect to the third sector and P3s, the more relevant changes taking place within Canada's public health sector are those that are occurring *within* the private sector (for-profit and not-for-profit) rather than between the public and third sectors. As for-profit entities begin to play a larger role in public health care, the role of not-for profit entities becomes subordinated in terms of decision-making and influence. At the same time, private financing and service delivery can mean greater project costs, and thus greater fundraising pressures, placed on third sector contributors.

## **Concluding remarks**

Neoliberal market expansion is achieved in a number of ways, with state restructuring through the introduction of market rule (i.e., privatization) and market-like rule (i.e., policy reorientation) playing key roles in this process. Marketization has come to take many forms, all of which appear to have a deleterious effect on the public health care system, due primarily to the internal erosion of medicare rather than to more overt forms of assault. This chapter has briefly examined some of the major neoliberal era trends and their drawbacks, from fiscal austerity in the 1990s and a loss of federal oversight, to provincial governments introducing marketization as a salve for all that ails the system (problems that are sometimes more imagined than real, or created by neoliberal policy itself), to the problems that this poses for social reproduction, care provision, and health sector workers.

Intertwined with these larger trends, P3 hospitals pose their own unique problems for public health care as well: they stifle innovation, create an internal bifurcation of authority, and unduly burden the efforts and resources of the third sector and local community. These factors highlight the error of homogenization that occurs when infrastructure projects are treated as interchangeable and equally amenable to the P3 model. Thus the increasingly ingrained bias toward P3 use, and the shifting of infrastructure decision making away from Ministries of Health and into the hands of P3 units charged with promoting privatization – topics to be addressed in

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<sup>49</sup> *Relative* insulation must be emphasized here. As discussed previously in the chapter, through the EPF and CHST health spending has certainly been reduced in the past. Further, neoliberal roll-out has meant the marketization and privatization of support services and infrastructure in the health care system.

the following two chapters – often contradict the unique needs of hospital infrastructure procurement, design, and management.

**SECTION 2. Analyzing P3 hospital policies and projects in BC and Ontario**

## Chapter 4. Normalizing dispossession: provincial P3 programs and enabling fields

This chapter will discuss the phases of P3 development that have shaped the Canadian landscape, and provide an explanation for how one phase has shifted into the next. Having originally emerged in the 1990s era of fiscal austerity, P3s were initially used in jurisdictions and sectors scattered across the country, justified mainly through an appeal to cost savings and off-book financing. In the past decade, on the other hand, P3 use has greatly expanded and is now the dominant form of procurement for large scale infrastructure projects developed in the BC and Ontario provincial health sector (amongst other areas, namely transportation). It is argued here that this current phase is distinguished by the creation and sophistication of sector-wide P3 programs, a concept that will be explored with reference to the institutional and procedural similarities and differences that have emerged in Ontario and BC. The analysis in this chapter will lead into a subsequent argument (to be presented in chapter 5) which suggests that these two major phases of P3 development in Canada can also be understood in terms of the relative degree to which this form of dispossession has been routinized, institutionalized, and depoliticized.

Sector-wide P3 programs do not stand on their own, rather they are nested within wider provincial P3 enabling fields. Enabling fields are the other major policy innovation contributing to the flourishing of Canadian P3 hospitals over the past decade. The concept of an enabling field encapsulates a number of regulatory, procedural and legal-institutional changes. In contrast, full-scale privatization might require only one piece of enabling legislation (e.g., the privatization of Air Canada through Bill C-29 in 1988). The multifaceted nature of P3 enabling fields attests once more to the uniqueness of P3s when compared with the various other forms of privatization that exist in Canada. As argued in chapter 1, with P3s dispossession occurs *within* the realm of the state and marketization involves not only an expansion of market rule but also the adoption of market-like rules by the public sector. Partnerships should thus neither be conflated with full-scale privatization (where public obligations are severed and private owners come to fully control the asset or service) nor are they limited to the privatized execution of policy choices made within the public sector (as is the case with contracting-out). The P3 model is therefore a contingent phenomenon, requiring the historical and contemporary occupation of certain sectors and services by the state, and is reliant upon the ascension of a particular ideology or governance paradigm: neoliberalism and its emphasis on new public management

and neoclassical economics. Further, neoliberalism can be subdivided into various forms, and it is within the roll-out phase that P3s and enabling fields take root.

The central elements of the P3 enabling fields set up by Canada's key P3 enthusiasts – the BC and Ontario Liberal governments – are as follows: legislation and capital planning frameworks; supportive secondary reforms; and new forms of institutional support. The legislative and capital planning framework changes relevant here are: BC's Capital Asset Management Framework and Ontario's Infrastructure Planning, Financing and Procurement Framework; and BC's *Health Sector Partnerships Agreement Act* and Ontario's Alternative Financing and Procurement model. Supportive secondary reforms refer to the 2001 restructuring of BC's regional health authorities and the 2006 initiation of Local Health Integration Networks in Ontario. New institutional support for P3s in each province is now provided by specialized P3 units, named Partnerships BC and Infrastructure Ontario, and these too will be discussed in this chapter.

## **Phases of Canadian P3 development**

Infrastructure P3s have existed in Canada since the mid-1990s although several divisions within the timeframe of their existence have been proposed by academic experts and industry insiders. Two principal divisions relate to those that emphasize changes in the political rationale provided to justify P3 use, and those anchored on the public sector institutional changes that support P3 development. The differing accounts of various eras of P3 development in Canada can be usefully cobbled together to form a more complete picture.

John Loxley (2010, 40-41) proposes the following three phases of P3 development: first, the emergence of a highly politicized, ideologically-driven era in the mid-1990s. P3s were adopted at this time as a way of reducing the size of the public sector in accordance with roll-back neoliberalism (e.g., P3s initiated by the Harris Progressive Conservative government in Ontario). Second, in the late-1990s to early-2000s Loxley argues that the rationale shifted slightly, from one that was strongly or overtly ideological to one that relied upon the purported financial and economic superiority of P3s. Finally, since the mid-2000s, he suggests that we have seen a reemergence of "a purely political rationale" (ibid, 40), indicated by the application of a P3 screen to federal infrastructure spending and the aggressive promotion of partnerships at the provincial level in select jurisdictions (namely BC, Ontario, Alberta and Quebec).

The industry publication *Infrastructure Investor* (2010, 6) also identifies three phases, but with its slightly different interpretation of the second and third phases it has a more

institutionally-oriented approach overall. From this perspective, the first stage began in the 1990s when all three levels of government developed P3s as “a way to try to get some off-balance sheet financing” (quoting Cynthia Robertson, executive director of the Canadian Council for Public-Private Partnerships, see p. 6). This was followed by a second phase that began in the early 2000s when provinces like Ontario and BC began to promote P3s as a way of capturing cost savings and efficiency gains, and created P3 units as procurement agencies and centres of excellence. Finally, the third and current phase is demarcated by the federal government’s 2009 creation of PPP Canada. It is suggested that in this current phase the federal government will “take a stronger leadership role in coordinating private investment in infrastructure” (ibid).

A third phase-related interpretation which is more clearly distinguished by institutional innovations within the public sector is represented by a Conference Board of Canada publication (Iacobacci 2010). It argues that there have been only two eras, divided according to the absence/presence of specialized government agencies devoted to P3 promotion. The second phase thus began with those projects “that reached financial close under the auspices of the P3 agencies (or offices) set up in the early 2000s” (Iacobacci 2010, 1). Colverson (2012) suggests that government ‘maturity’ is a very important factor in the development of P3 markets. To be discussed shortly, here it is argued that maturation in Canada’s leading P3-promoting provinces has meant shifting from individual one-off projects to focusing on sector-wide P3 programs that target areas earmarked for infrastructure renewal, such as health care. P3 programs are also supported by the creation of P3 enabling fields which provide a province-wide shape to P3 development.

The various justifications and forms of institutional support for P3 development identified by Loxley (2010), *Infrastructure Investor* (2010), and the Conference Board of Canada (Iacobacci 2010) correspond to the wider changes in neoliberal policy experienced over the past two decades. As discussed in chapter 1, neoliberalism is not a monolithic process – its policies and practices range from overtly ideological (normative), to more technocratic and pragmatic (normalized). The roll-back, roll-out, and rolling-with variants of neoliberalization identified by Peck and Tickell (2002) and Keil (2009) are relevant here. As a subset of neoliberal policy, privatization also takes many forms – ranging from full scale asset divestiture to contracting-out to P3s – and so too do the normative and normalized forms of support for P3s across the neoliberal era.

Although each perspective presented above has its merits, apart these various different accounts do not capture the whole picture. Both how policy makers justify P3s (i.e., rhetorically

and ideologically) and the mechanisms through which the state is restructured to accommodate and encourage this phenomenon (i.e., legally and institutionally) ought to be merged in order to generate a more well-rounded argument.<sup>50</sup> The concept of an enabling field (chapter 4) and its effects (chapter 5) addresses both. But first, before examining the items that form the BC and Ontario P3 enabling fields, it is important to situate this discussion within another major corresponding policy development: the shift from a project-focus to a program-focus in key sectors.

### **The shift from projects to programs**

In light of the poor track record of early (1990s) P3s in Canada,<sup>51</sup> this chapter argues that P3 proliferation continues, and has gained prominence in Ontario and BC under Liberal governments over the past decade (beginning in 2003 and 2001, respectively), through the shift from a project- to a program-based focus. Longevity of the P3 model in these jurisdictions has been accomplished not through any significant resolution of the larger problems and conflicts that are inherent to this procurement model, but instead by shifting from the development of one-off projects to instead creating P3 programs within suitable sectors (mainly health care and transportation).<sup>52</sup> This has helped to build up the high level of specialized knowledge, expertise, experience, and commitment needed to pursue dispossession within the public sector. The web of support offered to projects and programs, or the ‘P3 enabling field’, is the mechanism through which this shift is initiated. These distinctions are summarized in table 1 below.

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<sup>50</sup> Note that the relevant literature on this subject remains relatively mute with respect to any changes required on the part of the private partner – for capital (as was examined in chapter 2) the arrangement merely has to be profitable and predictable, both of which are dictated largely by how committed and enthusiastic governments are for partnerships. However, one significant change worth mentioning in relation to the private component of public-private partnerships is the growing network of industry experts and other groups reliant upon P3 markets such as private consultancy firms, accountants, lawyers, auditors, and advocacy organizations.

<sup>51</sup> For example, see Loxley (2010) on the Hamilton-Wentworth water and sewage system (ON), Evergreen Park School (NB), Confederation Bridge (federal), Charleswood Bridge (MB), and Highway 407 (ON).

<sup>52</sup> See Murphy 2008 for a description of which types of projects and conditions are most suitable for P3s. Considerations such as project size, scope, and opportunity for innovation and risk transfer are highlighted. Large capital projects within health and transportation sectors fit these criteria.

**Table 1. P3 Project, Program, Enabling Field**

<b>P3 project</b>	An individual piece of infrastructure and its support services, governed by a project agreement (typically 30 years), with a legally circumscribed public partner and private partner.
<b>P3 program</b>	The sum of all P3 projects in a particular sector and their implementation regime (health sector: outlined in chapter 5); influenced by individual projects and the wider P3 enabling field yet containing issues, elements, hurdles, and stakeholders unique to a given program.
<b>P3 enabling field</b>	The constellation of legal and institutional arrangements that facilitate, encourage, and allow for P3 projects and programs; it is inherently transformative (influencing preexisting structures and relationships) and is itself continually adapting to new circumstances and challenges. The enabling field is largely responsible for ridding jurisdictions of the pre-existing bias toward traditional project procurement through RID (routinizing, institutionalizing, and depoliticizing dispossession, see chapter 5).

The terms ‘program’ and ‘enabling field’ used in the table above have been inspired by, though differ from, the small but growing literature on P3 implementation (e.g., Greenway et al. 2004; Jooste and Scott 2012; Jooste et al. 2010; Rachwalski and Ross 2010). For instance, when Rachwalski and Ross (2010) use the term ‘P3 program’ they are referring to P3s in all sectors, but here it is used in a more narrow fashion as in fact P3 development can differ greatly from one sector to another. Sectoral differences are related to a number of factors. Canadian provincial health sectors, for example, have their own implementation regimes (relating to capital procurement procedures, the authorities and stakeholders that are involved, the level of public engagement, and other legal considerations such as the 1984 *Canada Health Act* which bans user fees) that are not accounted for when ‘program’ refers to all P3s within a given jurisdiction. Similarly, Jooste and Scott (2012, 151) focus on how enabling fields help overcome government, market and other related difficulties experienced by P3s, but for them the enabling field is composed of a “network of new ‘enabling organizations’ (public, private, nonprofit)”. The enabling organizations that they are referring to are, for example, specialized P3 units, Auditors General, private consultants, and advocacy organizations. These organizations are no doubt crucial to the maturation of P3 markets but focusing only on organizations (essentially the



'institutional support' category of the enabling field as presented in this chapter) ignores the legislation, capital planning frameworks, and supportive secondary reforms that are particularly important for P3 programs in Canada.

## P3 enabling fields

The three elements present in Ontario and BC P3 enabling fields,<sup>53</sup> along with examples of their primary components, are summarized in the table below. Note that these enabling fields were set up following Liberal election victories in each province: after May 2001 in BC (under Premier Campbell) and October 2003 in Ontario (under Premier McGuinty). There were no provincial infrastructure P3s developed in BC prior to this; Ontario had but a few in various sectors at the municipal and provincial level, and no hospital P3s were yet operational (see Loxley 2010 for examples and discussion).

**Table 2. P3 Enabling Fields**

	<b>BC</b>	<b>Ontario</b>
<b>Enabling legislation and capital planning frameworks</b>	<i>Community Charter Act</i> (2003)	<i>Municipal Act</i> (2006)
	Capital Asset Management Framework (CAMF) (2002)	Infrastructure Planning, Financing, and Procurement Framework (IPFP) (2004)
	<i>The Health Sector Partnerships Agreement Act</i> (Bill 94) (2003)	Alternative Financing and Procurement model (AFP) (2004)
<b>Supportive secondary reforms</b>	Regional Health Authority (RHA) restructuring (2001)	Local Health Integration Network (LHIN) creation (2006)
<b>Institutional support</b>	Partnerships BC (PBC) (2002)	Infrastructure Ontario (IO) (2005)

<sup>53</sup> Use of the word 'field' is relevant here as well: most elements within these provincial enabling fields inform decision-making across the bureaucracy and public sector (with the notable exception of supportive secondary reforms, these are sector-specific and linked to particular P3 programs).

## Enabling legislation & capital planning procedures

This category accounts for the nuts and bolts of the P3 enabling field: the legislative and policy changes that are necessary for developing P3 projects and programs. A range of items are included, from those that facilitate and regularize P3 development (AFP, Bill 94), to those that coerce public sector bureaucrats to contemplate and evaluate the P3 option (CAMF, IPFP), and those that simplify P3 adoption at the municipal level (*Community Charter Act, Municipal Act*).

### *BC's Community Charter Act*

The basic tenets of municipal government in BC, as identified by Bish (1990, 9; taken from Smith et al. 2010, 247) are as follows: “municipalities operate under rules set out by the province, they are mandated by the provincial government to perform certain administrative activities, and any actions undertaken by these municipalities have to be authorized by provincial legislation.” These powers are not constitutionally entrenched given that municipalities are (to repeat the cliché) ‘creatures of the provinces’. Municipal powers were, however, recently augmented through legislative changes introduced in 2004 by Premier Campbell when the *Community Charter Act* was enacted.<sup>54</sup>

Of the new powers introduced through the Community Charter, four are particularly relevant to the development of future P3s. These are (see Community Charter 2003, Chapter 26 part 3; Smith et al. 2010; Smith and Stewart 2005):

- 1) Within the boundaries of the constitution, municipalities are now allowed to establish any service they consider necessary;
- 2) Municipalities can now enter into partnership agreements with private entities in the following areas without prior provincial government approval: water, sewage, transportation, and gas, electrical or other energy supply system;
- 3) The counter-petition process initially established in the *Local Government Act* has been watered down by increasing the proportion of the local population needed to sign a petition before a new bylaw or large spending project can be subject to a referendum, and by making referenda binding only if they fail;

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<sup>54</sup> Vancouver is the one exception in the province as its power, authority and operations were set out in the 1953 *Vancouver Charter* which governs only the City of Vancouver.

- 4) The Community Charter also opens up the possibility, though it does not guarantee, that municipalities will be granted new ways to raise revenue beyond their historical reliance on property taxes (e.g., allowing them to apply new forms of taxation like entertainment and hotel taxes, to establish road tolls, and to enact user fees on various services);

These changes were promoted as a way of improving local governance by giving municipalities more flexibility and autonomy than they previously had, increasing accountability and good governance, and generating efficiencies through decentralization (Community Charter 2003; Smith and Stewart 2005; Smith et al. 2010; Vancouver Sun 2003, 15). So far these benefits have been more rhetorical than actual, as accountability has been eroded (Vancouver Sun 2003, 15), the provincial government can still “override any local government on any project it deems ‘of significant provincial interest’” (Smith et al. 2010, 249), and fears that decentralization is merely a euphemism for cost and responsibility shifting have been raised (Depner 2002). In many ways the promise of greater autonomy and better, more democratic forms of local governance has yet to materialize.<sup>55</sup> Instead what these regulatory reforms more clearly achieve is the promotion and simplification of the municipal P3 development process. Thus the Community Charter is a prime example of neoliberal reregulation allowing for dispossession at the local level.

The time and paperwork (‘red tape’) previously associated with establishing municipal P3s has now been reduced, and this eliminates the legal impediments and associated delays that may have previously discouraged P3 ventures at the local level. Less red tape translates into enhanced freedom to enter into P3 agreements, and P3s can be used to provide any new service within a municipality’s legal and jurisdictional purview – making it far easier to turn new services into commodities. The ability to hold city council accountable for unpopular P3s at an early stage in their development has also been curtailed through changes to the regulations surrounding counter-petition. In addition, by allowing municipalities to create new revenue sources by imposing user fees, the tax increases that would otherwise prove necessary to afford new P3s are not required, which avoids raising “concerns in the business community” as

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<sup>55</sup> In 2012, the BC provincial government announced the creation of an ‘Auditor General for Local Government’ (AGLG) in order “make sure British Columbians are getting the best value for their money” (BC Office of the Premier 2012). The idea of introducing a spending watchdog at the municipal level originated with the BC Chamber of Commerce and when the AGLG position was announced the President of the Union of BC Municipalities admitted that some communities were opposed to the idea (Bailey 2012). It is too early to tell what the specific impact of this new position will be on municipalities’ autonomy and local democracy but it could hold important implications in the future.

Ted Nebbeling then-Minister of State for the Community Charter put it (quoted in Palmer 2003, 18). The ability to more easily apply user fees to new services and infrastructure also makes P3 revenue both more lucrative and assured for the private investor. Finally, municipalities have now been given the ability to grant tax holidays to businesses, effectively shifting the burden of more costly P3 repayment onto residents.

### ***Ontario's Municipal Act***

Municipalities in Ontario are also governed mainly by provincial legislation. The 2001 *Municipal Act* (and later the 2006 *Municipal Statute Law Amendment Act*, both to be referred to simply as the '*Municipal Act*') was introduced in order to "provid[e] local governments with new broad powers and significant legislative freedoms," giving municipalities "more autonomy" (Ontario Ministry of Municipal Affairs and Housing 2007). Enhanced natural person rights and control over services promote P3s in Ontario municipalities much like the *Community Charter* does in BC. Natural person powers allow municipalities to enter into agreements (and conduct other types of business) without needing to seek or be given prior provincial approval.

In particular, section 110 of the *Municipal Act* (2001) grants municipalities the ability to "enter into agreements for the provision of municipal capital facilities by any person" – where 'any person' includes a private sector entity. Capital facilities covered here include sectors suitable for P3s: electrical facilities; municipal facilities for telecommunication, transit and transportation; waste management, water and sewer facilities; municipal housing facilities; and community centres, libraries and cultural facilities. While user fees within the public health care system are prohibited by the 1984 *Canada Health Act*, in other areas the application of tolls and fees can be a great boon to P3 developed given that it often means greater revenue for investors.

The *Community Charter Act* and *Municipal Act* are therefore forms of enabling legislation in the sense that they help ease the development of P3s at the municipal level by simplifying and accelerating implementation (granting greater autonomy to local decision-makers) and by providing new revenue sources from which P3s can be financed (helping to lure investors). However, these pieces of legislation in no way compel municipalities to adopt P3s. More coercive features of provincial P3 enabling legislation are the new public infrastructure procurement policy frameworks (the CAMF and IPFP) that now guide decision-making in BC and Ontario.

## ***BC's Capital Asset Management Framework***

In May 2002, the Capital Asset Management Framework (CAMF) was introduced to serve as new “rules of the road” for public infrastructure building in BC, governed by five best-practice principles: sound fiscal management, strong accountability, value for money, protecting the public interest, and competition and transparency (BC Ministry of Finance 2002, 1-2). The CAMF applies province-wide and thus all ministries, public sector agencies, and other public organizations must now comply with these rules when seeking approval and funding for infrastructure projects.

When introduced, the Ministry of Finance made an effort to present the CAMF as being pragmatic, claiming that it “does not predetermine that every project will be a public-private partnership” (ibid, 1). Further, the Value for Money CAMF document states that: “the framework does not assume that any one sector is inherently more efficient in building and operating public assets. Instead, it emphasizes that capital decisions will be based on a practical, project-specific assessment of a full range of options” (BC Ministry of Finance n.d., 5). Yet pragmatism is merely a mask for the dispossession-promoting evaluation process that makes up the bulk of CAMF procedures. In order to fulfill lofty principles like achieving the best value for taxpayers and protecting the public interest, there is a clear bias toward P3s. This bias is inherent to the very nature of CAMF-dictated decision-making. P3 preference is betrayed, for instance, through the best-practice principle of achieving value for money. Value for money, the CAMF advises, “will be enhanced through strategic use of public and private resources” (ibid).

Further to the point, the CAMF dictates that any capital project proposal in excess of \$50 million must *first* be considered as a P3, although from 2002-2008 the threshold was set even lower at \$20 million (since 2008 those in the \$20-\$50 million range are subject to a P3 screen which is used to determine whether a more comprehensive P3 evaluation should proceed) (BC Ministry of Finance 2008). As Cohn suggests, this shifts the bias away from traditional public procurement by “chang[ing] the terms of debate regarding P3s. Instead of explaining why a P3 was justified, it [is now] necessary to explain why a P3 (or some other form of alternative service delivery) [is] *not* being employed” (2008, 89).

Less obvious but equally important are the implications of its focus on market-oriented notions of risk and the heavy emphasis placed on identifying and valuating risk throughout CAMF procedures. Before a project can move beyond the initial proposal stage it is subject to a risk-based assessment which assumes that additional public sector responsibilities bring greater risks, and thus risk can be mitigated and minimized through partnership agreements. This

fosters an innate bias against public financing and ownership given that *any* new infrastructure project taken on by a public sector agency which does not involve the private sector is assumed to generate unnecessary risk. Risks are then monetized and added onto publicly delivered projects, penalizing public procurement even though these risks may be entirely hypothetical. Since risks are expected to be mitigated and minimized, new publicly financed, designed, owned, and operated capital projects are discouraged.

### ***Ontario's Infrastructure Planning, Financing and Procurement Framework***

Initiated in July 2004, Ontario's Infrastructure Planning, Financing and Procurement Framework (IPFP) is similar to BC's CAMF given that it outlines the strategies that will be used when developing (planning, building, financing, and managing) new public infrastructure projects across the province. The IPFP was crafted to guide a period of significant, targeted infrastructure renewal. The first phase of this process was the \$30 billion ReNew Ontario initiative (2005-10) which "direct[ed] infrastructure investments to the areas that Ontarians have said are their priorities – health care, education and economic prosperity" (Ontario Ministry of Infrastructure 2005). The IPFP continues to guide the subsequent (2011-13) three year, \$35 billion investment plan known as the 'Building Together' initiative which also targets important sectors such as health care and transportation. These efforts mark an improvement over previous year-by-year planning and help to address the significant infrastructure gap in Ontario, however under the IPFP framework the process through which investment decisions are made is skewed in favour of P3s.

Much like in BC, the IPFP framework enshrines five key principles in the planning, financing, and approval of project proposals submitted by Ministries, municipalities, hospital boards, and other public sector entities.<sup>56</sup> These are as follows: the public interest is paramount, value for money must be demonstrated, appropriate public ownership/control must be preserved, accountability must be maintained, all processes must be fair, transparent, and efficient (Ontario Ministry of Public Infrastructure Renewal 2004, 9). These are presented as a pragmatic, technocratic approach to infrastructure investment yet there is an explicit emphasis on "innovative engagement of the private sector to leverage expertise and capital" (ibid, 17); and P3s must be considered for all projects over \$20 million. Of the nine infrastructure and

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<sup>56</sup> There is evidence to suggest that some P3 enabling field initiatives in Ontario reflect policy transfer from the UK, British Columbia, and Australia – jurisdictions that had previously set up their own enabling fields. The issue of P3 policy transfer and transnational policy mobility will be briefly discussed in the concluding chapter.

procurement models discussed in the IFPF, eight are P3s (ibid, 21-22), and the public procurement option is only recommended for very minor investments (ibid, 24). A risk-focus is present here too, as is an emphasis on value for money (analyses that effectively double count risk to the detriment of the public option, as discussed in chapter 2).

Risk assessments have therefore come to assume an important role in capital planning in both BC and Ontario. Within both provinces, risk identification is integrated at an early stage into capital proposals, and risks are expected to be managed and mitigated.<sup>57</sup> Project risk categories are identical, and are as follows:

**Table 3. Project Risk (BC and Ontario)**

<b>RISK</b>	<b>EXAMPLE</b>
General	How an initiative fits with established objectives
Policy	How a project might be affected by a change in legislation
Public interest	Health, safety, security, etc.
Management	Team selection, availability of qualified managers, ability to work with private consortia
Design, construction, supplier	Availability of top quality supplies, contractors, permits obtainable within a suitable timeframe
Site	Site selection: affordability, physical suitability (e.g., soil), possibility of land claims disputes
Financing	Available at the appropriate time, creditworthiness of partners
Cost, economic, market	Any event that could affect cash flow during development
Ownership and operations	Labour relations, maintenance and technical obsolescence risks
Other	Force majeure

Source: IPRP (Ontario MPR 2004, 30) and CAMF (BC Ministry of Finance n.d., 18-19)

Beyond these similarities in assessing risk, some important differences begin to emerge. For instance, with regard to the five guiding principles used to inform infrastructure decisions, both provinces share an emphasis on protecting the public interest, achieving value for money, ensuring accountability, and establishing a level of transparency (although along with ‘transparency’ BC emphasizes competition, Ontario instead emphasizes fairness and efficiency). This leaves one major difference: in BC fiscal management takes precedence, not

<sup>57</sup> The operationalization, evaluation, and monetization of risk are also discussed in chapter 5.

public ownership or control like in Ontario. This difference, as it relates to provincial P3 programs, constitutes one of the most significant innovations offered by Ontario's Alternative Financing and Procurement model (discussed below). In actual practice, however, P3 hospital project agreements in Ontario offer neither greater public ownership nor control – they are structured nearly identically in both provinces.<sup>58</sup>

Another major difference between the two capital planning frameworks is that in Ontario risk is mainly associated with infrastructure development and must be considered when conducting assessments of procurement options. Risk for BC is a much broader concept as it not only encompasses infrastructure procurement but applies to all public sector agencies as well.<sup>59</sup> In BC, whichever public sector agency is “best able” to manage project risks is supposed to take on those responsibilities (BC Ministry of Finance n.d., 9). This accounts for the increased role of the province's dedicated P3 unit, Partnerships BC, with P3 hospital development (shifting some areas of decision-making away from the Regional Health Authorities and the Ministry of Health). Authority over capital projects is devolved only when a local agency is determined to be low risk, judged in light of its past fiscal and performance targets and track record of past project management. This turns a devolved, regionalized health management system into a hierarchical system when it comes to capital planning.

In addition, the CAMF holds that risks can be positive and negative, both of which incentivize P3 use. If an agency is unfamiliar with P3s and will be undertaking one for the first time, this carries some degree of risk. However, the CAMF contends that this is a positive risk given that “a defining feature of P3s is the opportunity they provide to share or transfer risks” (BC Ministry of Finance n.d., 15). Thus P3s are cast as bearers of positive risk (i.e., risks that ought to be taken) and mitigators of negative risk (i.e., through risk transfer to the private sector). It is a win-win situation for the P3 model.

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<sup>58</sup> To this must be added the important caveat that the land and facilities associated with P3 hospital deals initiated in Ontario prior to the Alternative Financing and Procurement (AFP) model would have been owned by the private partner, but under AFP the agreements are structured such that ownership of the land and facility remains with the public partner. The land and facilities associated with BC's P3 hospital agreements are also publicly owned.

<sup>59</sup> Every public sector activity is thus inherently ‘risky’ and since 2002 this has meant that Ministries and other public sector agencies must undertake Enterprise-Wide Risk Management (ERM) assessments. However, by 2011 the BC Auditor General had reported that “government has made insufficient progress in integrating enterprise risk management into its practices despite the official adoption of a risk-based approach in April 2002” (BC Auditor General 2011b, 6). Yet this has not put a damper on risk-based assessments for P3s. The government response to the Auditor General's report captures this with the following statement: “While recognizing that implementation to date, on a cross government basis, has not been consistent, ERM has been very successfully used on major projects within government, including all Public/Private Partnership initiatives” (ibid, 9). This nicely summarizes the situation: risk is the basis of justifying P3s but is more discursive than actual in other areas.



### ***BC's Health Sector Partnerships Agreement Act (Bill 94-2003)***

Designed to alter the rights of privatized P3 hospital support staff, BC's Bill 94-2003 (*The Health Sector Partnerships Agreement Act*) was introduced as a companion<sup>60</sup> to the earlier Bill 29-2002 (*The Health and Social Services Delivery Improvement Act*) which targeted contracted-out support staff employed in traditional non-P3 hospitals. The following has been said of Bill 29 though it could equally apply to Bill 94: this legislation was introduced for no other purpose but to "provide new investment and business opportunities for private corporations in the health-care sector and to reduce compensation for health-care support workers" (Cohen and Cohen 2006, 117-8). Dispossession was encouraged through both bills as they allowed for the elimination or alteration of several key provisions in signed collective agreements, namely those that provided job security protection and protection from privatization, applicable to all 'non-clinical' employees in BC's health care sector.

The implications of Bill 94 were not immediate as BC's first P3 hospital opened several years later in 2006 and the second one later still in 2008, but the effects of Bill 29 were swift and disastrous for non-clinical health care support staff. Within a few short years, more than 9,000 members of the Hospital Employees' Union had lost their jobs, and wages were slashed and benefits lost in newly contracted-out positions (Cohen and Cohen 2006).

After attempts by union and health care advocacy organizations to challenge Bill 29 through BC courts had failed, the case was brought before the Supreme Court of Canada. In 2007, in a 6-1 ruling, three sections of the legislation were found to be constitutionally invalid: sections 6.2 (no restrictions on contracting-out), 6.4 (no requirement of consultation prior to contracting-out) and 9 (relating to layoffs and bumping). The Province was given one year to remedy the situation and in May 2008 amendments were introduced through Bill 26-2008 (*The Health Statutes Amendment Act*) which removed those sections from Bill 29 and similar provisions in Bill 94 as they too would have also been vulnerable to the same Charter challenge. However, dispossession-promoting elements of Bill 94 still remain in place. Section 3, for instance, clarifies that the "private sector partner is the true employer" and that a non-clinical staff member is not to be considered "an employee of a health sector partner" (see Bill 94, s.3). Thus Bill 94 allows non-clinical support services provided in P3 hospitals to be privatized and clarifies the nature of this employment: even though they operate within the public health care

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<sup>60</sup> The language and provisions of Bill 94-2003 refer specifically to Bill 29-2002.

system, P3 support staff are in fact employees of the private contractor, not the regional health authority. Dispossession in the form of lower wages, fractured bargaining units, and more precarious employment overall have resulted from Bill 29-2002 and Bill 94-2003.

The definition of 'non-clinical' in the legislation opens the door to more expanded forms of privatization in the future. Not only does it include support services like laundry, security, housekeeping and food services but it also applies to *all* staff except for health services professionals working with patients "admitted to a bed in an inpatient unit in an acute care hospital" (see part 1 in Bill 29-2002, Bill 94-2003 uses its definition of 'non-clinical'). In other words, for-profit partners may eventually come to employ most staff working within a P3 hospital. As the BC Nurses' Union warns, "The private consortium could run the hospital emergency room, its rehabilitation beds, day surgeries, outpatient cancer clinics and any other outpatient services for profit. The only services that must be managed under the public health care system would be care provided by nurses and doctors to the sickest patients - those who actually have been admitted to an acute care bed" (BCNU 2003). There has yet to be a P3 hospital project agreement signed in BC that takes advantage of this expanded definition of 'non-clinical' in the legislation but the ability to do so in the future remains nonetheless.

### ***Ontario's Alternative Financing and Procurement model***

ReNew Ontario led to an explosion in the number of P3 hospitals in that province, with nearly 40 launched in the first three years alone (Ontario Standing Committee on Government Agencies 2008). Inheriting two yet-to-be-completed projects from the Mike Harris Progressive Conservative government (one in Brampton and one in Ottawa, both announced in 2001, discussed in chapter 7), Dalton McGuinty vowed during the election campaign to scrap these plans and assured voters that all hospitals in the province would be owned and operated by the public sector (Blackwell 2003, A7). This promise was not altogether abandoned as some changes were made to the nature of the ownership agreements of these two initial P3 hospitals, but semantic and procedural differences rather than substantive ones were mainly how it was fulfilled.

Branded a 'made in Ontario' solution to a serious infrastructure deficit, P3s in Ontario are now labeled 'Alternative Financing and Procurement' (AFP) projects, and are subject to the five key principles of the IPFP framework. The 'public ownership' and 'value for money' principles

constitute an improvement over the way previous P3s were developed,<sup>61</sup> yet in practice AFP projects are still P3s. Both models involve partnering with for-profit private consortia for the design, construction, financing, and operation of public infrastructure and support services. P3 industry insiders and advocates also confirm that they see no substantial difference between the two (e.g., see Ontario Standing Committee on Government Agencies 2008, 1530), as did the then-Minister of Health when initially presenting AFP to the private sector (e.g., see CCPPP 2005).

However, when comparing BC's health sector P3 program to Ontario's a clear distinction between AFP and P3 emerges in relation to BC's Bill 94: in 2006 the Ontario Ministry of Health and Long Term Care decided to exclude what they call 'soft support services' from future hospital deals (Sapsford 2006, quoted in Block 2008, 2). This is an important difference between the two programs. Since 'soft services' are now distinguished from 'hard services' (both of which are classified as 'non-clinical' services in BC), recent P3 hospital agreements in Ontario include only facility services like maintenance, security, and operation of the physical plant, exempting care-related services like housekeeping, dietary, and laundry services.<sup>62</sup> Thus there is no legislative counterpart to BC Bill 94 (with its broad classification of 'non-clinical services' and its 'true owner' provisions) in Ontario.

Why exactly soft services were excluded in Ontario is a multifaceted issue. On one hand, CUPE and the Ontario Health Coalition (OHC) claim that it is the result of a series of community-initiated plebiscites organized by the OHC which indicated overwhelming community support for the proposition that new hospital projects be kept fully public. A plebiscite in Hamilton, for example, returned a vote of 98 percent in favour of this proposition (OHC 2006b). From a more critical perspective, soft support services may have instead been exempted due to the serious and ongoing problems that have emerged following their incorporation into early P3 hospital project agreements in that province. The difficulties experienced with managing these contracts is illustrated through a response given by Ken White, former President & CEO of the William Osler Health System (the board that oversees the Brampton P3 hospital which includes soft support services), when asked about the 2006 exclusion of soft services: "I would say amen to that, actually ... these contractual arrangements ... are very detailed documents that, first of all, I think are difficult for folks to understand, and it's even more difficult to figure out what

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<sup>61</sup> Chapter 7 examines the problems associated with initial P3 development in Ontario and contrasts P3 procedures with AFP projects; see also Ontario Auditor General 2008 for how it applies to the Brampton Civic Hospital P3. Examples of improvements include: shortened project agreements and a reassertion of public ownership over land and facilities (instead AFP projects are structured as lease arrangements).

<sup>62</sup> Although soft services are no longer included in Ontario's P3 hospital agreements, they can still be contracted out by the public hospital corporation.

measures you want to use to make sure that you're getting the level of service that you need" (Ontario Standing Committee on Public Accounts 2009).<sup>63</sup> It is most likely that this exemption serves both purposes: assuaging public concerns whilst helping to make P3s run smoother in the future. By representing both a concession offered to P3 opponents and a pragmatic modification of the P3 model, overall this development has helped ensure the longevity of the P3 program in Ontario's public health care sector.

## **Supportive Secondary Reforms**

The 'supportive secondary reform' category encompasses elements of the enabling field that are not essential to P3 project development but are highly supportive reforms specific to particular P3 programs.<sup>64</sup> Within both provincial health sector P3 programs these reforms have shifted responsibility and accountability for certain procedural elements of P3 development to newly created health authorities.

### ***Regional Health Authority restructuring in BC***

The 2001 restructuring of BC's public health management system involved the devolution of authority from the Ministry of Health to new regional health authorities (RHAs) and the simultaneous concentration of power at the regional level (which shifted power away from local health boards, community health councils, and community health societies). The goals of RHA creation were not directly related to P3 promotion but rather were presented as a way of avoiding administrative duplication and achieving better regional coordination and greater equity across regions (related to budgets, decision-making, and accountability) (BC Ministry of Health Planning 2002, 2). However, along with these changes came two important P3-related initiatives. First, responsibility for hospital infrastructure planning was given to the RHAs just as budgets were cut (Murphy 2007). This meant that RHAs were suddenly responsible and accountable for tough decisions around service privatization and other 'pragmatic' cost cutting

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<sup>63</sup> For more on this, see chapter 7.

<sup>64</sup> Other supportive secondary framework items also exist, though they apply more generally to all P3 programs and thus will not be examined here. These include BC's Trade, Investment and Labour Mobility Agreement (TILMA) which has opened up public procurement and awards Canadian investors with protections and access to dispute settlement procedures akin to those provided by NAFTA to foreign investors (see Gould 2007; Lee and Weir 2007; SAHO 2007; Shrybman 2007a; TILMA 2009); and BC Bill 42-2008 which regulates third party speech during election campaign periods, helping to silence opposition to P3s (see Daub and Whiteside 2010).

measures, diverting attention away from how austerity and dispossession also dovetailed with Cabinet's broader neoliberal policy shift. Second, mandatory three-year performance agreements (known as 'service plans') with the Ministry of Health were initiated. Fiscal sustainability and performance became top requirements of these service plans (BC Ministry of Health Services 2003) as did compliance with the Ministry of Finance's new CAMF capital planning procedures. Together these two changes have all but forced RHAs in need of new infrastructure to seek out private funding via P3s.

Along with new RHAs came new board members appointed by the Minister of Health. These decision-makers are no longer chosen exclusively for their health care expertise but instead for their business acumen (e.g., see Fraser Health Authority n.d.; Vancouver Coastal Health Authority n.d.). This does not necessarily imply that board members are biased in favour of P3s but it does facilitate a shift in ethos – from a focus on public service delivery and enhancing health outcomes toward the management of contracts and fiscal performance. This private sector background is also necessary as RHAs must be increasingly market-oriented and business savvy. RHAs are now responsible for identifying infrastructure needs within their three year service plans, liaising with other public agencies and private partners during P3 development (throughout all initial stages of a project: bidding, negotiation, construction), and must monitor and enforce performance agreements with private partners during the operational phase of the project (typically 30 years).

### ***Creating Local Health Integration Networks in Ontario***

Ontario, unlike most other provinces, has a much more hierarchical health management structure and has never pursued regionalization. Some restructuring began in 2006 with the creation of geographically-based Local Health Integration Networks (LHINs) but actual devolution of authority remains limited as the Ministry of Health and Long Term Care has retained a significant degree of authority over the LHINs (OHC 2006a). Even though LHINs are responsible for allocating over \$20 billion and have the authority to merge services and restructure local health organizations, health systems experts report that LHINs have been little more than "another layer of unnecessary bureaucracy" and systems improvement has been "throttled by Ministry directives" (Ronson 2011; also see Sullivan and Born 2011). Similar fears, as well as the possibility that they would help facilitate privatization, were expressed by the Ontario Health Coalition in 2006 when the LHINs were first established (OHC 2006a).

LHINs have created a third layer in Ontario's chain of health system authority, sitting between the hospital boards that govern day-to-day activities within hospitals and the Ministry which sets overarching policy directives and ensures compliance with other Cabinet dictates such as the preference for Alternative Financing and Procurement (AFP). These roles and responsibilities are formalized through performance agreements between the Ministry and LHINs and accountability agreements between LHINs and hospital boards. Despite their disappointing performance in other respects, LHINs indirectly support P3 development as their administrative expertise helps streamline infrastructure spending and procurement. When a hospital board submits a proposal for new/redeveloped infrastructure valued above \$20 million, a LHIN is tasked with helping the board and Ministry develop the business case and functional program (Clarke 2010). When a project is valued below \$20 million the LHIN is given far greater autonomy from the Ministry and power over the hospital board (Ontario Ministry of Health 2011), but whether this will eventually apply to AFP projects remains to be seen.

### **New forms of institutional support**

New forms of institutional support for P3s are the backbone of the enabling field. The creation of specialized government agencies, or 'P3 units', best exemplifies this component. P3 units promote and evaluate P3s, and also act as repositories of knowledge (facilitating policy learning, contract standardization, skill building, and expertise associated with the complex bidding, negotiation, and operational phase of P3 projects). The presence of these P3 units has been essential to moving from the development of individual projects to sector wide programs. There are other organizations that could fit into this institutional support category (e.g., Ministry experts, fairness auditors, private consultants), although in BC and Ontario these organizations primarily interact with, or are subsumed by, P3 units and thus for simplicity sake will not be examined here. A far more extensive analysis of these P3 units is provided in chapter 5.

### ***Partnerships BC***

Created in 2002, the Crown corporation Partnerships BC (PBC) acts as a P3 champion, value for money evaluator, and knowledge centre. The latter includes developing best practice guidelines and standardizing contracts and bidding processes for future P3s (Rachwalski and Ross 2010). In BC's health sector program this expertise and assistance not only helps with

project development but the CAMF also dictates that PBC services must be used for all large hospital projects. Should an RHA propose that a hospital be re/developed within its jurisdiction, the business case must be first forwarded to PBC (and a fee is paid in exchange for the receipt of its specialized services). PBC then analyzes the business case to determine which procurement model is best suited for the project (P3 vs. traditional). Should the project proceed as a P3, PBC becomes involved in all subsequent stages of development (bidding, contract negotiation, monitoring construction and operations).

As both evaluator and promoter, there is a serious possibility that PBC is biased toward P3s. Even the World Bank has cautioned that the multiple roles played by PBC may lead to undesirable outcomes (Dutz et al. 2006). PBC denies that a conflict of interest exists (BC Select Standing Committee on Public Accounts 2006); however the fact remains that since the implementation of the CAMF there has yet to be a single health care infrastructure project valued at over \$50 million that PBC has not recommended for development as a full-spectrum DBFO P3 (where the private partner designs, builds, finances, and operates the project), and those in the \$20-\$50 million range nearly always proceed as design-build P3s (e.g., see Fraser Health Authority 2009; Interior Health Authority 2008).

### ***Infrastructure Ontario***

Created in 2005, Infrastructure Ontario (IO) performs many of the same roles as does PBC by evaluating, developing, and creating expertise around P3 implementation in the province. Beyond this, at the level of the P3 health sector program, a few differences between the two exist. First, IO is housed within the Ministry of Infrastructure, and thus is not as independent as PBC. Second, IO does not sell its services to hospital boards like PBC does with RHAs; instead it is assigned projects that Ministries wish to be developed as P3s. There are many implications that result from these differences but, with respect to how it affects procurement procedures, one worth noting here is that IO becomes involved at a later stage than does PBC. IO does not generally help with infrastructure proposals and business case preparation; this is done through discussions and negotiations amongst hospital boards, the Ministry of Health, and the relevant LHIN. It is only once a functional program is complete and approved by the Ministry that IO becomes involved. After these stages the differences between the two P3 units become less important given that under the terms of AFP and IPFP, projects above \$20 million are sent to IO for evaluation. IO and the Ministry will then initiate P3 bidding, with IO managing and overseeing the entire process. In all but a few instances IO has

recommended that projects be developed as P3s (Ontario Standing Committee on Public Agencies 2009) and thus the potential for conflict of interest may mirror the situation in BC.

## **Concluding remarks**

First phase P3s tended to suffer from several fairly high profile problems such as poor value for money, inadequate risk transfer, community resistance to support service privatization, the loss of public accountability, and other elements related to ill-conceived projects with poorly designed contracts (see chapters 2, 6, and 7). As a result, early P3 project development in Canada remained a highly politicized process. By the mid-2000s a second phase had clearly emerged, marked not by a resolution of these problems but instead by an entrenched and much expanded commitment to P3s through the development of sector-wide programs (shifting away from merely developing one-off projects) and the establishment of enabling fields that promote and normalize P3s as the ‘new traditional’.

While enabling field support does not eliminate the pitfalls associated with P3s, it does make them easier to implement, regularizes the process, creates a bias toward privatization; and to the extent that some policy learning takes place then P3s may perform slightly better – or at least appear to.<sup>65</sup> The real significance of the enabling field is thus the way in which it creates a new ‘common sense’ which alters public sector decision-making and procurement processes leading to more covert and enduring support for privatization when compared with earlier roll-back policy (such as Mike Harris’ self-styled ‘Common Sense’ revolution in Ontario in 1995). Because P3 policy development now operates at the mundane level of technocratic routines and standardized procedures, concessions can be offered – such as the exemption of soft hospital services from AFP project agreements in Ontario – which represent a victory for P3 opponents while simultaneously improving the longevity of the model. Changes made to P3 development processes are now done in a controlled fashion, orchestrated largely by P3 proponents and only marginally influenced by opponents of privatization. Further, there is no

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<sup>65</sup> Enabling field support cannot ultimately erase P3 problems such as higher priced private financing but policy learning and public sector expertise can help improve processes, for instance by standardizing contracts and creating more predictable bidding and negotiation procedures (see chapters 6 and 7). In BC and Ontario, therefore, P3 development has become more routine and predictable over time, yet this has little bearing on the social and economic costs associated with a P3 relative to a traditional project. The appearance of policy sophistication must always be checked against the actual functioning and implications of such policies. Ontario has institutionalized three value for money evaluation stages which superficially suggests greater rigorousness but does nothing to address the methodological deception inherent to these evaluations (see chapter 2 for more on the issues associated with risk transfer, overly high discount rates, and risk premiums).



guarantee that service exemptions will continue indefinitely, nor will dampening dissent do much good for the long run struggle against dispossession and marketization in the public health care system.

Bob Jessop has characterized neoliberalism as being 'ecologically dominant' in the sense that "the profit-oriented market-mediated capitalist economic order taken as a whole – including its extra-economic supports – [is able] to shape other ensembles of social action more than they affect it" (2010, 28). Enabling fields have not yet done for the P3 model what neoliberalism has done for the 'profit-oriented market-mediated order', and thus the model is not ecologically dominant even in Ontario and BC. However inroads of this sort have been made, specifically with respect to large infrastructure projects in these provincial health sectors. For hospital projects, P3s are in many ways the 'new traditional' method of procuring goods and services.

The connection between neoliberalism and P3s ought not to be lost in this discussion. Neoliberalism encourages privatization much like enabling fields encourage the selection of P3s over traditional methods. Whether P3s will continue to flourish indefinitely may be impossible to predict but one thing is certain: their success over the past decade could not have occurred without a reorientation of the public sector's institutions, agencies, and procurement protocols. This makes the items that form an enabling field highly transformative, not merely substitutes for older protocols or ways to fill in gaps that existed with P3 development processes. It is the nature of this transformation – the routinization, institutionalization, and depoliticization of privatization via P3s – that we turn to next.

## Chapter 5. Normalizing neoliberalism: routinizing, institutionalizing, and depoliticizing P3 hospitals

The creation of enabling fields in BC and Ontario encouraged the shift to P3s as the de facto standard method of delivering large<sup>66</sup> public infrastructure and support services in those jurisdictions. As discussed in the previous chapter, moving from the development of highly politicized one-off projects (represented by the four P3 hospitals examined in chapters 6 and 7) to normalized P3 programs within sensitive areas of public policy such as the public health care system relied on a host of new institutional, legal, and capital planning procedures. This constellation of new arrangements was referred to in chapter 4 as a 'P3 enabling field'. Enabling fields are more than an amalgam of new policies and institutions, they help rid jurisdictions of the traditional use of public procurement: infrastructure projects that are wholly owned and controlled by the public sector, with contracts awarded to a private for-profit service provider for a limited and specified role (e.g., construction or laundry services). This has created a new bias toward the P3 model as the standard choice for large capital projects through routinization, institutionalization, and depoliticization (RID).

Routinizing P3 implementation involves normalizing privatization-related policy protocols, and developing a familiarity around P3 adoption such that the process is regularized and even rendered mundane. These routines deeply embed the language and calculus of marketized<sup>67</sup> roll-out neoliberalism into the heart of public policy making. Public infrastructure and service decisions are henceforth determined almost exclusively through technocratic, market-oriented procedures: evaluating and monetizing risk, determining value for money, and minimizing upfront capital costs; all of which reorient the 'public interest' to favour considerations such as price and risk even if achieved to the detriment of quality and equity. Institutionalizing support for P3s further entrenches dispossession, and involves the creation of new capital planning procedures and the empowering of select (sometimes new) public authorities. As an ongoing process, institutionalization also helps create a sense of permanency for P3 policy. Interrelated with the previous two, the strong popular support exhibited for the public health care system in Canada has meant that initial P3 hospitals were subject to much debate and resistance in the past and thus depoliticization through the P3 enabling field helps obscure the political nature of

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<sup>66</sup> 'Large' refers to those projects where the provincial contribution for construction and equipment is valued at the proposal stage to be in excess of \$20 million. The emphasis on 'provincial contribution' is important given that hospital infrastructure (re)development funding often comes from public, private and third sector sources.

<sup>67</sup> Marketization is defined in chapter 1 as the advancement of market rule and market-like rules.

dispossession and makes this form of procurement appear as though it is merely a pragmatic decision. Rhetorical forms of depoliticization are also matched by the actual shift from public to private authority that occurs with P3s – making depoliticization both a reality and a strategy.

RID is an ongoing process, not a stationary state. It is ‘locked-in’ through changes and innovations in the P3 enabling field. As an enabling field becomes more sophisticated over time, P3 projects and programs begin to flourish and the model is entrenched, replacing public procurement as the traditional model (for large capital projects in particular). Furthermore, since this process requires policy learning and P3 program evolution, elements of the enabling field may be altered in response to community activism. However, so long as this involves changes made to *how* P3s proceed and not *whether* P3s proceed, adaptations ultimately strengthen the model overall.

This chapter will first summarize how enabling fields contribute to routinization, institutionalization, and depoliticization. This will be followed with a detailed examination of how capital planning and approval occurs in BC and Ontario, contrasting this with traditional methods. Finally, four themes will be identified which indicate how changes in health infrastructure procurement link to the larger context of marketization and neoliberalism.

## **Enabling fields and RID**

Once enabling fields were established by the McGuinty and Campbell Liberal governments in Ontario and BC, hospital project proposals which estimated a provincial contribution for construction and equipment in excess of \$20 million began to proceed mainly as partnerships with for-profit private consortia. Enabling fields embed accumulation by dispossession within the public sector through the routinization, institutionalization and depoliticization (RID) of for-profit partnerships with private consortia. Table 4 below summarizes how some of the examples provided in the previous chapter contribute to RID.

**Table 4. Routinization, Institutionalization, Depoliticization**

<b>RID</b>	<b>Description</b>	<b>Features</b>	<b>Examples</b>
<b>Routinization</b>	Capital planning procedures normalize P3 development	<p>P3s become standard practice (the 'new traditional')</p> <p>Decision-making focuses on risk, upfront costs, value for money, and a market-oriented notion of the 'public interest'</p>	<p>New capital planning procedures</p> <ul style="list-style-type: none"> <li>• BC's Capital Asset Management Framework (CAMF)</li> <li>• Ontario's Infrastructure Planning, Financing, and Procurement Framework (IPFP)</li> </ul>
	Familiarization and regularization of P3 development	Involves the standardization of documents, procedures and contracts; granting new powers to public authorities charged with promoting P3s	<p>P3 units</p> <ul style="list-style-type: none"> <li>• Partnerships BC</li> <li>• Infrastructure Ontario</li> </ul> <p>New health authorities</p> <ul style="list-style-type: none"> <li>• BC's restructured regional health authorities (RHAs)</li> <li>• Ontario's Local Health Integration Networks (LHINs)</li> </ul>
<b>Institutionalization</b>	The P3 model is entrenched through policy restructuring	New public sector authorities are empowered and/or co-opted; new modes of decision-making are created	<p>New capital planning procedures</p> <ul style="list-style-type: none"> <li>• BC's CAMF</li> <li>• Ontario's IPFP</li> <li>• Ontario's Alternative Financing and Procurement (AFP) model</li> </ul> <p>P3 units</p> <ul style="list-style-type: none"> <li>• Partnerships BC</li> </ul>

			<ul style="list-style-type: none"> <li>• Infrastructure Ontario</li> </ul> <p>New health authorities</p> <ul style="list-style-type: none"> <li>• BC's restructured RHAs</li> <li>• Ontario's LHINs</li> </ul>
<b>Depoliticization</b>	The political nature of P3s is obscured, as is the shift toward dispossession and private sector decision-making	Commodification by technocracy is accomplished through routinization and institutionalization	<p>P3 programs</p> <ul style="list-style-type: none"> <li>• BC Bill 94</li> <li>• Ontario's AFP model</li> </ul> <p>P3 units</p> <ul style="list-style-type: none"> <li>• Partnerships BC</li> <li>• Infrastructure Ontario</li> </ul> <p>New capital planning procedures</p> <ul style="list-style-type: none"> <li>• BC's CAMF</li> <li>• Ontario's IPFP</li> <li>• Ontario's AFP model</li> </ul>

**Routinization**

Routinizing dispossession within the public sector involves the development and normalization of protocols that facilitate the selection of P3s. There are two important components here: the language of the enabling field (and the entrenchment of risk-based value for money analyses as the primary focus of decision-making<sup>68</sup>) and the normalization of a market-oriented view of how the 'public interest' is to be conceptualized and guaranteed. This is accomplished not through grand, ideologically-laden offensives but instead through mundane, technocratic procedures.

Given the marketized nature of this form of decision-making, the language of the enabling field is part rhetoric and part reality. The notion that public provision is inherently riskier, more costly since paid for upfront, and of poorer value for money demonizes traditional

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<sup>68</sup> Chapter 2 outlines the inherent assumptions and biases informing P3 risk transfer and value for money assessments.

hospital projects in a way that is reminiscent of the roll-back variant of neoliberalism (Peck and Tickell 2002) and first phase P3 justifications identified by Loxley (2010). For this reason P3 development remains a highly normative process as adherence to, and support for, logics of dispossession require a strong ideological commitment to privatization. However, normative neoliberalism can also work through normalized neoliberal policy (as discussed in chapter 1, see also Hay 2004), and that is just what the establishment of routines surrounding P3 selection does. Once normatively-based enabling fields are set up and a commitment to developing sector-wide P3 programs is initiated, normalization can proceed through its everyday routines.<sup>69</sup> This indicates that normalized and normative versions of neoliberalism are not mutually exclusive processes.

Rhetoric is transformed into reality when, as Lerner (2000, 33) describes, discourse comes to constitute the institutions and practices of political groups. After a decade or more of developing most large hospital projects as P3s, and of placing an importance on market-based conceptions of risk, the public interest, and value for money, the normative basis of the P3 option is shored up in ways that transcend narrow ideological discourse. This is the essence of what Keil (2009) describes as 'rolling with' neoliberalization – when political and economic actors begin to lose a sense of alternatives (good and bad) and thus neoliberal policy becomes self-referential. It is also similar to Peck and Tickell's (2002) description of roll-out policy which is more technocratic and less overtly ideological.

Self-referentiality is a characteristic of P3 policy making, paradoxically so given that P3 selection remains, on the face of it, justified on the basis of mathematical comparisons made between the P3 and public sector comparator (PSC). However, as the PSC is merely a hypothetical scenario and values alien to marketization (such as a focus on collective decision-making, democratic accountability, and public services *at the expense of or without concern for* corporate input, commercial confidentiality, and profitability) are penalized, the role of the PSC is not that of engaging with alternatives to P3s. Rather the biases inherent to P3 value for money analyses (discussed in chapter 2) turn the PSC into a justification for P3 selection. Reinforcing this is the presumption that large infrastructure projects ought to be first considered as a P3. Rolling with neoliberalization in this area of policy making thus occurs through the language of the enabling field and is reinforced through its processes and routines. Even when improvements are made to overcome past problems with P3s, policy innovations (e.g.,

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<sup>69</sup> Routinization is thus similar to Gramsci's (1971) notion of hegemony which captures how social norms (in this case routine capital planning procedures) can foster and cement the dominance of the status quo through the consent of the governed (or here, depoliticize dispossession). Chapter 4 argues that the position of P3s as the 'new traditional', or status quo, is mainly the result of provincial enabling fields.

standardized contracts and bidding procedures) involve moving the privatization agenda forward.

## **Institutionalization**

An important element in the shift to P3s as the ‘new traditional’ is the institutionalization of this model as the de facto standard way in which large hospital projects are delivered in BC and Ontario. The term ‘institutionalization’ is used here to denote a number of different things. First, the root word – institution – should be taken to literally represent the creation of new public sector agencies (P3 units) which act as centres of expertise for P3 development protocols. Another way to think of institutionalization relates to the way in which new ‘rules of the game’ are formalized through the enabling field and come to shape future decisions, connoting a new system of action and a reorientation of standards and decision-making (see North 1990, 3; Scott 1995, 12). P3 units, new capital planning procedures, and new public agencies tailored to the development of P3s lead to a change in the rules of the game, the norms of the public sector, and the social processes and actions repeated by decision-makers.

An increasing permanence is also denoted by the use of the term institutionalization: these agencies and protocols are no longer expendable and temporary, but are indicative of a marketized regulatory shift. As Selznick states, “institutionalization is a process... to ‘institutionalize’ is to infuse with value beyond the technical requirements of the task at hand” (1957, 16-17). Once P3s begin to proliferate, reference to and experience with previous traditional methods narrows, and the model begins to take on a life of its own (as the ‘new traditional’). Institutionalization must therefore be conceptualized in process-based terms. In Selznick’s (ibid) description, institutionalization is something that happens to an organization over time but with the enabling field it is obvious that increasing permanence can also be sped up by the state. In fact both evolution and entrenchment are visible with P3 units and the norms and procedures they embody and reproduce.

This is not to say that processes relating to the evolution of an enabling field are unidirectional and heading ineluctably toward a marketized utopia of P3s as *the* hegemonic model for all public sector engagements. Perhaps a better way of thinking about this category of institutionalization is that it equally encapsulates how different moments of P3 policy are crystallized (i.e., the ways in which challenges are dealt with, created, and absorbed). These challenges come from many directions: neutralizing and accommodating P3 opponents; making good on election promises (or at least appearing to, i.e., AFP in Ontario); dealing with the

inherent problems and conflicts associated with privatization, economic/financial crises and the tendency toward market monopolization; and adjusting to the tensions and tradeoffs associated with market-led state restructuring. As Larner argues, “the emergence of new forms of political power does not simply involve the imposition of a new understanding on top of the old ... [it] involves the complex linking of various domains of practice, is ongoingly contested, and the result is not a foregone conclusion” (2000, 20). In other words, P3 development and the ‘locking-in’ of the privatization model is not a foregone conclusion by any stretch; in fact the argument made here is that the whole purpose behind enabling fields and institutionalization is that it provides some semblance of permanency even though dispossession via P3 requires constant renewal and therefore ongoing political/ideological commitment.

## **Depoliticization**

Depoliticizing privatization policy, or how dispossession is now initiated largely through technocratic decision-making rather than grand normative gestures, is another key implication of the P3 enabling fields in BC and Ontario. Burnham connects depoliticization to a particular governance strategy which “plac[es] at one remove the political character of decision-making” (2001, 127). This benefits state managers by redirecting blame and dampening expectations while still allowing them to retain control. More than merely rhetoric, depoliticization also relies on new bureaucratic practices and a shift from discretion-based to rules-based regimes in particular (Burnham 2001, 130-1). The routines of the new capital planning and procurement frameworks and P3 units correspond to this conceptualization. It is also suited to describing the larger P3 enabling field as it deals with the internal transformations that occur with state restructuring, indicating that depoliticized decision making remains simultaneously political in nature.

However, to Burnham’s (2001) version of depoliticization (which deals mainly with internal state restructuring) we must add the privatization dimension. Colin Hay (2007, 80-87) provides this in his description of three forms of depoliticization: when issues are demoted from the governmental to the public sphere, from the public sphere to the private sphere, and from the private sphere to the realm of necessity. Depoliticization is thus a process with many faces.

Changes that have occurred with P3s and the creation of enabling fields generally fall within the first two categories of depoliticization. Most obviously it involves shifting decision-making from the public sphere into the private sphere. This moment captures the new authority awarded to the private consortia representatives who now influence individual projects, and the



private consultants, accountants, auditors that form the private technocracy that informs policy evaluation. Second, when issues are demoted from the governmental sphere to the public sphere it means that public infrastructure and service decisions are no longer primarily managed through the formal democratic arena (where decision-makers are accountable and public deliberation takes place), but instead are shifted into the far less transparent zone of bureaucratic management (public or quasi-public agencies). This is the realm of the public technocracy and where officials become fairly insulated from public accountability (i.e., P3 units, Local Health Integration Networks, regional health authorities).

Like with routinization, depoliticization may become a reality in the sense that decisions are shifted into the private sphere, yet it also remains a powerful rhetorical tactic used by policy makers attempting to duck responsibility for, or reduce the visibility of, privatization. As Ascoli and Ranci (2002, 14) suggest, health sector marketization will always remain politicized since it “changes the direction in which [health care] policies are developing” making it “an eminently political process, which redistributes rights and power, modifies policy networks and the institutional context in which [health care] policy is made, and influences the ways in which [health care] needs are defined.” Furthermore, since hospital infrastructure delivered via a P3 remains a political responsibility (with the public partner ultimately on the hook for funding, procuring, and broadly overseeing the operation of new hospital infrastructure and support services), this form of privatization cannot be truly depoliticized given that issues are never entirely demoted to the private sphere.

With these three concepts now defined and explained, we turn to a more in-depth examination of how routinization, institutionalization, and depoliticization (RID) are connected to P3 development in BC and Ontario. While all enabling field components identified in the previous chapter play a role in RID, three of the most important elements for P3 hospitals are: new capital planning procedures, new/restructured health authorities, and the creation of P3 units in these provinces. Each will be discussed in turn although all three are highly interrelated.

### **RID and capital planning: procedures and authorities**

Examining the role of the enabling field focuses attention not only on what is lost (dispossessed) but also on how the neoliberal project restructures states, policy spaces and protocols, and relies upon the empowerment of new public authorities. The techniques of neoliberalization involve not only grand gestures (overt privatization initiatives) but also the

prosaic – the mundane practices and routines through which dispossession is gradually normalized.

Peering into the obscure netherworld of hospital capital planning and procurement illustrates the extent to which routines and new P3-supporting public agencies use market-like rules to make public policy choices, and the ways in which this decision-making is now a highly technocratic endeavour.

## **British Columbia**

Hospital infrastructure (re)development in BC is composed of two stages: capital planning and implementation (steps and descriptions adapted from the Capital Asset Management Framework Guidelines, see BC Ministry of Finance n.d., 22-59). It is the regional health authority (RHA)<sup>70</sup> which is ultimately responsible for identifying needs and ensuring that programs (services and infrastructure) are adequately funded and managed. RHA responsibilities are detailed within three year Service Plans, which are agreements between RHAs and the Ministry of Health outlining how responsibilities will be fulfilled.

The Service Plan lists the goals, priorities, and funding directed to services and infrastructure in that region. It is enforced through Performance Agreements signed between each RHA and the Ministry of Health, holding the RHA accountable for the how funding is spent. Devolution is not matched by a corresponding increase in discretion surrounding P3 use, this being beyond the control of any particular region. Power has thus been retained by the Treasury (Ministry of Finance) and is influenced in large part by the routines prescribed by the CAMF with its focus on risk identification and monetization, minimizing upfront spending, the P3 screen applied to all large capital spending, and its marketized interpretation of the public interest. Without these routines, decisions made entirely by the Premier or at the Cabinet level would remain highly politicized (see the Abbotsford P3 example in chapter 6); and, in contrast, if decisions are made entirely at the regional level there can be a lack of knowledge and expertise, undermining the normalization of P3 use (see chapter 6 on the Diamond Centre P3).

Table 5 below provides a step-by-step breakdown of how hospital infrastructure projects ('capital projects') are planned for and developed in BC, contrasting the NDP-era (1990s) traditional method with the routines of the current P3 health sector program (traditional steps adapted from Deloitte Consulting 2000; P3 program steps taken from BC Ministry of Finance

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<sup>70</sup> Vancouver Coastal Health Authority (VCHA), Fraser Health Authority (FHA), Vancouver Island Health Authority (VIHA), Interior Health Authority (IHA), and Northern Health Authority (NHA).

n.d.). Note that P3 program decisions made in the initial planning stages have been depoliticized (shifting somewhat<sup>71</sup> from the governmental realm to the public realm) through the creation of RHAs and empowering of Partnerships BC, and through the elimination of a previously institutionalized role for public stakeholder consultations. The latter further indicates a re-conceptualization of the public interest (or at least a transformation in how it is gauged). Depoliticization also takes the form of shifting authority and decision-making into the private for-profit sphere. The embedding of P3 bias and private partner decision-making has been italicized in the table below.

**Table 5. BC Capital Planning & Development**

Capital Planning				
Step	Agency		Activity	
	P3 program	Traditional	P3 program	Traditional
1) Identifying local capital needs	RHA	Local agencies <sup>72</sup>	New capital needs decided on the basis of: age/quality of infrastructure, demographics, access, technological change	Consultations with many stakeholders to decide needs
2) Conducting a Strategic Options Analysis	RHA	N/A	CAMF criteria (cost, risk,	N/A

<sup>71</sup> Only “somewhat” because even though RHAs are one step removed from more politicized governmental decision-making, they are still accountable to the public via the province’s *Best Practice Guidelines, Governance and Disclosure Guidelines for Governing Boards of British Columbia Public Sector Organizations* and they regularly hold question and answer sessions with the public.

<sup>72</sup> BC’s Ministry of Health capital planning and funding process prior to 2002 was far more complicated than most. Many ‘local agencies’ were involved, including but not limited to: community health councils, community health service societies, regional health boards, cluster boards, regional hospital districts (and funding agencies), and various associations (e.g., BC Health Association). While the goals of involving a wide range of local agencies may have been lofty – including holding consultations with many stakeholders and ensuring that local planning needs were met simultaneous to provincial health delivery strategies – this added a great deal of complexity and ultimately made health capital projects more costly and difficult to complete (the process was much slower and more problems tended to occur along the way relative to other Ministries) (Deloitte Consulting 2000, 5). Some degree of streamlining and restructuring of the traditional capital planning and procurement system was therefore needed, however the introduction of profit and private decision-making was far from imperative.

		(traditional procurement bias)	complexity, agency track record)  <i>P3s must be considered if capital costs exceed \$50mn</i>	
	<i>Partnerships BC</i>	N/A	<i>VfM assessment</i>  (methodology biased in favour of P3s)	N/A
	<b>P3 program</b>	<b>Traditional</b>	<b>P3 program</b>	<b>Traditional</b>
4) Creating project lists	Ministry of Health	Ministry of Health	<i>Projects are ranked highest if delivered using a P3</i>	Long-Term Capital Plans created by Ministry of Health
5) Constructing Capital Asset Management Plans	Ministry of Health	N/A (similar to step 4)	Forecast of capital asset needs, list of projects that will be used to meet needs	N/A (similar to step 4)
6) Coming up with a Provincial Consolidated Capital Plan	All Ministries	Capital division (Ministry of Finance)	Priorities ranked and funding established for all Ministry requests	Projects reviewed, submitted to Treasury Board
7) Project approval by the Treasury Board	Treasury Board	Treasury Board	If approved, the project is developed through Partnerships BC and by private consortia	If approved, the project is developed mainly by local agencies

Capital Development				
Step	Agency		Activity	
	P3 program	Traditional	P3 program	Traditional
8) Design	<i>Private bidders</i>	Local agencies	<i>REOI, RFQ, RFP (private design)</i>	Schematic designs prepared, options weighed according to design cost & design value analysis
9) Evaluate, <i>negotiate</i>	Partnerships BC <i>Private bidders</i>	Capital division (Ministry of Finance)	<i>Negotiation of project agreement</i>	Final design approval
10) <i>Project agreement struck (P3), tender (traditional)</i>	<i>Public partner, private partner</i>	Local agencies, private contractor	<i>Private financing, construction, support services</i>	Private construction
11) Implementation	<i>Private partner, public partner</i> Partnerships BC	Local agency  British Columbia Building Corporation (BCBC)	Operation, management	Operation, management

Consider the differences presented above, both in terms of incorporating profitability concerns and with respect to the new processes of public sector decision-making that are initiated. Using traditional procurement methods, private for-profit firms are almost entirely shut out of the infrastructure and service delivery process. Where they are involved, they merely execute the plans and decisions made by the Ministry Health, Ministry of Finance, and local health authorities. Under the new model, Partnerships BC becomes involved – often as the most important public sector agency, not the agencies normally thought of as responsible for

health care: the Ministry of Health and RHA. This infringes upon democratic openness and transparency, as well as accountability. It also ensures that Partnerships BC has a vested interest in P3s since these projects secure its influence, decision-making position, and are its main source of revenue. It has no role beyond of the development of P3s (though it does offer its services outside of BC, more on that later). P3s are therefore a form of marketization in two ways: they allow for direct market rule (private for-profit decision-making) and market-like rules (pushed by the CAMF and Partnerships BC).

Although several roles and responsibilities were devolved to the province's five regional health authorities in 2001, control by the Ministry of Health is ensured through the three-year Service Plan agreements it holds with each health authority. These commitments outline, amongst other things, the funding that will be made available from the province for capital project spending in that region. Service Plans offer a snapshot of how RID operates at the regional level in BC since they list all approved capital projects with a cost of over \$2 million. Reviewing these agreements (see FHA 2009, 2011; IHA 2011; NHA 2010; VCHA 2010; VIHA 2010) produces some interesting results.

First, P3s are being institutionalized through the routines and rules established by the CAMF given that *all* capital projects with an estimated cost in excess of \$50 million are now going forward as P3s. Said another way, no capital project that could have been delivered as either a P3 or in the traditional public fashion, will be a public project. P3s are now the standard model for large hospital infrastructure development in the province. This indicates a high level of P3 institutionalization.

What is occurring with the projects that fall within the gray zone of costing between \$20 and \$50 million is equally informative. In 2012, seven hospital re/development projects were listed in the five RHA Service Plan agreements, with costs ranging from roughly \$23 million to \$44 million.<sup>73</sup> None are being developed as DBFO P3s but few are being delivered through in-house tender either (the truly 'traditional' version of a hospital project) – most are design-build P3s and not listed on the PBC website, under-representing the degree to which bundled for-profit contracts are a feature of the BC capital development landscape. Those that are fully public (e.g., both Vancouver General Hospital projects in the Vancouver Coastal Health

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<sup>73</sup> *Fraser Health Authority*: Surrey Memorial Hospital Site Immediate Capacity Development \$26mn, Chilliwack General Hospital Redevelopment \$35mn; *Interior Health Authority*: Coronary Revascularization Transition Plan \$21mn; *Vancouver Coastal Health Authority*: St. Mary's Hospital Redevelopment total project \$44mn, Vancouver General Hospital Robert H.N. Ho Research Centre \$39mn; Vancouver General Hospital Tertiary Mental Health – window pavilion \$29mn; *Vancouver Island Health Authority*: Nanaimo Regional General Hospital Emergency Department/ Psychiatric Emergency Service/Psychiatric Intensive Care Expansion \$37mn. (NHA: no capital projects with a value of between \$20mn and \$50mn)

Authority) are those closest to the \$20 million threshold and have received sizable contributions from third sector sources (donations to hospital foundations and auxiliaries).

The language and risk emphasis of the CAMF also favours P3 use. One of the key objectives of the CAMF is to link RHA needs with provincial policy priorities. This embeds a P3 bias into decision-making early on, and risk-based assessments (using value for money and other technocratic criteria) are relied on to gauge whether RHA needs match up with CAMF dictates. Since risks must be minimized, and this is to be accomplished by keeping upfront costs down, the public role in new infrastructure must be kept to a minimum.

Furthermore, the public interest is now to be determined primarily through marketized criteria such as: assessing service outcomes (through monetization) and monitoring the performance of service providers (through market-based contracts containing performance agreements). In order to do so, commodification of health care support services and a reorganization of tasks within hospitals must first occur.<sup>74</sup> The public interest is also 'ensured' through the caveat that service users must be protected (i.e., user fees may not be applied to medically necessary services protected by the *Canada Health Act*). No protection is offered against commercialization and the establishment of for-profit clinics within P3 hospitals. The public interest is conflated with access and cost sustainability in an immediate sense – there is little concern demonstrated for the long-term implications that might result from higher costs over the life of the project, the potential for trade agreement disputes, and service quality deterioration. This is a very narrow conception of the public interest.

## Ontario

The stages that major capital projects (hospital planning and development) are subject to in Ontario, and the respective roles played by the various public and private sector agencies are summarized in table 6 below (adapted from Barrett and Hodnett 2010; Clarke 2010; LHIN 2010; MPIR 2004). Like table 5, the embedding of P3 bias and private partner decision-making has been italicized.

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<sup>74</sup> See Armstrong and Armstrong (2010, 160-162) for a description of how neo-Taylorist techniques have been introduced into hospitals in order to control ancillary workers and reduce the costs of support services; the implications of hospital service privatization are also discussed in greater detail in chapter 3.

**Table 6. Ontario Capital Planning & Development**

<b>Initial Stages (AFP and traditional follow the same path)</b>		
<b>Step</b>	<b>Agency</b>	<b>Activity</b>
1) Infrastructure planning needs assessment	Public hospital board  (Service portion may be conducted with LHIN)	New capital needs decided on the basis of: age/quality of infrastructure, demographics, access, technological change
2) Proposal	LHIN  Ministry of Health and Long Term Care (MOHLTC)	Hospital board submits a description of the program and service elements of a capital initiative to the LHIN for review.  If approved by the LHIN, the hospital board provides an estimate and description of the physical elements and capital costs to the MOHLTC
3) Functional Program development	Hospital board  LHIN  MOHLTC	With MOHLTC support, the hospital board and its integrated consultant team prepare the function program, outlining the size and scope of the project  LHINs are mainly responsible for ensuring that infrastructure plans match with service needs in the region  MOHLTC ensures submissions are consistent with government priorities and that <i>alternative infrastructure delivery options</i> are provided
4) Functional Program analysis	MOHLTC  Ministry of Infrastructure	<i>Procurement alternatives are assessed.</i> <sup>75</sup> This takes place before a project is assigned to Infrastructure Ontario and AFP value for money assessments (if cost exceeds \$20mn)

<sup>75</sup> The strategic options analysis involves 9 models, ranging from traditional to design-build-own-operate (DBOO). Criteria include financial considerations, risk assessments and value for money calculations, but also emphasize a context assessment for different sectors. Health care projects must engage community and key stakeholders and feature public ownership, control, and accountability (MPIR 2004, 27). The Ministry of Infrastructure is mainly involved as a way of ensuring that infrastructure financing and procurement follow the IPFP criteria (risk-based, value for money assessed, upfront costs minimized), and it provides direction on the procurement approach chosen.



<b>Advanced Stages (AFP and traditional follow different paths)</b>					
<b>Step</b>		<b>Agency</b>		<b>Activity</b>	
<b>AFP</b>	<b>Traditional</b>	<b>AFP</b>	<b>Traditional</b>	<b>AFP</b>	<b>Traditional</b>
1) Preliminary design development	1) Preliminary design development	Infrastructure Ontario  MOHLTC	MOHLTC	Schematic design and transaction documents are developed  <i>Using AFP guidelines, Infrastructure Ontario conducts a value for money (VfM) assessment</i>	In-house design development (block schematic report, sketch plan report)
2) <i>Contract development</i>	2) RFP, commercial close and financial close	Infrastructure Ontario  Hospital board (RFP stage)  <i>Private bidders</i>	MOHLTC  Hospital board	<i>Private design</i>  <i>VfM assessments (prior to contract, after financial close)</i>  <i>Negotiation of project agreement</i>	In-house working drawings, final cost estimates  Procurement (construction contract)
3) Implementation	3) Implementation	<i>Private partner, public partner</i>  Infrastructure Ontario	MOHLTC  Hospital board	<i>Private financing, construction, support services</i>	Public infrastructure (MOHLTC)  Public services and infrastructure maintenance (hospital)

The procedures in Ontario differ somewhat from those in BC for several reasons, due primarily to the difference in public authority structures (within the health sector and for the P3 unit), not with the criteria used to evaluate proposals/business cases despite AFP being touted as fundamentally different from P3. Since Ontario does not have a regionally devolved decision-making structure within its provincial health care system, the MOHLTC has retained more formal control and decision-making authority over P3 development than is the case in BC (although, as was presented above, Ministry of Health guidelines control RHAs in a similar way). However, some administrative functions have been assigned to Local Health Integration Networks (LHINs), and hospital boards play an initial role in infrastructure planning and service needs identification. As discussed in the previous chapter, the various roles and responsibilities of each level of decision-making is formalized through performance agreements struck between the Ministry and LHINs and accountability agreements between LHINs and hospital boards.

The emphasis on minimizing risk and addressing needs through options determined using market-oriented value for money assessments is similar in Ontario and BC. The strong cost savings language in BC is not present in Ontario's IPFP, however. Whatever the justification, in Ontario hospital infrastructure projects with construction and equipment costs in excess of \$20 million are all now being delivered through a P3,<sup>76</sup> and projects under this threshold typically go forward as traditional projects (falling under different capital planning procedures known as the 'Health Infrastructure Renewal Fund' guidelines).

A clearer attempt to ensure public ownership and control over hospital P3s is present with Ontario's IPFP and AFP (in contrast to BC's CAMF) but guidelines offer no guarantee. In addition, the same concerns that exist with the market-oriented conception of the public interest in BC are present in Ontario. A few differences exist with respect to the role of the P3 unit in each provinces, although these are best dealt with in the section that follows (which looks at RID and P3 units).

Prior to the development of the P3 enabling field in Ontario, the Harris Progressive Conservative government initiated some important capital planning changes worth highlighting as they further indicate the degree of RID attained under Liberal governments since 2003.<sup>77</sup>

Whereas the 'Common Sense Revolution' of the Harris government's first term (1995-9) corresponds quite strongly to roll-back neoliberalism, the second term (1999-2003) saw a softening of this 'revolutionary' emphasis and thus began some attempts at roll-out neoliberal

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<sup>76</sup> Although in Ontario P3 hospital (re)development can vary quite widely in type, from build-finance to design-build-finance-maintain. In BC P3 hospital projects are most often design-build-finance-operate.

<sup>77</sup> There were no infrastructure P3s developed, and no significant attempts to establish a P3 enabling field in BC prior to 2002, making this type of comparison impossible for that province.

policy aimed at normalizing P3 development. Most notably this includes commitments made to greater infrastructure spending, the creation of a public sector agency with features resembling those of a contemporary P3 unit, attaching guiding principles to public spending, and the reorganization of capital planning procedures. However, as the short description below reveals, these initiatives did not lead to routinization, institutionalization, or depoliticization; nor did they constitute a sophisticated enabling field.

In 1999 the Harris government launched a 5-year, \$20 billion infrastructure spending plan, known as the SuperBuild initiative, which aimed to address the growing provincial infrastructure deficit (Ontario SuperBuild Corporation 2000, 6). Infrastructure needs were to be met through both public and private financing and the use of P3s, under the strategic direction of the newly-created Cabinet Committee on Privatization and SuperBuild (CCOPS). These SuperBuild funds were to be distributed and managed by the SuperBuild Corporation (created in 2000), an agency that reported to the Ministry of Finance and Deputy Premier. The SuperBuild Corporation was responsible for P3 and capital infrastructure strategies province-wide (including providing expertise to other public sector agencies).

Three principles that guided the SuperBuild Corporation's activities: the agency was to facilitate joint public-private investments in infrastructure, to reorient capital planning procedures and priorities, and to ensure that investment decisions brought the best value to taxpayers and highest returns to private partners (Ontario SuperBuild Corporation 2000, 6-7). SuperBuild was to report all spending and capital recommendations to the CCOPS – creating a unique decision-making structure given that “for the first time in Ontario, all provincial infrastructure policy, investment and capital planning decisions [were] consolidated under a single Cabinet committee” (ibid, 6). Two P3 hospitals were initiated in this fashion – the Brampton Civic Hospital and the Royal Ottawa Hospital – but they had only entered the early planning stage by the 2003 provincial election. The details on how this affected the planning and implementation of these hospital P3s are examined in chapter 7.

Prior to the reorganization of capital spending and planning procedures under the CCOPS, the process followed a traditional route similar to the one described above for BC (see Ontario Ministry of Health 1996): the hospital board identified capital needs and sought MOHLTC approval for all proposals, options, plans, funding, design, and tendering stages. If approved, the hospital board was responsible for executing and managing these stages. For its part, the MOHLTC was given its own capital funds by government and set its own list of priorities for distributing these funds. SuperBuild changed this arrangement by requiring that all

capital plans be sent for approval to the CCOPS prior to the Ministry receiving any funding for infrastructure (re)development (Ontario SuperBuild Corporation 2000, 8).

SuperBuild was similar to Infrastructure Ontario in that it was to be a centre of expertise on P3s and was positioned to be the evaluator of P3 proposals. It also signaled the beginning of an institutionalized partnership program. However, the CCOPS process was highly politicized (located within Cabinet itself) and SuperBuild was never designed to be an arm's length decision-maker. There was also no effort made to initiate the routinization seen with the technocratic procedures of the IPFP process developed under the McGuinty government. Finally, the more pragmatic principles of AFP (such as three value for money assessments, greater transparency and more effective risk transfer, public ownership of hospital sites and facilities, and the \$20 million P3 threshold) stand in contrast to the opaque SuperBuild decision-making process that was rhetorically (and intentionally) biased toward short term cost savings, maximizing private returns, leveraging private investment, and developing as many P3s projects as possible. As a testament to the importance of RID and the Liberal's P3 enabling field, SuperBuild produced only an handful of highly controversial deals (e.g., the sale of Highway 407 and the 20 year Bruce Power nuclear power plant lease) and "the very few deals that have worked as the model envisaged have been small projects" (McFarland 2001, B9).

## **RID and P3 units**

P3 units have played a crucial, if not the most important, role in routinizing, institutionalizing, and depoliticizing P3 use (RID). The importance of P3 units comes across in the P3 implementation literature and when considering the various phases of P3 development in Canada (see chapter 4). They are the primary public sector agencies charged with promoting P3 projects and overseeing project agreements. The encouragement of RID by these agencies is achieved indirectly through the support they offer for the capital procurement routines that privilege P3s and the health authorities (provincial and local/regional) that must follow these protocols. Support is also directly provided through the role played by P3 units in standardizing documents, bidding procedures and contract development.

## **New public sector capacity: commonalities & particularities**

New forms of institutional support for P3s are the backbone of any sophisticated P3 program. P3 units promote and evaluate these projects and act as repositories of knowledge which facilitates policy learning by building government expertise surrounding the complex bidding, negotiation, and operational phase of P3 projects (Rachwalski and Ross, 2010). The presence of these P3 units has been essential to the entrenchment and normalization of privatization within the public sector. Yet the role of the P3 unit extends beyond the activities outlined on their websites and in policy documents as they must translate policy models and neoliberal privatization imperatives, ensuring that this unfolds in ways which meet local needs whilst simultaneously ensuring profitability for global investors.

Without the institutional support that P3 units provide, problems experienced with individual projects would not readily transform into a sophistication of provincial P3 programs and instead could easily lead to policy abandonment. As discussed in chapter 1, P3s are unique from other types of privatization. Whereas individual projects are locked in through multi-decade contracts, the program itself must be future-oriented since it is only renewed through new projects. Committed policy makers must therefore take into consideration the long run implications of decisions made today. P3 units are currently the central way to ensure that this happens. As Jooste and Scott (2012, 150, emphasis added) put it: “The move toward private participation in infrastructure does not simply substitute private sector capacity for public sector capacity, *it requires new forms of public sector capacity to be developed to overcome [P3] challenges*”.

The need for new forms of public sector capacity to facilitate internal privatization was resolved in BC and Ontario through the creation of Partnerships BC and Infrastructure Ontario (in 2002 and 2006, respectively), both of which are Crown corporations. This organizational form is significant given that in some countries greater political control is retained through the development of expertise and P3 unit-like roles within line departments (e.g., Mission d'Appui aux PPP in France and Parapublica in Portugal; see Farrugia et al., 2008). On the opposite end of the spectrum, many of the activities performed by P3 units can also be provided by private fairness auditors, consultants, and accountants.

The use of Crown corporations, an arm's length quasi-public organizational form, has a long history in Canada and they have been assigned many different purposes ranging from economic development to cultural preservation (Whiteside 2012). Yet something entirely new appears to have occurred in the past decade with P3 units: the use of Crown corporations to

facilitate dispossession. This occurs not through their sale but through their very existence – they are developed by the state to manage and encourage privatization in other areas of the public sector. Thus the Crown corporation is now being employed to extend market-led restructuring within Canada’s public sector.

The monopolization of support roles required to deal with P3 problems by arm’s length public agencies (rather than being shared with line departments or the private sector) improves the longevity of the P3 model for several reasons, all of which relates to RID. First, it lends itself to depoliticization since they appear to represent the public interest and fall under the direction of government, but are free from a high degree of public scrutiny and control. Thus P3 units are at best *quasi* public agencies. A related consideration is that P3 units clearly serve the interests of capital. As former PBC President and CEO Larry Blain so aptly described, “There are two sides to a [P3] market. There is the province, which has an interest in procurement on an effective and least-cost basis. There is also the private partners who need to be interested in British Columbia and want to do business here and want to do business with us [PBC]. We have to attract them, so we have to attract both sides ... that’s our role” (BC Select Standing Committee on Public Accounts 2006).

Second, as Crown corporations they are able to offer salaries and bonuses that often exceed normal bureaucratic pay scales and opportunities. Higher salaries and bonuses for those employed by P3 units mean that private sector business leaders and P3 industry insiders can be more easily recruited into the public sector. For example, in 2005 then-President and CEO of PBC Larry Blain earned \$519,448 in salary and bonuses (bonuses being tied to the number of P3s developed). These exorbitant earnings for a ‘public sector’ employee, along with revelations that taxpayer-funded reimbursements for expenses included, for example, a June 23, 2005 restaurant bill for \$1,567.11, created a minor scandal in BC when the figures were eventually made public in 2006 (see Macleod 2007). When pressed to account for this level of compensation, then-Finance Minister Carole Taylor claimed Larry Blain’s compensation was justified on the grounds that it was necessary “to bring someone with tremendous financial experience in the private sector into the public sector” (Francis 2006). Compensation for upper echelon decision makers within Infrastructure Ontario is slightly more modest. For instance, those holding positions such as Executive Vice President and CEO earn roughly \$330,000-\$375,000 – in line with similar positions in Crown agencies like the Ontario Energy Board, but nearly triple the amount of most other publicly disclosed public sector salaries (Ontario Ministry of Finance 2012).

Another feature relevant to institutionalization is a creeping expansion of the roles played by these P3 units. For PBC expansion has been both internal and external to the province. Internally, the development of P3 programs in key sectors targeted for provincial infrastructure renewal has meant that PBC has been gradually taking over the roles previously played by the BC Building Corporation (BCBC) (McKellar 2006). Thus BCBC, the public sector agency responsible for real estate, land, and infrastructure management since 1977, is being incrementally replaced with a market-oriented quasi-public Crown corporation geared toward privatization. PBC has also become more externally-oriented. As indicated in its 2011 annual report (PBC 2011), PBC's future strategy includes diversifying its client base. This involves selling its expertise to other jurisdictions without P3 units (e.g., Yukon and Nova Scotia, see Whitehorse Star 2005 and Government of Nova Scotia 2008) and expanding into new sectors within the province (see table 7 below).

The roles assigned to Infrastructure Ontario (IO) have also been greatly expanded over the years and it is now responsible for many different aspects of infrastructure and land development in the province: from large P3 infrastructure development and operation beginning in 2005 to small infrastructure loans (offered to municipal borrowers only) as of 2006 when it absorbed the Ontario Strategic Infrastructure Financing Authority (OSIFA), and more recently in 2011 it took on the responsibilities of the Ontario Realty Corporation (ORC) (the manager of government owned and occupied land and buildings) (see Infrastructure Ontario 2011). This has not only given IO a greater degree of permanence within the province but it also means that its P3-specific tasks are ever more normalized within the day-to-day operations of government.

But along with similarity comes particularity. A major divergence between these two P3 units is where they are located within the public sector: PBC reports only to the Ministry of Finance whereas IO falls under the purview of the Ministry of Infrastructure. This relates to a second difference: PBC is far more autonomous and entrepreneurial than IO as Ontario's P3 unit remains more tethered to government. For instance, IO is assigned projects by line-ministries and its operations are paid for out of the Ministry of Infrastructure's<sup>78</sup> budget (for budget expenditures related to IO see Ontario Ministry of Finance 2009). PBC, on the other hand, must generate its own business and touts its operations as being 'self-sustaining' since it acts almost entirely independent of government funding by charging 'work fees' in exchange for its services (PBC 2011). However, 'work fees' are better thought of as a hidden drain on the budgets of other ministries given that this acts as a way of funneling money into PBC coffers.

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<sup>78</sup> Since the creation of IO in 2005, this Ministry has been also named the Ministry of Energy and Infrastructure and the Ministry of Public Infrastructure Renewal.

The fees it receives are substantial, as table 7 below indicates. Note that the Ministry of Health and regional health authorities are the single largest contributor, owing to the large amount of hospitals and health care-related P3s initiated since 2002.

**Table 7. Partnerships BC Work Fees**

	\$			% of PBC revenues		
	2011	2010	2009	2011	2010	2009
<b>Ministry of Health Services and provincial health authorities</b>	\$1,908,576	\$2,205,279	\$2,948,454	22.7%	33.2%	42.4%
<b>Ministry of Transportation and Infrastructure</b>	1,919,946	1,475,085	1,196,532	22.8	22.2	17.2
<b>Ministry of Labour and Citizens' Services</b>	665,465	472,888	426,005	7.9	7.1	6.1
<b>Ministry of Education</b>	520,763	314,745	176,815	6.2	4.7	2.5
<b>BC Crown corporations</b>	1,731,669	462,895	177,980	20.6	7.0	2.6
<b>BC vocational institutes</b>	98,741	301,180	741,944	1.2	4.5	10.7
<b>Other provincial governments</b>	36,876	215,305	220,395	0.5	3.2	3.2
<b>Government of Canada</b>	657,037	706,284	614,976	7.8	10.6	8.8
<b>Others</b>	865,698	498,302	453,711	10.3	7.5	6.5
<b>Total</b>	8,404,771	6,651,963	6,956,812	100	100	100

Source: PBC 2011, 20; PBC 2010; 22

Besides transferring funds from in-house Ministry project development to PBC project development, an additional concern with PBC's work fees is the potential for a conflict of interest to exist given that this P3 unit both evaluates and promotes P3s. As Colverson indicates, "If a dedicated unit is not wholly funded by the government and derives part of its income through user fees it charges there is a risk that P3s can be pushed into inappropriate situations because the unit will have a vested interest in producing business" (2012, 14). Larry Blain denies that this warning applies to PBC, saying "part of our [PBC] mandate and our vision statement is that



we serve the public interest. We are owned by the province of British Columbia, and part of our mandate is to serve the public interest. We would be sensitive to that in everything that we do” (BC Select Standing Committee on Public Accounts 2006).

A few additional procedural differences worth noting are that IO reimburses the design and bid fees incurred by unsuccessful consortia that make it past the RFP stage whereas PBC does not do this. PBC has also created an important role for privatized aspects of the enabling field, private fairness auditors in particular.

### **Failing forward: flanking and deepening (concessions and co-option)**

Bob Jessop (2002) argues that neoliberalism and the social, economic, and political problems that it creates require flanking by other non-neoliberal strategies such as neo-statism and neo-corporatism. In his words, “governance has always depended upon a contradictory balance between marketized and non-marketized organizational forms” (Jessop 2002, 238). This insight dovetails with Tickell and Peck’s (2003, 165) discussion of how neoliberal market politics have always been hybrid in nature – never appearing in ‘pure’ form, local neoliberalisms are the result of the balance of class forces, institutional legacies, and modifications in light of resistance, path dependency, and crises. Thus we are alerted by both of these perspectives to be on the lookout for unevenness and local particularities, conditions which are generated especially in light of the internal and external problems produced by neoliberal reforms. Peck (2010 6, 21-23) calls this ‘failing forward’: despite the regulatory inadequacies of neoliberal policy, failures lead not to the abandonment of neoliberalism but to their deepening and complexification through concessions, exceptions, and corrections. With provincial P3 hospital programs, flanking and deepening are best exemplified through the creation of, and actions of, P3 units.

It is crucially important to remember that P3 projects are not developed by P3 units *tabula rasa*. They unfold within the context of interaction and comparison with real and hypothetical models of traditional infrastructure projects. This comparison (at the heart of establishing value for money) is in fact one of the main features that drives the selection of P3s over public hospitals by PBC and IO. This dichotomy both justifies P3s and presents continual challenges to future P3 development: it offers the potential for crises of faith to occur, allows for overt failures to emerge, forces hard questions, fans the flames of resistance, and can ultimately strengthen the P3 model by forcing adaptation and concessions. The issue of stabilization amid P3 project and policy contradictions will be returned to in the concluding chapter.

## **RID and enabling fields: four themes**

Four themes emerge from the discussion in chapters 4 and 5:

1. The creation of new P3-oriented agents, institutions, and procedures suggests that state restructuring and reorientation have occurred, not merely that one form of project procurement is being substituted for another. It also indicates that P3 markets in Canada are well beyond the experimentation stage. Institutionalization proceeds without any systematic effort to evaluate P3 model success in either jurisdiction. Hence the policy is mainly ideologically-driven rather than being empirically-based as proponents most often suggest.
2. There are many similarities and differences between enabling fields in Ontario and BC, and thus while there may be a global trend of P3 proliferation, jurisdictions and processes remain variegated and locally particular. RID flourishes amid, and in spite of, differences between enabling fields.
3. Both flanking and deepening are occurring. The former refers to the elements of state restructuring that contribute to dispossession (i.e., the adoption of market-like rules and routines by the state), and the latter captures how P3s are transformed into the 'new traditional' through token concessions made to opponents, modifications of the P3 enabling field, and ultimately the insulation of the P3 model from crises of faith on the part of policy makers through institutionalization.
4. Pragmatism (e.g., the \$20 million threshold) and sophistication (e.g., contract and bidding standardization, AFP) are important developments in Canadian P3 policy given that dislocations and controversy are better absorbed when enabling fields are present. This helps to shore up the P3 model overall and means that the benefits of enabling field innovation are mainly captured by investors not by service users, labour, or taxpayers.

## **Concluding Remarks**

P3s are a form of ongoing and future-oriented dispossession. Their recent proliferation has been pre-staged by a number of legal-institutional and policy supports that operate as both flanking mechanisms (Jessop 2002) and as a way of embedding market-enhancing strategies

within the heart of public policy making. Deepening the influence of market actors and market-based reasoning has meant forging enabling fields out of a hybrid combination of preexisting and novel institutional/regulatory arrangements through P3-oriented routines and institutions. Enabling fields both subsume and transform preexisting bureaucratic processes and lead to depoliticization (both real and rhetorical).

The routinization, institutionalization, and depoliticization of P3s is therefore an ongoing process, not a stationary state. RID is 'locked-in' through various changes and innovations, including: legislative changes and new capital planning procedures, supportive secondary frameworks as indirect support for P3s, and new institutions/government agencies. Together these changes enable P3s to move from being one-off projects to the new norm for large infrastructure development and its accompanying support services.

Nothing presented here should be taken to suggest that jurisdictions without enabling fields are not, or have not been, developing P3s. Whether at the provincial or municipal level, most provinces in Canada have developed at least one P3 in the past, although outside of BC and Ontario these efforts have been sporadic and the focus thus far has been mainly limited to developing projects not programs (Quebec and Alberta may be shifting to a program focus). At the federal level there are also several operational P3s and the Harper Conservatives have implemented a P3 screen (applicable to all funding through the Building Canada initiative) and a P3 unit (PPP Canada). However, due to the constitutional division of powers, the sectors with projects that have thus far proven most suitable for partnership agreements are mainly located within provincial jurisdiction (e.g., hospitals, schools, highways, water treatment facilities).

Furthermore, the argument made here is not that enabling fields unequivocally force Ministries and other public authorities to choose the P3 procurement model. Instead what enabling fields do, as the name would suggest, is *enable* P3s by simplifying processes, and encouraging, supporting and promoting their use. 'Enable' may be an understatement as some items do compel public authorities to consider P3s (i.e., CAMF and IPFP) even the more coercive items are mere frameworks that could be easily altered, transcended, or ignored if the political will to do so existed. Rather it is the sheer bulk of the enabling field and all of its constituent categories (enabling legislation and new capital planning frameworks, supportive secondary reforms, and new institutions) that act as a form of soft lock-in by shifting the bias away from traditional public procurement. Soft lock-in also helps depoliticize these activities just as P3s themselves depoliticize dispossession through technocratic decision-making.

Enabling fields may also help P3 programs weather crises, whether the crisis is economic or political in nature. From a value for money perspective, as examined in chapter 2,

we have recently seen the insulating effects of enabling fields when the serious problems with the private finance portion of early stage P3s in 2008/9 led only to minor changes in P3 programs (e.g., the use of a 'wide equity' model in BC). Politically, though this has not yet been tested in BC and Ontario, should an election bring a change in government, institutionalization may lead to policy inertia and thus dissuade P3 program abandonment.

Whether lock-in has or will occur is of utmost significance to the study of privatization policy. A greater understanding of how exactly dispossession now proceeds within the public sector allows for resistance to be made more effective. Just like how P3 promoters have shifted their focus from projects to programs, the organizations and actors that hope to eliminate privatization from the public health care system must too. Targeting individual P3s is one way to do so but with enabling fields left untouched these efforts will likely be of limited success.

## **Chapter 6. Launching transformations: BC's pioneering P3 hospitals and the evolution of the province's health sector P3 program**

For the insights that they offer into P3 hospital projects, health sector privatization, and enabling fields chapters 6 and 7 focus on the trailblazers of the Canadian P3 hospital market: the country's pioneering design, build, finance, operate (DBFO) hospitals, located in BC (chapter 6) and Ontario (chapter 7). BC's first two P3 hospitals (in Abbotsford and Vancouver) were developed at the same time as the provincial enabling field and thus before routinization, institutionalization, and depoliticization (RID) had truly begun. For this reason they are exceptionally revealing. Cast as 'pilot' projects by the Liberal government in the early 2000s, they were not used, as one might assume, to establish whether the P3 model had a place in future BC hospital development but rather to launch a P3 program in the health sector. This first round of P3 hospital projects, however, lacked the well-honed routines, institutional support, and established forms of depoliticization that now shape this program. The cases examined here reveal the significant effort that went into normalizing health sector marketization and dispossession; as well as clearly indicating the economic, financial, and social implications that enabling fields and RID have attempted to ameliorate, suppress, and ignore ever since.

Two sections make up this chapter on BC: initiation and proliferation. The first section examines the performance and legacy of each DBFO hospital: the historical and political circumstances under which they were created, their economic and financial consequences, and the impact of the P3 model on staff and services. The second section, dealing with the subsequent proliferation of P3 hospitals in the province, relates to the influence of pioneering P3s on more recently developed projects, noting key ways in which the latter were affected by the legacy of those initiated first. The appendix should also be consulted for its detail on the timeline and milestones of all four hospital projects.

### **Initiation: BC's Pioneering P3 Hospitals**

The emergence of private for-profit P3 hospitals in BC began with the Abbotsford Regional Hospital and Cancer Care Centre in 2003 (operational in 2008) and the Diamond Centre<sup>79</sup> in 2002 (operational in 2006). Both facilities were sorely needed. The new hospital in

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<sup>79</sup> Originally the project was called the 'Academic Ambulatory Care Centre'. It was renamed the Gordon and Leslie Diamond Centre in 2006 when the Diamonds donated \$20 million to "fund state-of-the-art medical equipment at the new centre, establish a new Leslie Diamond Fund for Women's Health, expand

Abbotsford replaced an older, rundown and inadequate hospital in the region; and the Diamond Centre allowed for the reconfiguration and consolidation of existing facilities as a way of improving teaching and training done by the University of British Columbia and patient access to ambulatory services provided by the Vancouver General Hospital. As of mid-2012, there have been another 8 P3 hospital and health centre projects launched across the province, and these two pioneers were commonly seen at the time to be a 'proving ground' for the P3 model in the health sector (e.g., McInnes 2003, B5). Yet despite the obvious need for each facility, the use of a P3 to deliver this infrastructure and its support services was far from imperative. Instead their development demonstrates the highly political nature of P3s, rather than being, as they are far too often justified, the product of financial necessity or clear value for money superiority.

## **Background**

In May 2001, the Liberal party won a landslide victory, taking 77 of 79 seats in the provincial legislature and ousting the two-term NDP government that had held power since 1991. With this victory came a great many changes in government policy and practice, P3s being but one part of the neoliberal flowering that ensued. Infrastructure DBFO P3s of the sort that had been used for nearly a decade in the UK had popped up here and there across Canada but had not yet been attempted in BC. The NDP introduced the language of P3s in 1997 when the Minister of Finance said, in a Budget speech, that "we are also committed to pursuing public-private partnerships that allow for cost-effective solutions to developing and financing new facilities" (BC Liberal Party 2009). And in 1999 the NDP released a document which counseled municipalities on the (potential) advantages of partnering with the private sector (BC Ministry of Municipal Affairs 1999), but these two relatively minor items had amounted to little by 2001. Privatization was not a major feature of the BC policy landscape, and there were only a handful of small municipal P3s that were mainly support service-related. This would change dramatically after the 2001 election.

Having campaigned under their 'New Era' banner of prosperity through fiscal prudence, reinventing government, and creating private sector investment opportunities, the Liberal government quickly began a process of simultaneous neoliberal roll-back and roll-out. The most important roll-out reforms relevant to P3 development are the items that formed the enabling

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the women's and men's urological health program and help provide funding for a new CT scanner for the emergency department at Vancouver General Hospital" (Campbell 2006). This portion of the hospital's redevelopment does not relate in any way to the P3 deal (it was established for separate purposes), yet since that is the name of the new Centre, here the P3 will be referred to as such.

field – especially the 2002 creation of Partnerships BC and the Capital Asset Management Framework. Roll-back reforms included Bill 29-2002 (*The Health and Social Services Delivery Improvement Act*) and Bill 94-2003 (*The Health Sector Partnerships Agreement Act*) (see chapter 4).<sup>80</sup> It is also worth highlighting that corporate and personal income taxes were slashed immediately following the Liberal victory. This seriously undermined the government's main source of revenue and was subsequently used to justify the need for greater private financing of public infrastructure (Cohn 2008).

Along with the decisive Liberal majority came opportunism as high profile, much needed infrastructure projects were targeted for the unfolding of its P3 agenda. These efforts zeroed in on the transportation and health sectors, four prime examples being the currently-operational Sea-to-Sky highway, Canada Line, and the two hospitals that will be examined shortly. But it must also be noted that there were equally high profile collapses of two other would-be pioneers: the Coquihalla highway project and the Vancouver Conventional Centre expansion.

The Coquihalla P3, announced in February 2002, was slated to be a 55-year DBFO with tolls imposed for the first 35 years, but it was quickly abandoned in light of concerted public objection to the private tolling scheme in particular. Once tolls became politically impossible, the revenue streams needed to attract private investment also dried up and the DBFO model was scrapped. In 2003 the P3 was scaled down significantly and it is now a much more limited operation-maintenance partnership, and no tolls were imposed on the highway. With respect to the Convention Centre expansion, negotiations collapsed in December 2002 when the preferred bidder pulled out due to a disagreement over revenue sharing and risk transfer. This was partially related to public outcry that centred on the proposal to establish a casino on the premises in order to generate the revenue needed to attract private investors.

These early Liberal-era collapsed deals provided important lessons for P3 policy design. First, public resistance to P3s could and would lead to significant results – even to an outright rejection of the model, highlighting the importance of depoliticization as a long run goal for proponents.<sup>81</sup> Furthermore, since these high profile collapses occurred prior to the establishment of the provincial enabling field, it did little in the long run to squash the ultimate

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<sup>80</sup> Both bills were designed to “provide new investment and business opportunities for private corporations in the health-care sector and to reduce compensation for health-care support workers” (Cohen and Cohen 2006, 117-8). This legislation allowed for the elimination or alteration of several key provisions in signed collective agreements, namely those that provided job security protection and protection from privatization (discussed in greater detail later in this chapter and in chapter 4).

<sup>81</sup> To be examined shortly, with the Abbotsford project resistance did not lead to P3 abandonment but instead was matched with a dogged commitment by government to see P3s go forward in the public health care system, revealing the underlying ideological motivations that inform all policies of dispossession.

aim of government: P3 prominence. Second, the need to ensure that P3s offer private investors adequate and guaranteed returns on investment was demonstrated through both collapsed deals. This narrowed the range of potential P3 projects but bolstered the commitment to those that were feasible. The Canadian health care sector is thus 'ideal' for privatization by stealth given that the government is the purchaser of P3 infrastructure and services, not the public (i.e., patients), avoiding the need for user fees and guaranteeing strong and predictable rates of return for investors. Profitability for the Diamond Centre's private partner has also been boosted by the commercialization of hospital space, a feature that is unique amongst P3 hospitals in Canada. Thus the collapsed deals did not discourage P3 policy enthusiasts, rather they provided important lessons. Ultimately, the Coquihalla and Convention Centre projects were the only provincial-level P3 pioneers that did not come to fruition.<sup>82</sup>

## History

Built in the early 1950s, the Matsqui-Sumas-Abbotsford (MSA) hospital was run down by the late 1980s and functionally obsolete by the end of the 1990s, not even able to power up the high tech equipment that had become standard use in most other hospitals. Beginning in the early 1980s, a replacement hospital had been proposed by local health authorities. Recognizing this need, the NDP government had made promises over the course of its tenure to replace the hospital, but these were never fulfilled. Then, mere months before the 2001 election, the Abbotsford Hospital and Cancer Centre was announced and appeared in the 2001 NDP budget, to be publicly financed, built and operated. The hospital again appeared in the spring 2002 Liberal budget as a public project but by late 2001 the government had hired the accounting firm PricewaterhouseCoopers<sup>83</sup> to provide an assessment of the private-for profit options available to deliver this facility. By November 2002 the evaluation by PricewaterhouseCoopers was complete and Premier Gordon Campbell stated for the first time, in a speech made to the Independent Contractors and Builders Association of BC, that the hospital would "go private" (Dix 2003, A6). In their spring 2003 Budget the hospital was

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<sup>82</sup> The Seymour Water Filtration Plant is another prime example of an early Liberal-era collapsed P3 deal, however this was a municipal project and not a provincial-level initiative.

<sup>83</sup> PricewaterhouseCoopers was hardly a neutral choice given that it was an established beneficiary of the UK's PFI market. It should also be clarified that this study was commissioned by the regional health authority but it was the Ministry of Health Planning that "gave the direction to the health authority to go and do the report" (Sandler 2002, A1).



dropped from the government's capital plans as they sought to take advantage of accounting rules which at the time favoured P3s through off book financing.<sup>84</sup>

Addressing very different needs, the process of redeveloping the Vancouver General Hospital's (VGH) teaching and ambulatory outpatient care facilities<sup>85</sup> would soon be forever twinned with the Abbotsford greenfield hospital project since they were the first P3 hospitals in the province and developed at roughly the same time – though not in the same manner (as explained in the next section). Financial planning for the VGH Diamond Centre began in late 2001 and by early 2002 the health authority's proposal had been targeted by government as a potential P3 (BC Select Standing Committee on Public Accounts 2011). In October 2002 Premier Campbell announced that the redevelopment of VGH offices and teaching facilities would be BC's first P3 hospital project (also making it Canada's first DBFO hospital). Without the province having developed or evaluated a single P3 hospital, Premier Campbell promised that this P3 would be the "first of many" (Middleton 2002, A3).

### **Justifying & initiating P3 use**

By nearly all accounts the new hospital in Abbotsford is of high quality design. It has garnered many accolades, including for its use of natural light and other green features, its top of the line infection control design, and its spacious and time-saving layout (e.g., wards are oriented around a central hub) (Lewis 2008, A6).<sup>86</sup> It is also three times the size of the hospital that it replaced, has nearly 100 additional beds, a much larger emergency room, and allowed for high-tech care and cancer care to be provided for the first time in the region (Lewis 2006, A8). Yet aside from the obvious benefits that a new hospital and well designed facility have provided for patients and staff, why exactly privatization was necessary remains an unanswered question. The government's explanation for this decision has varied over the years, owing more to scandal and public pressure than to forthrightness and transparency.

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<sup>84</sup> Off-book financing allows P3s to appear as lease payments in provincial budgets rather than upfront capital costs. This accounting loophole has since been tightened through the adoption of new public sector accounting principles known as GAAP or generally accepted accounting principles, discussed in chapter 2.

<sup>85</sup> 'Ambulatory care' refers to specialty outpatient clinics, diagnostic and testing facilities, and physicians' offices.

<sup>86</sup> Although Robbin Knox, Director of Membership Services for the Hospital Employees' Union points out that the hospital's information architecture is poor: signage is confusing and/or inadequate, causing staff and patients to get lost and requiring volunteer time to direct traffic (2012, Phone Interview, November 29). Due to the P3-induced internal bifurcation of authority, staff could not hang signs, even if addressing workplace safety concerns, without the private owners' approval.

The initial explanation provided by government was that a P3 would offer cost savings, with the PricewaterhouseCoopers evaluation being used to support claims of P3 superiority. This rationale soon evaporated when a technological glitch revealed the redacted portions of the study, details which public service advocates and health care unions had been fighting for some time to access. When the specifics of the study were revealed they raised serious concerns. PricewaterhouseCoopers – a frequent beneficiary of the P3s industry – concluded that a P3 could at best deliver a cost savings of 1 percent, and this was if all went smoothly; it could deliver a savings of 5 percent if some clinical services were privatized, in violation of the *Canada Health Act* (Sandler 2002, B3; Cohn 2008, 77). After examining the report, forensic accountant Ron Parks proclaimed that it “relie[d] on ‘suspect data’, [was] inconclusive and ‘should not be used as the basis for a definitive government decision’” (Canada News Wire 2002b, 1). This effectively eliminated the cost savings argument.

Running concurrent to these developments were the ideological justifications offered by Liberals in 2001 and 2002. Here too the government held steadfast in the face of opposition, which in this case extended beyond unions and advocacy groups as province-wide public opinion polls were clearly indicating significant, widespread opposition to private involvement in the development of the new Abbotsford hospital (e.g., Canada News Wire 2002a, 1). Aside from the general P3-friendly atmosphere that began with the Liberal election victory in 2001, more specific evidence of an ideological bias first emerged a few months after the election when a memo sent by the Ministry of Health Services and Health Planning to each regional health authority informed them that the Ministry would soon be “set[ting] criteria around which patient populations would be best served in a private setting” (Harrison 2001, A6). Thus the desire to introduce privatization and marketization began in earnest.

By mid-2002 Premier Campbell stated to journalists, shortly after creating Partnerships BC and implementing the Capital Asset Management Framework (CAMF), “one of the things I think we have to do is *we have to be committed* to trying to getting the ones [P3s] that work out there” (Enchin 2002, D5, emphasis added). A few months later, in November 2002, the Abbotsford hospital P3 was announced and then Finance Minister Gary Collins is quoted as saying that “the project was not only important as an individual health facility but also *for the future of the P3 model in British Columbia*” (Goldsworthy 2002, emphasis added). From this Cohn (2008, 77) concludes that “some projects had to be first, and the Abbotsford Hospital was seen as a good candidate” since the Abbotsford region was a strong Liberal support base and this reduced the political risks involved.

In order to see this 'pilot project' come to fruition, commitment to the P3 model meant not only creating the initial contours of an enabling field and pushing forward with flimsy cost savings arguments and thinly veiled ideological ambitions, but also disciplining local public health authorities who questioned the suitability of a P3 for their proposed facility. Mike Marasco, then-chief project officer for the Fraser Health Authority (FHA), was an outspoken champion of the P3 route but other members of this regional health authority (RHA) were less convinced (many of whom had extensive private sector finance and real estate experience). When they expressed skepticism with the use of a DBFO P3 early on in the process, the provincial government ordered the Board of Directors to accept the project as a P3 or face removal (Cohn 2008).<sup>87</sup> The RHA had instead preferred a less involved design-build P3 on the grounds that the project was too small to generate sufficient competition (and thus capture the gains promised) and that traditional financing and operations arrangements would be preferable (ibid). Having lost confidence in the RHA to shepherd the nascent P3, several staff members were shuffled into other positions and a special purpose operating company was created to interface with the private consortia on behalf of the public partner. Guided by Partnerships BC and headed by Marasco (as chief project officer of the FHA), the operating company was intentionally designed to be arm's length from the RHA (ibid).

Established in 2003 and named Abbotsford Hospital and Cancer Centre Inc. (AHCC), this operating company acts as the public partner in the P3 arrangement. It has representatives from the Ministry of Health, Partnerships BC (and the chairman of AHCC is also the former head of Partnerships BC), the relevant health authorities (FHA and, because of the cancer care component, the Provincial Health Services Authority), and the Fraser Valley Regional Hospital District. Despite this combined expertise, value for money claims have since been exposed as being suspect at best, to be examined in the section that follows.

Like the Abbotsford hospital, the Diamond Centre renovation and expansion was clearly needed and the building now houses 40 offices that had previously been scattered around the VGH area. The improved layout has earned the facility an 84 percent satisfaction rate by the patients who use it (BC Select Standing Committee on Public Accounts 2011). On the other

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<sup>87</sup> A similar incident occurred with the FHA with respect to the Surrey Ambulatory Care Facility. Through a freedom of information request by the BC Health Coalition it was revealed that during a meeting with the deputy Health Minister in 2006, the Chair of the FHA, Keith Purchase, stated in relation to the Surrey facility, "P3s are the not the first choice of the committee" (reported in Sandborn 2007). At a separate committee meeting Purchase elaborates, "... if we undertake the traditional partnerships strategy (P3) there is a lesser ability to control design, longer lead times and additional risk" (ibid). A P3 was later chosen to develop this project. Keith Purchase resigned as Chair of the FHA in 2007 stating that it was partially due to the demands placed on the FHA by the provincial government to follow "a budget process which compelled me to keep my board colleagues out of the loop" (ibid).

hand, there are also limits to this type of satisfaction-based assessment given that, as the Auditor General reports, external stakeholders such as taxpayers and other government agencies do not have an adequate way to rate their satisfaction with the new facility (BC Auditor General 2011a, 12).

One negative aspect of the design is its single heating and cooling system. The project agreement assigns responsibility for heating and cooling to the private partner from 7am to 7pm (within this ambulatory care facility and doctors' offices close at 5pm). Should the public partner wish to have the building open before/after that time, heating and cooling becomes their responsibility. The restrictive nature of these hours meant that the services provided by the sterile processing department had to mainly coincide with when doctors' offices were open, an inefficient and ineffective arrangement; and if sterile processing was to be done after 7pm the public partner would have to pay for heating and cooling throughout the entire building given the single HVAC system. The latter would be far too costly for the health authority and thus it determined that the sterile processing department would require separate heating and cooling. Arranging for the private partner to alter the HVAC system on one floor alone cost the RHA roughly \$50-60,000, plus a 15 percent administration fee (Public Partner Manager 1 2012, Phone Interview, October 29).<sup>88</sup>

The Diamond Centre facility, as with the Abbotsford example, lacks a solid justification for being developed as a P3. In October 2002 it was announced that the Vancouver Coastal Health Authority (VCHA) would begin searching for a private partner but value for money had yet to be established and the official report was released only two years later, in November 2004. As one reporter commenting on the 2002 announcement put it at the time: "Premier Gordon Campbell's plan to use a private-public partnership to build a new wing at the Vancouver General Hospital may sound good to him, but he has to let the rest of B.C. in on why" (Maple Ridge, Pitt Meadows Times 2002, 6). This sentiment was echoed by other news reports which stated that there was no clear explanation ever given for how the P3 could save money in the long run (e.g., Middleton 2002, A3).

Unlike the relatively high profile development of the Abbotsford hospital, the establishment of the Diamond Centre P3 flew under the radar, arousing far less public attention. There are several likely reasons for this. First, it is at least partially due to the nature of the project itself. Since the Diamond Centre P3 mainly involved redesigning clinics and offices and

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<sup>88</sup> Though it is only a single example, this stands as an important indicator of several problematic elements of P3 agreements: the additional (hidden) costs for the public sector and the inherently inflexible nature of these agreements given that HVAC repairs could only be done through the private partner which was not necessarily the most cost effective scenario.

was less than a third of the cost of the Abbotsford greenfield project, the latter was the more obvious cause for public concern at the time. Second, the Diamond Centre did not receive as much attention from public sector unions. With both pioneering P3s being developed at roughly the same time, the smaller size and scope of the Diamond Centre project made it a relatively less important target than the Abbotsford project which was set to affect hundreds of support service workers for decades to come.

A related explanation for the low profile of the Diamond Centre P3 pertains to the labour relations climate at the time. Public sector unions such as the Hospital Employees' Union (HEU) (BC's health care services division of the Canadian Union of Public Employees) have been, and remain, a strong source of resistance against P3s. Yet at the time that the Diamond Centre was being developed the HEU was also facing significant assault imposed by Bill 29-2002 (*The Health and Social Services Delivery Improvement Act*) (a factor that was highlighted by Reynolds 2012a, Personal Interview, September 17), and later Bill 37-2004 (*The Health Sector (Facilities Subsector) Collective Agreement Act*) (highlighted by Knox 2012, Phone Interview, November 29).

As discussed in chapter 4, Bill 29 was introduced shortly after the Liberal victory, and allowed for the elimination or alteration of several key provisions in signed collective agreements, namely those that provided job security and protection from privatization. This new legislation applied to all 'non-clinical' employees in BC's health sector. Within a few short years, more than 9,000 members of the HEU had lost their jobs, and wages were slashed and benefits cut in newly contracted-out positions (Cohen and Cohen 2006). In the Abbotsford region, contracting-out first took place in 2004 at the older Matsqui-Sumas-Abbotsford hospital, affecting all HEU housekeeping staff (i.e., prior to when the P3 opened in 2008). Many of the support service contracts had been awarded to Sodexo, the company that later came to form the service partner of the winning private consortia (along with Johnson Controls). Thus Bill-29 brought the threat of privatization to staff working in *all* hospitals, not only those subject to P3 arrangements. Further, Bill 37 imposed wage rollbacks affecting 43,000 hospital and long term health care workers and allowed for greater casualization of health sector employment (HEU 2004b). In light of wider concerns at the time, it is no surprise that the Diamond Centre P3 received little attention.

Finally, the low visibility of the Diamond Centre deal can be attributed to the enthusiasm and leadership displayed by the RHA. Unlike with the Abbotsford P3 planning process, the Diamond Centre project began as a business case initiated by VCHA. The RHA also led the

planning and procurement stages of development;<sup>89</sup> with the Ministry of Health and Partnerships BC acting only as process observers during these phases (BC Auditor General 2011a). After the winning consortium was selected, negotiations with the private partner were headed up by VCHA. Once the negotiations with the preferred partner were nearly complete, in April 2004 the private accountancy firm Ernst & Young was contracted by the RHA to review the financial modeling (CPP AACC 2004, 4); and Partnerships BC was contracted by VCHA to assist with writing the value for money report after the project agreement was in place (BC Select Standing Committee on Public Accounts 2011).

Thus from the start the Diamond Centre was relatively depoliticized when compared with the Abbotsford hospital.<sup>90</sup> However, flying under the radar came at the expense of the routinization and institutionalization enjoyed by the latter since it was the VCHA that led the entire process, not a team of experts and wider variety of stakeholders like we see with AHCC. This meant that a local health authority with no prior knowledge of P3 procedures was responsible for selecting the preferred private partner and negotiating with a multinational private consortium. When pressed for details about the negotiations in 2004, VCHA spokesperson Viviana Zanocco refused to name the preferred partner with whom discussions had already begun, and was surprisingly candid when she said: “in terms of timelines or deadlines or anything like that . . . it’s the first time we’ve done it, so we have no way of knowing how long it’s supposed to take” (O’Connor 2004, A4).

More significantly, this lack of routines and expertise foreshadowed the misleading nature of value for money claims. In 2011 BC’s Auditor General found that the “VCHA did not have a clear understanding of the scope and user requirements before going to market for a private partner” which led to a number of undesirable outcomes (2011a, 11). This included changes to the functional design of the facility *after* the project agreement had been signed, meaning the changes were paid for entirely by the VCHA even though in 2004 scope risks were said to have been transferred to the private partner (Partnerships BC 2004). Altogether, the lack of expertise amounted to variations that cost the RHA \$10.68 million (BC Auditor General 2011a, 11). CAMF protocols now ensure that the functional design is complete before the P3 route is initiated. Another major bungle relates to the recordkeeping procedures of the VCHA as

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<sup>89</sup> Planning also involved input from the University of British Columbia’s Faculty of Medicine.

<sup>90</sup> This is not to say that stakeholders were kept fully informed of the true nature of Abbotsford project. Up until 60 days prior to the hospital’s opening, the HEU knew only that the infrastructure would be a P3, they were not told that the project agreement would include the full range of support services (e.g., patient portering, food, housekeeping, maintenance, etc.). They were informed of this in spring 2008 (Knox 2012, Phone Interview, November 29).

the BC Auditor General (2011a) found that by 2011 there was no longer any documentation available to support the 2004 value for money report released to the public.

### **Value for Money?**

Both official value for money reports produced by Partnerships BC claim that these two P3s were delivered 'on time' and 'on budget' (Partnerships BC 2004; 2005). Yet arriving at this determination requires adopting an overly narrow interpretation of these terms. With the Abbotsford P3 construction costs increased by 68 percent, from an estimated \$211 million in 2001 when the project was first announced, to \$355 million in 2004 when construction actually began (Palmer 2008, A3). This cost increase is partially due to changes (improvements) in design, yet can also be traced back to the lengthy contract negotiations inherent with complex P3 arrangements. These protracted negotiations pushed the initiation of the project into a booming construction market, and added \$63 million in inflation costs alone (Cayo 2005, D5). It also delayed the opening of the hospital. Originally, in 2003, British Columbians were told that the P3 route would mean faster delivery – that construction would begin in 2004 and the hospital would open in early 2007 (Harrison 2003, A40) – but bidding and contract negotiation delayed the project by nearly two years and the hospital only began accepting patients in late 2008. This is not reflected in Partnerships BC's (2005) official value for money report, and instead the hospital is labeled as being on time and on budget since once the agreement was in place, the hospital was delivered as specified.

The Diamond Centre track record fares slightly better, although it too was late and more costly than originally promised. In 2002 the Campbell Liberals touted the P3 model as a way of delivering the facility by spring 2005, at a cost of \$90 million (O'Connor 2004, A4), yet it ended up opening in fall 2006 at a purported cost of \$95 million (Partnerships BC 2004). However, as it turns out, discussed in greater detail below, there is no basis of support for this figure of \$95 million and instead the final capitalized value of the redevelopment project is \$123 million (BC Auditor General 2011a, 9). There are also the additional (hidden) costs associated with very minor items that should not be overlooked. Hanging a picture in an office, for example, is not only a "hassle" for the health authority since it has to be arranged through the private partner (i.e., VCHA cannot use their own maintenance staff), but it also may be more costly since VCHA cannot use the cheapest vendor and the private partner charges a 15 percent overhead fee each time a service such as this is provided (Public Partner Manager 1 2012, Phone Interview, October 29).

Perhaps of greater concern than the delays and cost creep is that value for money has never been clearly established with either hospital, despite adamant claims of P3 superiority by Partnerships BC. As discussed above, the P3 route was chosen well before value for money had been adequately assessed even though best practice (now and at the time) dictated that this be established in advance since it is supposed to be the basis upon which the selection of a P3 is made.

The methodology used to later produce the value for money assessments was also angled in favour of privatization.<sup>91</sup> With the Abbotsford P3 a discount rate of 6 percent was used to determine value for money when in the UK (pioneers of the P3) best practice dictates using a rate of 3.5 percent (Parks and Terhart 2009, 8). At a rate of 6 percent, delivering the hospital as a P3 appeared to save \$39 million, yet this result is highly sensitive. Forensic accountants Parks and Terhart (2009) calculate that at 4.5 percent neither the P3 nor the PSC are favoured, and at a rate of 3.5 percent a publicly delivered hospital would produce a savings of roughly \$80 million when compared to the P3 option. On this basis, Parks and Terhart conclude that the methodology used to determine value for money in the Abbotsford case was “biased in favour of the P3” (2009, 16).<sup>92</sup>

Erroneous value for money claims are similarly present in the official value for money report produced by Partnerships BC for the Diamond Centre. The report claims that the leading factors supporting a P3 were that the project would offer a good return on private investment, that a P3 would be the most cost effective option from a life cycle cost perspective, and that a P3 would offer other benefits such as risk transfer, timely delivery, and innovation (Partnerships BC 2004, 4). Yet in his 2011 assessment, BC’s Auditor General found that many of these promises did not materialize, with the important exception of offering a good return on private investment. For instance, variations in the functional design led the Auditor to conclude that “the P3 agreement in this case did not effectively manage the project scope risk” (2011a, 11).

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<sup>91</sup> Explained in chapter 2, value for money assessments compare the cost of a P3 to a ‘public sector comparator’ (PSC) (a hypothetical model created to represent the traditional delivery method) and a central component of this process is the application of a discount rate to the project costs as a way of calculating “the cost of capital over time”, accounting for considerations like interest and inflation (Partnerships BC 2005, 19). Yet the choice of which discount rate to apply is not a neutral decision, it is highly political and extremely controversial. This is because the higher the discount rate used, the more attractive the P3 option becomes since this favours expenditure in later years relative to that which is spent now (Gaffney et al. 1999, 117).

<sup>92</sup> As discussed in chapters 2 and 5, having the same government agency that promotes P3s also act as ex-post evaluator of project success is controversial. In a report for the World Bank, Dutz et al. (2006, 3) list Partnerships BC as an example of this type of agency given that it provides information and guidance, advocates in favour of the development of P3s, helps with project development, and carries out ex-post evaluations of P3s in the province. The potential for conflict of interest raises many concerns, chief among them being the evaluation and costing methodology used to determine value for money.



The value for money report also suggests that the RHA's operational risks are minimized given that payments made to the private operator and service provider can be adjusted on the basis of performance (Partnerships BC 2004). However, the Auditor's report reveals that "the quantitative performance standards set out in the Service Requirements were not measured and monitored" (2011a, 12). Without any effective ability to measure and monitor performance, this risk is certainly not transferred.

Financial savings are also highlighted in the Diamond Centre's official value for money report, with it claiming that the P3 option would save \$17 million in net present value<sup>93</sup> terms compared to the PSC (Partnerships BC 2004). These calculations used a discount rate of 7.12 percent on the grounds that this rate "reflected the inherent risks transferred to the private partner" (ibid, 11). BC's Auditor General would later conclude that this discount rate was too high and ought to have been more accurately set at 5.37 percent. Using the lower and more appropriate rate adds \$17 million to the total capitalized value of the P3 project (BC Auditor General 2011a, 6). This adjustment, along with the nearly \$11 million cost increase due to the functional design variations discussed above, means that the final capitalized value of the P3 was actually \$123 million – which amounts to \$28 million above the 2004 figure (see BC Auditor General 2011a). This final value is well in excess of the PSC generated at the time.<sup>94</sup>

High transaction costs are also present with these P3 hospitals. With the Abbotsford hospital, the BC provincial government spent over \$7 million in administrative costs, and \$24.7 million on legal and consultant costs (Partnerships BC 2005, 34). Given that the Diamond Centre was developed by the VCHA, it had to hire private advisors to the tune of \$2.4 million, or 2.5 percent of the project's total estimated capital costs in 2004 (Partnerships BC 2004, 7).

All told, the delays, increased costs, poor value for money, high transaction costs, and methodological deception greatly undermine any financial/economic rationale upon which these P3s could be justified. Satisfactory architectural design and functionality of these projects hardly outweighs all of the drawbacks. Politically, we see that the strong ideological desire to have P3 hospitals developed in the province led to broken promises by government officials and little transparency overall. Despite this strong political support at all levels of government, there is also no accountability assumed by P3 proponents. The bad choices, poor results, and ongoing concerns have been neither acknowledged nor addressed.

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<sup>93</sup> The net present value of a project is the sum of all the future cash flows discounted to present value. This allows future financial commitments (i.e., debt repayment) to be valued in today's money (see Loxley 2010, 29).

<sup>94</sup> However given the scope changes it is important to avoid comparing apples to oranges.

## Private Partners, Private Services

With the Abbotsford hospital, the private partner holds a 30 year lease on the facility and was awarded responsibility for design, construction, finance, maintenance, and management and operation of the hospital (involving general management, help desk, food services for patients and non patients, housekeeping, laundry and linen services, material services, plant services including facility maintenance, protection services, patient portering,<sup>95</sup> utilities management, and parking services) (Partnerships BC 2005, 17). In the case of the Diamond Centre, the private partner also holds a 30 year lease and was similarly awarded responsibility for design, construction, finance, maintenance, and management and operation (involving housekeeping, security, grounds keeping, and leasing space not used by the public partner) (Partnerships BC 2004, 9-12). These 'full spectrum' P3s (or DBFOs) are the norm for BC hospital partnerships.<sup>96</sup>

Both hospitals' winning private partner consortia were composed of large, mainly multinational actors. For Access Health Abbotsford (AHA) financing was provided and arranged by ABN AMRO Bank, facilities management and support services are operated by Johnson Controls and Sodexo, and construction was handled by PCL Constructors. Similarly, Access Health Vancouver (AHV) involved financing from ABN AMRO, PCL oversaw the construction, and Johnson Controls now manages the facility. Architectural design was provided by different private partners: Silver Thomas Hanley and Musson Cattell Mackey (AHA) and IBI/HPA (AHV). Thus the Abbotsford private partner was composed of only two Canadian firms (PCL and Musson Cattell Mackey), as was the Diamond Centre (PCL and IBI/HPA).

The composition of the private partner subsequently changed for both P3 hospitals. Originally financed by the Dutch bank ABN AMRO, in 2005 it sold its share in each partnership to the Australian investment bank Macquarie; and in 2007 this was sold once more to John Laing PLC. These P3 hospitals therefore had three different owners in as many years (2005-7) (CUPE 2011, 11; Sandborn 2008). Refinancing is a huge source of profits for private P3 partners (see Whitfield 2009) and John Laing PLC, the current financial partner for both P3 hospitals, was criticized in 2008 by the Chair of the UK House Public Accounts Committee for

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<sup>95</sup> The BC Cancer Agency retained in-house management of patient portering for oncology services (Knox 2012, Phone Interview, November 29).

<sup>96</sup> Variations do exist, however. For instance, the Interior Health Authority has exempted some cleaning services from its recent P3 deals, but all other support services are included. P3 hospital deals in procurement as of fall 2012 (for an updated list, see Partnerships BC n.d.) include 'hard' facility services such as maintenance, help desk, and physical plant, whereas 'soft' services tend to be limited to housekeeping.

representing “the unacceptable face of capitalism” for its 2003 refinancing of a UK PFI hospital which led to “windfall” profits and a 60 percent return on investment (Sandborn 2008). In BC, P3 hospital agreements contain clauses that require the private partner to share half of all revenue earned through refinancing with the public partner. However the profit associated with refinancing after project agreements are signed cannot be built into ex-ante value for money calculations, affecting the applicability of previous assessments.

With the Diamond Centre, AHV won through a competitive bidding process, although, as noted above, selection was highly opaque. On the other hand, AHA won the contract when the other three potential bidders dropped out, confirming earlier fears expressed by the RHA surrounding poor market competition. When there is only a single candidate, a primary argument in support of P3s is eliminated: that competition for the P3 contract will ultimately benefits taxpayers and service users. With only one bidder, best practice is often to move away from a DBFO by unbundling some of the project’s components. AHCC member, and chief project officer for the FHA at the time, Mike Marasco defends their choice to go with AHA’s bid in the following way:

We may have ended up with one at the very end, but we started with four strong teams, and thanks to the process that we’ve put in place, there was competitive pressure put on the final team in the homestretch because they had already spent a significant amount of money on preparing their bid ... we had an intensely competitive bid that resulted in our having an innovative design and a project that we could say we expect to receive value for money from (BC Select Standing Committee on Public Accounts 2006).

The private fairness auditor hired to evaluate this irregularity also concluded that it was a competitive process. Yet an initially competitive process is not necessarily the same as competitive market pressures producing the best value for money. Ultimately AHCC partnered with the only consortium that had not withdrawn their bid – hardly a ringing endorsement for the preferred proponent and the benefits of a P3.

P3 value for money analyses fare poorly when it comes to capturing the social concerns associated with the use of private for-profit service operators. Social costs can vary but in the health care sector they typically relate to problems with inadequate training, poor hygiene control, and deep cuts made to wages and benefits (e.g., CBC 2009; Cohen and Cohen 2006; Leyne 2009). In January 2004 many of the support services at the Matsqui-Sumas-Abbotsford hospital were contracted out to Sodexo – the very same company that would soon be a member

of the private consortia awarded the Abbotsford P3 contract.<sup>97</sup> Within four months (April 2004), the *Abbotsford Times* found evidence of declining standards in the hospital. For example, it reported on “tales of blood smears in labour rooms that should be spotless, litter left behind beds in the emergency ward and inexperienced workers entering infectious isolation rooms” (quoted in HEU 2004a). Inadequate training may have contributed to this, with the HEU hearing that newly privatized staff were given only a day of training, outside of a hospital setting (Knox 2012 Phone Interview, November 29).

While there have yet to be any reports of this occurring at the P3 hospital, in fall 2012 Sodexo’s cleanliness and infection control standards were once again in the news with the outbreak of the superbug *C. difficile* in Burnaby Hospital (like Abbotsford, this is also within the Fraser Health Authority). The outbreak led the HEU to call for a housekeeping audit given that Sodexo passed cleaning standards despite the infectious outbreak. The union claims that “right now hospital cleaning is based on visual appearances only” (HEU 2012). When housekeeping services are kept in-house rather than privatized the public sector retains full control over the types of cleaning products used and method of cleaning; as well as controlling the number of staff employed. Private partners, on the other hand, have a vested interest in getting work done quickly and at a low cost. With hospital staff often working in several different hospitals each day, the implications of cut corners in any one facility can easily reverberate across the whole region (Knox 2012 Phone Interview, November 29).

Problems with the Diamond Centre’s housekeeping subcontractor Bee-Clean have also emerged. According to one interviewee, “they [Bee-Clean] don’t understand how to clean up a clinical unit” (Public Partner Manager 1 2012, Phone Interview, October 29). The performance of this cleaning subcontractor remains an “ongoing frustration” for the public partner and they “just aren’t happy with the service” (ibid; also confirmed by Public Partner Manager 2 2012, Phone Interview, November 8). Bee-Clean is a Canadian janitorial and building maintenance company and does not specialize in health sector housekeeping. Despite the dissatisfaction of the health authority, the P3 project agreement awards full control over housekeeping services to the private partner (AHV). Thus AHV, not VCHA, chooses the subcontractor for these services.

The Abbotsford project agreement, on the other hand, is more robust in its support service provisions. The project agreement allows for ‘market testing’ every five years (meaning that a service provider’s overall performance is graded at regular intervals), and this applies to

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<sup>97</sup> Sodexo is a multinational corporation specializing in food services and building maintenance in hospitals, schools, prisons and other similar institutions. It has a record of industrial standards violations and union-busting (e.g., see HEU 2004a).

all privatized services except for general management (i.e., AHA itself) and physical plant.<sup>98</sup> 2008-13 marks the first five year period for market testing. The review process began in summer 2012 (looking at scores, surveys, other performance indicators) and if the expectations set out in the project agreement are met, the price paid by the RHA for the private partner's services will remain the same – and hence the subcontractor is likely to be retained. The incentive for good performance is therefore instilled principally within subcontractors. The private partner is able to pass on any payment deductions that it faces to the vendors it has hired, raising the question of what risk AHA truly holds during the operational phase of the project. As of fall 2012, it is likely that, due to suboptimal performance, 10 of 12 services provided by AHA will be “taken back to market” in 2013 (Public Partner Manager 3 2012, Private Seminar, October 31).<sup>99</sup> In other words, 10 of 12 subcontractors have been performing below expectations.

Low wages and benefits are another feature of BC's privatized health care support services. As mentioned, in 2002 Bill 29 rescinded signed collective agreements, cutting wages for staff now employed by the province's 'Big Three' private contractors (Sodexo, Aramark, and Compass Group) to \$9-10 per hour, and rolling back benefits. By 2004-7 the HEU had organized most contracted-out support staff in the province. The first round of bargaining began in 2004 and this led to a \$3-4/hour wage increase (HEU 2008). The next round of bargaining began in 2008 and produced a 15 percent wage gain (\$15 per hour by 2011). As of fall 2012 bargaining has recommenced. These improvements are significant and the HEU has acknowledged Sodexo's willingness to work with the union however the effects of Bill 29 are still being felt a decade after its implementation given that nominal hourly wages in 2012 were in many instances below what they were in 2002. In contrast, P3 agreements like the one governing the Abbotsford hospital provide for yearly inflation-adjusted increases in service payments made to private contractors. Furthermore, privatization is now clearly entrenched within the public health care system. Regional health authorities no longer employ the vast majority of support staff in BC's health sector, although the opposite was true in 2001.

The internal bifurcation of authority within the Abbotsford hospital has also meant that staff cannot hang pictures without the private owners' approval, or even signs addressing workplace safety concerns. In some instances bifurcation may be little more than an annoyance; in others it hinders service delivery. Given the 'true employer' provisions of Bill 94

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<sup>98</sup> Physical plant is considered a lifecycle risk and therefore performance (and risk transfer) can only truly be established at the end of the thirty year project agreement.

<sup>99</sup> The price paid by the public partner for these services may rise in 2013 if market testing reveals that AHV initially underbid its service costs (Public Partner Manager 3 2012, Private Seminar, October 31).

and 29 (see chapter 4), work directions for privatized staff can come only from private managers. Thus public and private hospital staff are effectively “kept segregated” even when it disrupts the timeliness of cleaning services (Knox 2012 Phone Interview, November 29).

### **Operations, contracting monitoring and enforcement**

The Diamond Centre contains an element of commercialization not seen with other Canadian P3 hospitals: commercial and retail activities have been incorporated into the project agreement in order to allow for greater profitability. Provisions for rental revenue stipulate that the private partner, AHV, is able to keep all profit up to a certain threshold, above which a percentage is shared with the health authority (CPP AACC 2004). In exchange, AHV holds the risk that this space may be vacant. Located within a large hospital and health services area, as well as a prime retail location within the city of Vancouver itself, this risk has not yet materialized. The retail space has been consistently occupied by eateries, coffee shops, and since 2006 the large pharmacy chain Shoppers Drug Mart. There are currently no other examples of for-profit commercial retail space in VCHA hospitals (Public Partner Manager 1 2012, Phone Interview, October 29). Small gift shops are a feature common to traditional hospitals, but these are run by charitable organizations and hospital auxiliaries with revenue dedicated to patient services/support. An exception to this is the retail coffee shop Café Ami run by Sodexo in the Jim Pattison Outpatient Care and Surgical Centre, however this is also a P3 facility and Sodexo holds the food services contract.

Although comparative data is lacking, it would be fair to say that for most privatized hospital staff, P3 environments can be nearly identical to contracting-out (Reynolds 2012a, Personal Interview, September 17). However, for public sector authorities the operational phase of the P3 agreement presents particular challenges which set the two forms of privatization apart. First, P3 agreements are far longer; and second, all contracts are bundled into one agreement. Thus a P3 private partner does not face the discipline that accompanies contracting-out since those contracts are renewed every few years, not every few decades. Further, the private partners of a P3 enjoy a monopoly position given that even in the case of very poor performance it is not legally possible to sever any one portion of a project agreement without renegotiating the entire project agreement – which in most instances would be a prohibitively expensive, time consuming ordeal.

The long term and bundled nature of P3 contracts also mean that most components contributing to value for money, risk transfer, and cost savings – the foundational justifications of

the P3 model – ultimately manifest during the operational phase of any given project. Contract monitoring and the enforcement of performance standards are therefore integral to reaping the purported rewards of a P3. Yet the Diamond Centre agreement does not actually allow the public partner to alter service payments in the case of poor performance or service non-availability (BC Auditor General 2011a). Should problems arise with housekeeping and security services, for example, there are provisions in the agreement that allow the private partner to release subcontractors, but there is no such power given to the public partner to impose payment deductions. Dealing with these issues from the public partner’s perspective thus requires “developing a long term relationship and working together” (Public Partner Manager 2 2012, Phone Interview, November 8). This stands in stark contrast to the typical P3 proponent rhetoric of using private contracts to insulate the public from unnecessary cost and risk.

For the Abbotsford hospital a different concern exists with respect to risk transfer (or the lack thereof) during the operational phase of the P3 – it appears to be common practice for the provisions in the project agreement to be overlooked, and, in at least one instance, changed for the benefit of the private partner. The following statements made at a private seminar by the General Manager of AHCC, the Abbotsford P3 public partner, are especially revealing (Public Partner Manager 3 2012, Private Seminar, October 31):

I don’t ever check that project agreement, I only check the writing in the book as a very last [step] ... I figure out what the right thing is to do and I sit down with the private people and say ‘here’s the right thing’ and we reach agreement and then we go back and make the language of the book fit what the right thing is.

I haven’t gone to dispute, haven’t gone to the lawyers in the [several] years that I’ve been there because I’ve been able to find the happy medium, the win-win.

We had a payment deduction that we were entitled to millions of dollars from our private partners and my belief and the belief of my board was that it was too strong a payment deduction for them, it would have bankrupted them and they would have gone out of business. It was just an error in the writing of the project agreement, it was way too severe a penalty for something so minor so we actually settled on something substantially less than that because it was the right thing to do and then we corrected the book, we actually went back into the book did an appendix to the project agreement.

While there can be no doubt that managing a complex, thirty year relationship requires compromise on all sides, it is unlikely that a private partner would be willing to return these favours. In fact, the General Manager (ibid) further stated with respect to the millions of dollars owed to AHCC for a particular payment deduction, “they [AHV] believed that they didn’t have to pay us [AHCC] anything.” Not only do these day-to-day practices defy the ‘market-discipline’

and ‘risk transfer’ promises of those promoting P3s, but they also reveal the deep reorientation of public sector decision-making: public hospital managers now thoroughly incorporate and accommodate the interests of private for-profit partners.

## **Proliferation**

BC’s pioneering P3 hospitals clearly suffer from several major problems: cost creep and delays leading to broken promises with little public accountability or recognition that this has occurred; P3 development proceeded without having been subject to a proper value for money analysis; the value for money assessments that were later produced used methodological deception to ex-post justify the use of a P3; there were problems with bidding (Abbotsford) and changes made after the project agreement was in place (Diamond); dubious risk transfer; and both private partners were composed of nearly the identical group of multinational corporations. At least some of these issues resulted from a lack of public sector expertise and were corrected through the routinization of P3 procurement and enabling field reforms. The next round of P3 hospitals were initiated several years later – the bulk of which were launched after 2007, some 5 years after Partnerships BC was up and running and the CAMF had been put in place.<sup>100</sup> So the pertinent question becomes: were the problems exhibited by these pioneering P3s isolated incidents due mainly to inexperience? In other words, what benefits, if any, have enabling fields provided? A full reporting of the similarities and differences would require a thorough examination of each new case; nevertheless several trends can be identified and listed here, leading to the conclusion that benefits have been procedural rather than substantial.

First, government ministries and the Office of the Premier in particular are no longer as directly involved, or at least they do not appear to be. The commitment to P3s has been maintained, and in fact expanded upon, as the number of P3 hospitals swells, but it now occurs in a far more depoliticized fashion. Depoliticization takes the two forms discussed in the previous chapter. Most obviously, decision-making is shifted from the public sector to the private sector as the number of P3 hospitals grows (the effects of which have yet to be fully seen since only a small number are currently operational). Further, and likely of greater

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<sup>100</sup> As of late 2012, these are: the Residential Care and Assisted Living Capacity Initiative (RFP issued in 2006); the Royal Jubilee Hospital Patient Care Centre (RFP issued in 2007); Jim Pattison Outpatient Care and Surgery Centre (RFP issued in 2007); Kelowna and Vernon Hospitals Project (RFP issued in 2007); Fort St. John Hospital and Residential Care Project (RFP issued in 2008); Surrey Memorial Hospital Redevelopment and Expansion: Emergency Department and Critical Care Tower (RFP issued in 2009); BC Cancer Agency Centre for the North (RFP issued in 2009); and the Interior Heart and Surgical Centre (IHSC) Project (currently in procurement).



importance for the normalization of P3 policy is the shifting of decision-making from the governmental sphere to the realm of public and quasi-public authority. Partnerships BC has taken the lead role in determining the contours of negotiations, contract development, the selection of preferred bidders, in promoting privatization, and in guiding the regional health authorities with which it partners to represent the public interest. This is not to say that the Ministry of Health no longer participates in the P3 planning process, but its role is confined mainly to oversight tasks, such as approving the business case and sitting on the board of major capital projects.<sup>101</sup> The Ministry of Finance, of course, has maintained a strong indirect role through its CAMF. The creation of these routines, as presented in chapters 4 and 5, has meant that all P3 hospitals now follow the same series of steps to establish project scope, schedule, cost, and risks upfront rather than after the fact.

Along with these procedural similarities comes a second trend, this one being of greater significance than is the streamlining and predictability identified above. Process harmonization without any substantial evaluation of the appropriateness of the P3 model has meant that the accounting and methodological issues associated with the Abbotsford hospital and Diamond Centre P3 deals have not been ameliorated but instead systematically engrained and obscured through sophisticated technocratic techniques and routines.

Speaking to the Select Standing Committee on Public Accounts in 2011, Duncan Campbell, the current CFO of the VCHA, claims that many lessons have been learned and processes improved upon since the Diamond Centre P3 was developed. For instance, he argues that “the accounting treatment is very clear now” and that “the rules have changed. They’re much more transparent” (BC Select Standing Committee on Public Accounts 2011). This sentiment is echoed by representatives of Partnerships BC. In 2006 then-CEO Larry Blain also told a Select Standing Committee on Public Accounts that “the idea of producing a value-for-money report was an initiative of Partnerships B.C. Our intent was to raise the level of disclosure around major capital projects, and I believe that we are reporting out at a level of disclosure which is unprecedented in Canada” (BC Select Standing Committee on Public Accounts 2006).

These claims are misleading. Even though value for money reports are now conducted by Partnerships BC ahead of time and are displayed on their website – both of which were much needed improvements – the amount of data that is actually made public leaves much to

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<sup>101</sup> Like with the Abbotsford example, the project board of all new major hospital capital projects is composed of representatives from the Ministry of Health, the Ministry of Transportation and Infrastructure, Partnerships BC, and the relevant regional health authority.

be desired. As John Loxley (2012, 22) puts it, it is “impossible to deconstruct or reproduce VfM assessments,” with the result that “transparency is really quite opaque, a form of window-dressing.” The reason consistently offered by Partnerships BC is that this is needed to protect commercial confidentiality. Be that as it may, it nonetheless provides the illusion of enhanced public disclosure and transparency while maintaining nearly the same level secrecy as with the Abbotsford and Diamond Centre P3s. It therefore goes a long way towards normalizing and depoliticizing P3s while doing very little to substantially improve outcomes and address public concerns.

In addition, methodological deception remains (ibid). Discount rates are still far too high, and thus value for money calculations remain mathematically biased against the PSC; risk transfer claims are still vague and lacking justification, though entirely relied upon as the basis for declaring P3 superiority; and oversight into these issues is still almost non-existent. When the Auditor General reported on the Abbotsford hospital in 2006 it was merely an attestation report, not a direct audit. All that this exercise accomplished was providing confirmation that the numbers used by Partnerships BC did in fact add up; it did not independently verify any of the value for money data, and thus could not say where those numbers came from. When the Diamond Centre P3 was audited in 2011 the Auditor General exposed many significant problems (as identified throughout this chapter) – but even this audit was limited. It did not tackle how and on what basis the P3 was developed (and thus whether a P3 should have been chosen at all), but instead assessed whether the project succeeded in achieving three of its value for money goals, which it did not. As of late 2012, the Auditor General has yet to report on any other P3 hospital in the province.<sup>102</sup>

Another looming issue that has yet to fully reveal itself relates to the inadequate quantification of service outcomes (also flagged by the Auditor General (2011a) in his report on the Diamond Centre). Without certainty on this front the public partner loses the ability to adjust the level of payments made to the private partner, and thus to control operational outcomes. Further, long term monitoring and formal reporting on how operational P3s are functioning remain sorely lacking. All too often P3 policy champions point to, and focus resources on, the procurement and construction phases. In BC, public sector expertise targets the two or three years required to procure a deal – from Partnerships BC to the various Ministries involved (including the Office of the Premier for pioneering P3s) as well as the private sector consultants

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<sup>102</sup> A similar lack of official auditing exists for P3s in other sectors as well. Aside from the reports previously cited in this chapter, at the time of writing there is only one other P3-related report, concerning the Sea to Sky Highway Improvement Project and the Britannia Mine Water Treatment Plant Project (BC Auditor General 2012).

and fairness monitors hired to ensure that value for money has been secured. Construction is another high profile time for P3 hospitals, and proponents are quick to cite 'on time' and 'on budget' results. The operational phase of a P3 project, in contrast, unfolds over 30 years and Partnerships BC has yet to put in place any systemic resources devoted to contract monitoring and operations management. As suggested by the General Manager of AHCC (Public Partner Manager 3 2012, Private Seminar, October 31):

We only look at the sexy part of the business ... it's not hard to manage a budget when you can't go over time and over budget ... when you cut the ribbon the purse strings are wide open and you have to be really cognizant of what is happening in the operating 30 year term ... I've been in this job for [several] years and I've probably had less than six hours of conversation with anyone [at Partnerships BC] asking me how it's going.

It is doubtful that greater transparency and contract management would significantly ameliorate the P3 model but improvements in operational monitoring could help to ensure that the elements of cost savings and risk transfer that have been included in the project agreement are actually being achieved. It was only in 2011, nearly five years after the first P3 hospital opened its doors in BC, that Partnerships BC acknowledged that they need to develop long term monitoring and operational reporting procedures (BC Select Standing Committee on Public Accounts 2011). Some procedural changes have been made in light of the Diamond Centre service contract problems, for instance contracts now "are much more specific" (ibid), but the Auditor General's (2011a) recommendations on operational management and improving the performance metrics have yet to be implemented by the VCHA.

Just like with the initiation of the P3 model in health care, there are few proactive protections for the public interest during the operational phase of these hospitals. Rather than anticipating the problems that might occur with P3s, it appears as though the BC provincial government and its agencies are satisfied simply to develop them without actually scrutinizing them.

A final theme worth noting is the way that BC's P3 market has been developing. It is a quirk of the Abbotsford and Diamond Centre agreements that both private partners were nearly identical and this supported fears that concentration would occur and that smaller contractors and medium sized companies in the province would be squeezed out (e.g., Knappett 2008). These concerns appear to paradoxically have been both accurate and as of yet unfounded in the health sector. They are unfounded because smaller projects still go forward using either traditional or design-build P3 procurement, and private partners of large DBFOs subcontract their work to smaller local firms. There is also now a wider range of private partners bidding and

winning than the AHV and AHA results would have suggested at the time (see Partnerships BC n.d.). On the other hand, these fears have also proven accurate because within the DBFO P3 market it is still only the largest corporations (predominantly multinationals) that have been consistently awarded these contracts – and thus they control, and benefit the most from, large hospital (re)development projects in the province. Provisions prohibiting changes in private consortia membership, as occurred with the AHV and AHA financing partner, have yet to be implemented in BC. Changes in P3 ownership therefore remain beyond the control of government.

## **Concluding Remarks**

The hospital P3s examined in this chapter provide important examples of the disconnect that exists between the rhetoric of P3 proponents and the reality of P3 projects: the higher costs, lengthy bidding and negotiation stages, erroneous or misleading value for money claims, and social and labour concerns that arise from support service privatization. These projects also demonstrate the contradiction inherent in attempting to achieve value for money through *privatization* given the realities of managing a decades-long *partnership*. Gaining the greatest possible number of public sector benefits from privatized P3 service providers can only come from having a strong commitment to enforcing the project agreement, yet effective service provision requires the opposite: negotiation, compromise, and collaboration. The distinctive nature of the partnership aspect of a P3 has been affirmed by public and private partners alike (Private Partner Manager 2 2012, Phone Interview, November 16; Public Partner Manager 1 2012, Phone Interview, October 29; Public Partner Manager 2 2012, Phone Interview, November 8).

The ongoing proliferation of P3s in the face of problems and concerns lends support to Clarke's (2008) notion of neoliberal 'doubling', or the way in which instances of neoliberalism are both integrated within and serve to remake the whole (see also Peck 2010, 22). P3 pitfalls reflect problems inherent to the model yet simultaneously urge process (policy) change that suppresses or helps to ignore suboptimal outcomes. There is a model of P3 development which represents an ideal, the way these projects are 'supposed to' work, and then there is the reality of how actual project development and operation functions. 'Evidence' from each new project is marshaled by proponents to confirm the superiority of the P3 model even when it is impossible to do so given the rampant and uncorrected value for money errors, deception, and

secrecy; the pseudo science that goes into these calculations; and the lack of any oversight and corrections made before new projects are initiated. Thus the 'evidence' that is used to confirm the superiority of the model and justify future projects is based on circular reasoning and self-referentiality, and is intensely ideological despite depoliticization.

It should also be pointed out that any discussion of P3 faults must be set within the context of earlier delays, broken promises, cost overruns, and low transparency with traditional projects. One of the strengths of the P3 model offered by industry proponents and scholarly analyses is that once project agreements are in place, the P3 contract ensures that the infrastructure will be built.<sup>103</sup> However, this is less an argument in favour of P3s than it is a reminder that election promises are not always kept. Fixing public procurement problems through public solutions was the obvious next step in BC but this was never given the effort that establishing enabling fields and P3 projects received. There was, to reiterate, no obvious financial imperative urging on the P3 route with either facility. BC's initial P3 hospitals were pushed through by the government of the day based on sheer political will, in the face of public opposition, protest by civil society groups, concern expressed by members of the regional health authority (Abbotsford), and with value for money having never been clearly established.

Given the propensity to increase the cost of infrastructure, as well as many other social disadvantages that accompany the use of P3s in health care, it is difficult to see how they create solutions to rising health sector costs today. The higher costs associated with P3 use not only undermine proponents' arguments that they help curb wasteful government spending, it also means that less is available to be spent on future social concerns and other infrastructure projects. The legacy of broken promises, delays, higher costs, and hidden fees associated with P3s greatly undermine arguments that oppose traditional public infrastructure on the grounds that it is too costly for the cash strapped provinces to afford.

Enabling fields may have marginally improved the P3 policy landscape today but improvements have not reduced costs or increased public oversight and accountability, they have only made it appear as though this has happened. RID has made P3s more palatable, and thus more dangerous. This chapter has examined how that has happened in BC, next we look at how it has occurred in Ontario.

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<sup>103</sup> Of course, tying the hands of future governments is also a negative aspect of P3s.

## **Chapter 7. Launching transformations: Ontario's pioneering P3 hospitals and the evolution of the province's health sector P3 program**

A complex relationship exists between the development of Ontario's initial P3 hospitals and the unfolding of its P3 enabling field. In contrast to the experience in British Columbia (as discussed in chapter 6), P3 projects and policies did not emerge concurrently but instead the province's first DBFO hospitals were initiated several years prior and under a different government than the enabling field. First announced by the Mike Harris-led Progressive Conservative (PC) government in late 2001, the Brampton Civic Hospital and Royal Ottawa Hospital projects got off to a rocky start with much public resistance throughout the development process. Later, in the lead up to the October 2003 provincial election, these two P3s were again a hot topic and subject to much public, politicized debate. Concern over P3s would not be assuaged through an abandonment of the model by the victorious Dalton McGuinty Liberals but instead through alterations (both rhetorical and real) to the hospital project agreements and the creation of a supportive edifice around P3 development, referred to here as an enabling field. In so doing the government shifted the policy emphasis from cost savings to efficiency, from necessity to prudence, from roll-back to roll-out. It is under these conditions that routinization, institutionalization, and depoliticization have allowed the P3 model to flourish in Ontario, and this province is now the single most important P3 market in the country. From a shaky start marred by years of delays and controversy, as of mid-2012 there are over 30 P3s in various stages of development in Ontario's health sector.

Three large sections form the bulk of the analysis here: P3 hospital initiation, observations, and proliferation. Ontario's Brampton Civic Hospital and Royal Ottawa Hospital projects will be examined for their performance and legacy, including the historical and political circumstances under which they were created, value for money-related issues, and some of the operational concerns that have emerged. The appendix should also be consulted for its detail on the timeline and milestones of each P3. Observations on how these pioneers influenced, and were influenced by, the evolution of provincial enabling fields will also be provided. The final section will discuss the key ways in which subsequent P3 hospitals were affected by the legacy of the trailblazers initiated first.

### **Initiation: Ontario's Pioneering P3 Hospitals**

Ontario's initial P3 hospitals were highly politicized, offered poor value for money, and came in much later and at a higher price than originally promised. This experience contributed to P3 policy alteration and the development of the current enabling field. As will be discussed, the change in government in 2003 led to the amelioration of some concerning features of these project agreements but it also opened the door to a much more systematic P3 program in the health sector. The new approach developed by the McGuinty Liberals was so successful that by 2008 the Executive Vice President of Infrastructure Ontario estimated that roughly 75 percent of all P3s in the province were hospitals (Ontario Standing Committee on Government Agencies 2008).

A common element shared by both pioneering P3 hospitals is that despite the decades-long need for these facilities they suffered neglect under the traditional procurement model. This situation was not the result of an intrinsic failure of the public procurement model, funding was simply not made available despite the clear need for each project. Perhaps because of this neglect the hospital boards responsible for these projects embraced either public or private involvement – whichever would prove most expedient. Yet regardless of any local 'buy-in', the decision to use a P3 in both instances was never truly left up to the local authorities, it was a Cabinet-level initiative from the start and continued to be after the change in government in 2003. These projects indicate the features and failures of the earlier PC SuperBuild framework (a proto-enabling field) and illustrate the importance of the Liberal government's enabling field for the routinization, institutionalization, and depoliticization of the P3 health sector program.

## **Background**

Ontario's use of P3s did not begin with the McGuinty Liberals in 2003 when the elements of the enabling field were first beginning to form or even with the PC's 'Common Sense Revolution' in 1995, but instead was touched off much earlier under the Bob Rae-led NDP government of the early 1990s. Prior to the Liberal victory, P3s were never a sector-wide affair and only a handful had been developed in the province. 'Experimentation' with this procurement model would be the term that best captures P3 policy in the 1990s, as there was little effort made to systematize P3 use before Harris' second term, which started in 1999. This is not to say that individual P3 projects were insignificant, several large and high profile projects were developed in the 1990s in a range of sectors. For example, in the transportation sector

there was the 1993 Highway 407 deal,<sup>104</sup> and in social services there was the 1997 Ontario Business Transformation Project; municipally, in 1994 the Hamilton-Wentworth Water and Sewage System P3 agreement began.<sup>105</sup> Each suffered several problems, from cut corners and safety concerns resulting from the profit motive (Highway 407), to collapsed deals and inadequate upkeep (Hamilton-Wentworth), to poor/unsubstantiated value for money (Business Transformation) (see Loxley 2010). Issues of this sort, combined with little effort to create an enabling field, kept P3 use relatively marginal throughout most of the 1990s.

In 1999 the situation began to change when the PC government was reelected for a second term.<sup>106</sup> The 'Common Sense Revolution' that ousted the NDP in 1995 was focused mainly on rolling back much of the welfare state through neoliberal restructuring and fiscal austerity and thus it did not privilege roll-out maneuvers such as developing sector-wide P3 programs to promote partnerships with the private sector. This would change in 1999 with the creation of the SuperBuild infrastructure plan, and this initiative stands as the Harris government's attempt to institutionalize P3 development.<sup>107</sup> However, by housing decision-making within the Cabinet Committee on Privatization and SuperBuild and offering little by way of systematized capital planning procedures, this proto-enabling field remained far too politicized and lacked the routines necessary to sufficiently transform government operations and normalize P3s as the 'new traditional'. Nonetheless it did lead to the initiation of the province's first two P3 hospitals. From a P3 proponent perspective, SuperBuild can be considered a disappointment relative to the Liberals' Alternative Financing and Procurement (AFP) strategy – though this was far from obvious at the time.

The intention to use a P3 to deliver the Brampton Civic Hospital and Royal Ottawa Hospital projects was announced in November 2001, and by 2002 both Requests for Proposals had been issued. These P3s received heavy criticism and much publicized concern, with resistance directed mainly by public sector unions and public health care advocates, though the Brampton hospital initially received more attention due to its much larger size.<sup>108</sup> By September 2003 both projects were fiercely targeted by a coalition of union/public service advocacy groups (the Canadian Union of Public Employees, CUPE; the Ontario Public Service Employees Union,

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<sup>104</sup> Highway 407 was fully privatized in 1999 when the government's special purpose vehicle representing the public partner was sold off.

<sup>105</sup> The P3 later collapsed and this facility is now being operated by the public sector.

<sup>106</sup> Mike Harris served as Premier from 1995-1999 and was reelected in 1999. Ernie Eves (PC) held this position from April 2002 to October 2003 after Harris stepped down.

<sup>107</sup> For more on SuperBuild see chapter 5.

<sup>108</sup> In 2001 Brampton was to be a roughly 700 bed facility and Ottawa was to have a little fewer than 300 beds. This also meant that the cost was much less for the Ottawa project: an estimated \$95 million in 2001 versus nearly \$400 million estimated for Brampton in that same year.



OPSEU; and the Ontario Health Coalition, OHC) which launched a court injunction to stop the proposed deals.<sup>109</sup> The group claimed that P3 hospitals violated the *Canada Health Act* and provincial *Public Hospitals Act* but their case was ultimately rejected by the Court due to insufficient evidence (Daily Commercial News and Construction Record 2003). Other tactics were taken, including a four year legal battle to gain access to financial details and other information surrounding the Brampton P3. Eventually details were released relating to the project agreement and lenders' agreement, but some crucial information has yet to be made public (Ontario Standing Committee on Government Agencies 2008). The NDP also sought out details through freedom of information requests but received documents so heavily redacted that they were of little use (ibid).<sup>110</sup>

Civil society-led resistance was also matched with politicization through partisan policy debate. During the spring and summer of 2003 McGuinty was steadfast in his efforts to distance himself and his party from the PCs' P3 agenda. Typical promises made during this part of the election campaign were that McGuinty would 'dismantle' these agreements if he came to power (Blackwell 2003, A7). Once it became clear that the Liberals would likely be forming government after the October election, in September 2003 McGuinty affirmed that these much needed projects would still go forward though not as 'P3s', stating that P3s "represent an extraordinary departure from our history when it comes to public hospitals in the province of Ontario" and therefore the projects would be brought "back within the public system" (Lindgren 2003, 1).

When the McGuinty victory finally came, P3-related election promises were only partially fulfilled given the nearly identical features of P3 and AFP hospital projects (see chapter 5). SuperBuild was replaced by the Liberals' new Ministry of Public Infrastructure Renewal (which would later house Infrastructure Ontario), and Alternative Financing and Procurement (AFP) rules and routines were introduced through the Infrastructure Planning, Financing, and Procurement Framework (IPFP). Thus the P3 enabling field as it stands today was put in place over the first few years that followed the election.<sup>111</sup> This has allowed infrastructure P3s to proliferate in key sectors such as health and transportation to a degree that may not have been possible under the PC government given the degree of resistance and politicization witnessed from 2001 to 2003. What became of the province's pioneering P3 hospitals is also a testament to the commitment that the Liberals have shown to private for-profit involvement in the public

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<sup>109</sup> As well as the proposed Centre for Mental Health and Addiction in Toronto.

<sup>110</sup> Except, of course, this result is a clear indicator of the secrecy that accompanies P3s and of the arduous nature of the fight against privatization.

<sup>111</sup> See chapters 4 and 5 for dates and descriptions.

health care system<sup>112</sup>: project agreement lengths were shortened, project scope was changed, and public ownership of the land and facilities was reasserted but aside from these aspects both went forward as full-spectrum design, build, finance, operate (DBFO) P3s.

## History

The roots of the Brampton Civic Hospital project run deep, with the first steps toward a new hospital being taken in 1971 when the Chinguacousy County Council voted to buy 20 hectares of land and dedicated the use of this lot to a future public hospital (Keung 2003, H02). Since there was only one hospital in the immediate area at the time (Peel Memorial), when the population in Brampton began to swell<sup>113</sup> so too did the need for a new hospital. However by as early as 1984 the lack of public funding had the district health council entertaining notions of allowing a privately built hospital to be established on the site in order to fulfill this need (McMonagle 1984). During the 1985 provincial election campaign, David Peterson promised that if he was elected Premier he would make building a second hospital in the region a “major priority” for his cabinet (Barker 1986, W6). Peterson won the election but this promise was never honoured and the project languished in the proposal stage for years. In 1986 the Chinguacousy Health Services Centre Board, formed in 1973 to develop plans for a second hospital in the region, submitted their proposal to the province for a new 300 bed hospital in Brampton (Steen 1986, W1) but by 1991 the project was not only stalled, it had been scaled down to a far more limited crisis centre and drop-in clinic to accommodate the lack of public spending (Mitchell 1991, W5). Frustrated by decades-long inertia, in 1991 Brampton Mayor Peter Robertson requested that if the newly-elected Bob Rae NDP government were “unable to assist us at this time, then please set us free to negotiate with private interests for this health care centre” (Funston 1991, BR1). Despite the appeal, and the clear need for a new hospital in the region, neither public nor private plans went forward.

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<sup>112</sup> Aside from an ideological commitment to privatization, there is also a financial dimension to consider. The Liberals inherited an unexpected \$5.6 billion deficit in November 2003 which some say forced them to not entirely scrap the P3 deals – not only because they ‘needed’ the private financing but also because reneging would have cost the government an estimated \$10 million (Hill 2003, 1; McArthur 2003, B1). Though these arguments would appear to hold merit, the subsequent proliferation of P3 hospitals under the Liberal government discredits any notion that they were not onboard with privatization from the start. Furthermore, the \$10 million penalty was later revealed to be only \$2 million (OPSEU 2007, 6).

<sup>113</sup> For example, Brampton’s population increased by 19.2% between 1981 and 1985 alone (Steen 1986, W1).

Later that decade, in 1997, the Health Services Restructuring Commission<sup>114</sup> (HSRC) decided that the three hospital boards in the region (governing the Georgetown and District Memorial Hospital, Etobicoke General Hospital, and Peel Memorial Hospital) should be amalgamated under the newly-created William Osler Health Centre (WOHC) (then known as the Northwest GTA Hospital Corporation), becoming the province's sixth largest public health corporation. At the same time, the HSRC reaffirmed the need for a new hospital in the Brampton region, and decided that the Peel Memorial Hospital should also be renovated and redeveloped. By late 2001, provincial Finance Minister Jim Flaherty and Health Minister Tony Clement had announced that the Brampton project would go forward as a P3 (Boyle 2001, A24). The new hospital was to be built alongside the redevelopment of the Peel Memorial Hospital, the latter being slated to gain an additional 112 beds using traditional public financing and procurement (OHC 2008a, 3). The P3 project eventually went through but the redevelopment of Peel Memorial was later scrapped and by 2007 health services at Peel Memorial were discontinued and transferred (along with 234 patients) to the newly built Brampton Civic Hospital.

First opening its doors in 1910, the Royal Ottawa Hospital (then known as the Lady Grey Hospital) initially treated tuberculosis patients but by the early 1960s had begun to focus on mental health and psychiatric disorders (The Royal n.d.). By the late 1980s many problems were beginning to crop up with this facility as, for instance, issues relating to overcrowding began to emerge (e.g., Dyer 1987, A9); and leaks, cramped spaces, and a functionally obsolete design were growing concerns. In addition, in 1997 the HSRC announced that 140 patients would be transferred from a Brockville mental health facility to the Royal Ottawa Hospital by 1999, with \$11 million suggested for renovations to accommodate this transfer; no additional funding was earmarked for improving the already cramped conditions and increasingly decrepit facility (Schliesmann 1997, 4; Denley 2000, A1). Separate redevelopment plans were thus initiated by the hospital board in 1999, although this was only made public in May 2000 when it announced that negotiations had begun with the provincial government to demolish the facility and replace it with a new \$85 million hospital (ibid). This 'brownfield'<sup>115</sup> proposal was purported to be more economical than simply renovating the old facility, a less desirable option since the hospital board estimated that a new facility would cost \$4 million less a year to run (ibid). Announced at the same time as the Brampton P3, in November 2001 the province committed to

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<sup>114</sup> The HSRC had been established in 1996 to advise the Ministry of Health and Long Term Care on decisions relating to "restructuring Ontario's public hospitals ... [and] on other aspects of Ontario's health services system" (Ontario Auditor General 2008, 108).

<sup>115</sup> A 'brownfield' project is a new facility (not a redevelopment) that is built on an existing site.

building a new 284 bed Royal Ottawa Hospital from the ground up, using a P3. One interviewee (Public Partner Manager 5 2012, Phone Interview, October 15) reports that without private funding, it would have taken roughly 10 years to receive funding from the province given the many projects already in line. Perhaps for reasons of expediency, the hospital's chief executive George Langill was an enthusiastic supporter of the P3 approach from the start (Egan 2001, C2).

## **Initiation**

When both P3s were announced in late 2001 the justifications for deviating from the traditional method varied. Initially Tony Clement (then-Health Minister) promoted P3s as being 'faster, better, and cheaper' (e.g., Lindgren 2001; Calgary Sun 2002). Critics were quick to point out that P3s rarely save the government money given the presence of a profit motive and the higher interest rates paid by private borrowers, yet Jim Flaherty (then-Finance Minister of Ontario) shifted the debate away from absolute cost into the more opaque realm of efficiency and value for money (Boyle 2001, A24).

The resolve to use P3s to deliver these hospitals clearly did not rest on an established track record given the earlier problems with P3s in the province nor was it based on the merits of each individual case since the Ministry of Finance had announced six months earlier that P3s would have to be first considered before the government would commit to funding any new hospital projects (Ontario Auditor General 2008, 102). This bias was also made clear in a Ministry of Health and Long Term Care (MOHLTC) letter sent to the WOHC in February 2002 that "directed that the P3 model must be the one used for the development of the new [Brampton] hospital, and that other options or deviations from this model could not be considered" (ibid, 108). The government was promising that these pioneering projects would be "the first of many" and it was hoping to extend the model into all feasible sectors: "from hospitals to hockey rinks" (Boyle 2001, A24).

Once the government announced in November 2001 that they would be launching these P3s, the various bidding stages were quickly initiated in early 2002 which allowed for little public input and deliberation. Private input, on the other hand, was solicited.

With the Brampton project the prospective private partners were given significant latitude to mould the P3 as they wished. For instance, rather than the public sector dictating the parameters of the project agreement, at the Request for Expression of Interest stage in March 2002 bidders were asked "to state their interest in contracting for *some* or *all* of the necessary

work (Canada News Wire 2002c, 1, emphasis added). The government then required that the WOHC compare the price of private sector bids to the cost of delivering a fully public hospital (Ontario Auditor General 2008, 104). As the WOHC assessment was merely a reference point and not a full business case, P3 value for money was never truly established and the private proponents' bids largely guided the comparison and decision-making.

Private consultants were also relied upon, especially once the bidding and negotiation stages began. As reported by the provincial Auditor General, the WOHC and MOHLTC hired nearly 60 legal, technical, and financial consultants at a cost of \$34 million (2008, 105).<sup>116</sup> Not only were these costs not added to the price of the P3 but the use of multiple private consultancy firms produced a wide variety of estimates – leading to confusion, criticism, and misinformed public debate later on. One of the first consulting firms hired by the WOHC (September 2000, prior to the decision to use a P3) estimated that the traditional procurement method would cost roughly \$357 million. In October 2001 this was updated to \$381 million. Another private consulting firm (commissioned in January 2003) came up with a much larger figure - \$507 million. This was later updated to \$525 million in November 2004. Not only did the hospital board “not question the large difference in the two estimates,” but Ontario’s Auditor General also notes that these figures greatly overestimated the cost of the traditional method (2010, 306).

The actions and decision-making procedures of the public sector demonstrate the lack of routinization and in-house expertise at the time. In contrast to AFP routines (examined in chapter 5) where the functional plan and project’s scope and size are set out ahead of the decision to use a P3 and three standardized value for money stages occur during procurement, the steps taken with the Brampton hospital suggest little forethought went into the public sector role. These steps are summarized by the Auditor General (2008, 114-5): in January 2003 the WOHC came up with its initial estimate of what the hospital would cost if a traditional public approach was used, which was almost a year after the Request for Proposals had been issued. This value for money estimate should have instead been the basis upon which the P3 route was pursued in the first place.<sup>117</sup> The WOHC updated this estimate two years later, in November 2004, after the preferred bidder had already been chosen. Meanwhile, the MOHLTC was conducting its own reviews of the WOHC’s analyses, the first being finalized after the Request for Proposals stage was complete and the second (which, remarkably, the WOHC was unaware

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<sup>116</sup> \$6 million was incurred prior to the government’s decision to use a P3, \$28 million once this route was chosen.

<sup>117</sup> Bias in favour of the P3 model is present with this best practice as well, see chapter 2 on the methodological deception inherent in value for money assessments.

of) was finished in 2005 after the project agreement had been struck. Though each phase confirmed the superiority of the P3 route, using a P3 appears to have been a fait accompli from the start no matter what the results. Furthermore the Auditor General has since discredited all of these value for money calculations (to be addressed in the next section) leading one to reasonably question whether intentional manipulation rather than mere error had occurred.

With the Royal Ottawa Hospital the choice to use a P3 was also made prior to establishing value for money but this decision was reached in much different way than it was with the Brampton hospital. First the hospital board (the Royal Ottawa Health Care Group, ROHCG) sought and was awarded approval through SuperBuild to begin the P3; next, the ROH Project Implementation Management Team issued a formal Request for Proposals, selected from amongst the bidders, and later came to form the public partner. Thus, unlike with the WOHC, it was the public hospital board (ROHCG) that largely drove the process of using a P3. This is consistent with the ROHCG's previous track record of enthusiasm for support service privatization – it was amongst the first in Ontario to contract out non-clinical care (1995), slashing staff numbers nearly in half in order to save money. Laird and Langill (2005, 71), lead consultant to the ROHCG and former CEO of the ROHCG respectively, explain that given the combination of prior experience with contracting-out, a supportive hospital board, and the recent creation of SuperBuild, “the timing was right to consider this [P3] approach in the healthcare arena.” The board's justifications for the P3 followed the familiar refrain of saving money, building the facility more quickly, and improving staff and patient wellbeing (ROMHC 2003). Each justification has since been shown to bear no correspondence with the reality of this project (to be addressed in the next section).

The bidding and negotiation phases occurred during 2002 and 2003, and were kept highly secretive. The opaque nature of this process was excused by the ROHCG at the time on the grounds that confidentiality would “ensure fairness and a strong competitive process” (ROMHC 2003, 30). Indicative of the lack of routinization under SuperBuild, the steps taken to deliver this project differ significantly from the Brampton experience. Laird and Langill (2005) describe the major steps that they took, and how they came to these decisions. After deciding to use a P3, the ROHCG prepared a very limited functional program in hopes that giving the private partner significant leeway would lead to superior designs. The board also recognized that a P3 would require “a major realignment of our governance and management resources” so experts (including an experienced project manager) were sought out to provide financial, technical, and legal assistance and the board created the Expansion and Redevelopment Committee to oversee the entire process (ibid, 72). Even if this helped improve the

development of the P3, these experts were never called on to judge whether a P3 should be used; and between the hospital board's commitment to privatization and the embedded involvement of leading P3 market actors, conflict of interest and bias were almost certainly present.

The Committee then produced a Value for Money Benchmark (VFMB) which was used as a way of evaluating bids; however it was also disclosed to the bidders at the Request for Proposals stage. Allowing those bidding to see this information effectively squashed the competitive pressure needed to ensure that proposals were as cost-effective as possible. Two bidding stages then followed (Request for Qualifications and Request for Proposals), running throughout most of 2002 and 2003. Shortly after the negotiations with preferred bidder had begun, the provincial election took place in October 2003.

Having yet to reach commercial and financial close, the newly-elected McGuinty government forced through several changes prior to signing the Royal Ottawa Hospital project agreement in July 2004. This included shortening the length of the agreement from what would have likely been 66 years to 21 years (Adam 2003, B7), and amending the legal arrangements pertaining to ownership of the facility and land (putting these elements back in public hands). The analogy used by then-CEO of the ROHCG George Langille to characterize the change in ownership provisions was that it amounted to the difference between leasing a house and taking out a mortgage to finance the purchasing of a house (Adam 2004, E1). Langille describes the changes that McGuinty's government imposed in the follow way: "there is no question that you have a public ownership component that you didn't have before" (ibid). These are certainly improvements on the more egregious aspects of initial P3 arrangements but the NDP were also right when they pointed out at the time that "whether it is a lease or mortgage, the private consortium will still make the usual 20-per-cent profit -- money that will be 'siphoned off patient care to big private companies'" (quoted in Adam 2004, E1).

### **Value for Money?**

In 2001, Ontario's Finance Minister pegged the cost of building the Brampton hospital at roughly \$350 million, to begin in 2002 (Daily Commercial News and Construction Record 2001, A5). Construction instead began in 2005 at a cost of \$550 million – an increase of \$200 million. And rather than opening in 2005, it began accepting patients in late 2007. To be fair, this delay was not only due to the protracted nature of P3 negotiations. Additional factors included the change in government and the lawsuit launched by CUPE, OPSEU, and the OHC. On the other

hand, the Auditor General notes that complications with finalizing the financial arrangements contributed to the delay, which certainly can be attributed to the P3 itself (Ontario Auditor General 2008, 115).

Cost increases have not corresponded to more beds, instead capacity dropped from the September 2000 estimate of 716 to 479 beds in service when it first opened in 2007 (Ontario Auditor General 2008, 102-3). A full capacity of 608 beds was supposed to be reached in 2012 (ibid), yet a public partner manager interviewed for this study confirms that as of November 2012 the hospital has only 554 beds (Public Partner Manager 4 2012, Phone Interview, November 12). This public partner manager suggests that the failure to reach full capacity is not related to the P3 agreement but rather is the result of changes in the hospital's post construction operating plan (decided by WOHC) (Public Partner Manager 4 2012, Phone Interview, November 12). Regardless, with the closure of the Peel Memorial Hospital came the scrapping of the 112 beds promised with that redevelopment project, representing a significant net loss for the community. In 2003 the Regional Hospital Infrastructure Plan estimated that by 2008, 930 hospital beds would be required to adequately care for patients in the region (OHC 2008a, 5).

The Royal Ottawa P3 suffers from similar shortcomings. Construction costs came in not at \$95 million as promised by the Health Minister in 2001, but ended up amounting to \$146 million (OPSEU 2007, 1). It also has fewer beds than the facility it replaced. Original estimates were for 284 beds but it opened with nearly 100 fewer, for a total of 188. Delays also plagued this P3. The PC government first suggested that the P3 route would speed up the process and estimated that completion would be achieved in May 2004 (Egan 2001, C2), but the facility was only operational in 2006. Despite these problems, the P3 is touted as being 'on time', 'on budget' (e.g., Laird and Langill 2005, 79).

As alluded to earlier, value for money was not established ahead of time with either P3. Thus the decision to use the P3 model could not have been based on P3 cost or value superiority. In Brampton the decision was also heavily skewed: the Province overestimated the costs of traditional procurement by \$289 million which made the P3 option seem cheaper (Ontario Auditor General 2008, 114-117). This included overestimating design and construction costs and adding the costs associated with some non-clinical services which should not have been attributed to the public sector comparator (PSC) (ibid, 104-5). The WOHC also incorrectly added \$67 million to its estimate of what a traditional hospital would cost as a way of accounting for the risk transfer that could be achieved with a P3. Yet the Auditor General found that, "a properly structured contract under a traditional procurement agreement could have mitigated



any such cost overruns” (ibid, 104). Thus a full spectrum DBFO P3 was not necessary, making these errors both mathematical and indicative of bias in favour of the P3. Furthermore, the higher price of private financing added an estimated \$200 million over the lifetime of the project agreement (ibid, 105). The interest rate spread was not considered when the WOHC compared the P3 to the traditional approach.

Scope and other related project changes that occurred after the project agreement was finalized led to additional costs incurred by the public partner, rather than being transferred to the private partner. This included a \$63 million modification of the facility to accommodate equipment installation, owing to the disintegrated nature of P3 planning which separates construction plans from equipment installation (ibid, 116). Finally, hidden transaction costs not accounted for in the final price of the P3 (and thus borne entirely by the taxpayer) added an additional \$28 million due to the large number of private advisors, consultants, and legal experts used (ibid, 105). Despite all of these problems, the Brampton P3 has been labeled as being ‘on time’, ‘on budget’ and of ‘value’ for taxpayers (e.g., Canada News Wire 2007, 1).

Confirming or refuting value for money with respect to the Royal Ottawa Hospital is more difficult as there has been no public audit conducted to date – although data produced by economist Hugh Mackenzie are revealing. In 2005 he calculated that “if the hospital had been funded through government debt, the cost [of financing the capital and facility management services] in present value terms would have been \$174 million lower” (quoted in Loxley 2010, 107). This is mainly the result of the higher interest rate paid by the private partner (6.33%) (Adam 2009, A1).<sup>118</sup>

These findings along with construction costs coming in at over \$50 million above what the P3 was originally supposed to cost, justify an audit. The call for involvement of the provincial Auditor General gained even greater salience once the damning report on the Brampton hospital was released in late 2008. Public health care advocates and P3 critics have since been strongly advocating for this type of investigation. George Weber, the current president and CEO of the ROHCG, is more apathetic, arguing that “Infrastructure Ontario say they’ve learned some lessons from Brampton, so what’s the use? Time has moved on” (Ottawa Citizen 2009). A public partner manager interviewed for this study echoes these sentiments – suggesting that with the creation of Infrastructure Ontario the process has been streamlined and changed significantly, thus if a P3 hospital were to be audited, it should be one developed under Infrastructure Ontario (Public Partner Manager 5 2012, Phone Interview, October 15). There

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<sup>118</sup> While the transaction costs have not been made public, one P3 industry expert estimates that they would be likely 10-12 percent of total costs (Mackenzie 2012, Personal Interview, June 20).

can be no doubt that additional audits of P3 hospitals are needed in the province, yet these arguments hardly inspire confidence in the robustness of the value for money delivered by the Royal Ottawa P3. This stance also indicates that accountability and transparency remain poor.

Beyond the financial and methodological value for money details, value in terms of the quality of the building and equipment can be judged to be poor. Staff working within the Royal Ottawa Hospital have reported many significant problems with the building's design and the negative impact that this has had on patients, staff, and visitors (which is especially concerning given that it is a psychiatric facility).<sup>119</sup> Problems run the gamut. There was an insufficient number of drinking water stations initially installed in the building, inadequate safety design in the reception area, poor air quality due to improper ventilation, ineffective sound insulation between clinical offices, unsuitable shower facilities and difficult to operate doors to wards in the geriatric unit (OPSEU 2007; Adam 2008, A5). Equipment failures were also significant, particularly those which were security-related. This includes problems with the security cameras, malfunctioning wireless technology (including telephones, fax machines, and switchboard operations), a lack of handheld panic buttons and sterilization equipment, security breaches and patient escapes due to a lack of security (ibid). George Weber calls these "teething problems" and suggests they have nothing to do with the use of a P3 (Adam 2009, A1). One interviewee (Public Partner Manager 5, Phone Interview, October 15, 2012) further defends the P3 by highlighting that this was one of the first hospitals in Canada with a wireless environment (including fax machines, security cameras, etc.), and reports that all issues were resolved satisfactorily by the private partner within six months. However, even if one agrees that these types of problems could occur with any new hospital, particularly one using new technology, the speed and effectiveness with which labour-related issues in particular have been addressed was less than stellar. For staff working in a P3 hospital, the internal bifurcation of authority, to be examined in the section that follows, presents its own unique challenges.

### **Private Partners, Private Services**

In his 2008 report on the Brampton Civic Hospital P3, the provincial Auditor General expressed concern that the government had not conducted a market assessment in order to gauge whether there was sufficient construction sector capacity and the competitive pressure needed to generate the best bids possible. Had a market assessment been conducted, it would

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<sup>119</sup> The many problems that emerged within the first six months of its operation also challenge the notion that this project was in fact delivered 'on time'.

have become apparent that, in the Auditor's words, "only a limited number of construction contractors in the province [were] able or willing to undertake a project of this size. The same construction companies would be involved in the bidding and work regardless of whether WOHC followed the traditional procurement or P3 approach" (2008, 108). These findings are equally applicable to the Royal Ottawa Hospital project. Both Request for Proposals generated three bids, but a lack of competition and capacity overall led to a situation where the identical consortium formed the private partner for both project agreements.

The Brampton Civic Hospital's 2005 winning bid came from a consortium named The Healthcare Infrastructure Company of Canada (THICC). THICC designed, built, and financed the infrastructure, and since 2007 holds a 25 year non-clinical support service contract (including laundry, housekeeping, patient portering, security, maintenance, and dietary services). THICC is a partnership between Canadian construction giant EllisDon, Borealis Capital Ltd. (the investment arm of the Ontario Municipal Employees Retirement System, a public sector pension fund), and Carillion Canada Inc (a subsidiary of the UK's Carillion, a longstanding P3 market actor providing infrastructure support services). Architectural design was provided by Parkin Architects and Adamson Associates Architects of Toronto. Similarly, in 2004 THICC was awarded the contract to design, build, finance, maintain, and operate the Royal Ottawa Hospital. Upon its opening in 2006, there has been a 21 year non-clinical service agreement in place.

Small and medium sized contractors in Ontario have expressed concern with the monopolization of P3 markets by large firms. This problem is generated at least in part through AFP rules which stipulate that financial risks are transferred to all members of the winning consortium – meaning that even the construction firm has to qualify for surety insurance, bonding, and parent company guarantees that may not be available to smaller contractors (Ontario Standing Committee on Government Agencies 2008). Another problem, and one which is shared by small contractors in all P3 markets, relates to the essence of the P3 approach: contract bundling. Proponents claim that bundling is what allows for innovation and efficiencies to be generated by P3s, but it is also the main feature that reduces competition overall since it increases risk, the timeline for development, and the costs taken on by the companies that form the private partner. Mike Sharp, Chairman of the Ottawa Construction Association, argues that for trade contractors the risk profile with DBFOs is extremely high, estimating this to be two times greater than what would be present with large, traditional projects (Ontario Standing Committee on Government Agencies 2008). He also estimates that AFP bidding procedures are nearly four times as expensive as they are with traditional bidding

(ibid). Thus while P3 profitability for private partners is produced mainly by taking on risks that do not materialize, only relatively secure and well capitalized firms can operate successfully in this niche. A scan of all P3 hospital projects in Ontario that have reached agreements with private partners as of April 2012 confirms that it is still only the largest construction companies – PCL and EllisDon in particular – that participate in Ontario’s P3 hospital market (see Infrastructure Ontario n.d.).

Private governance-related concerns arising from these pioneering P3 hospitals relate to three important issues: the length, breadth and bundling of contracts; the internal bifurcation of authority (including commercialization); and the reduced accountability that accompanies their use. Even though several important aspects of the Brampton and Ottawa project agreements were changed for the better after the 2003 election (e.g., alterations made to ownership provisions and reduced contract lengths), all P3 hospitals suffer from problems related to their partially-privatized mode of hospital governance.

The Ontario Health Coalition prepared the following list summarizing how the features of the Brampton P3 went well beyond earlier forms of privatization in Ontario’s public health care system: support service privatization was far longer than ever before (20+ years), and contracts involved a wider range of services; bundling support services with all other project elements was completely novel; the project agreement allowed the private for-profit partner unprecedented rights to develop commercial ventures inside and around the hospital; and no other previous agreement had ever allowed the private partner to sell their interest in the project after the agreement was signed (OHC 2008a, 9).<sup>120</sup> This list applies to the Royal Ottawa Hospital as well with one caveat being that support service privatization had already taken place in that hospital in 1995.<sup>121</sup>

Within both hospitals, the private partner (THICC) controls and oversees the management and operation of all non-clinical services. This is referred to as an ‘internal bifurcation of authority’ given that the hospital board is no longer responsible for, nor does it control, this part of the hospital’s operations. Shrybman (2007b) argues that there are two important problems that arise from this arrangement: first, it can negatively affect health service delivery and efficiencies since the integration of non-clinical and clinical patient care is vital to

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<sup>120</sup> While equity sales are permissible, refinancing (another major concern associated with P3-related financialization) may only occur with the prior approval of the WOHC, and the WOHC must receive half of all refinancing gains (Loxley 2010, 110).

<sup>121</sup> Johnson Controls held these contracts and the employees were simply transferred over to Carillion when the P3 began. In the 1990s provincial wage settlement agreements ensured that CUPE-organized staff working for Johnson Controls were paid roughly the same CUPE-organized public sector workers (Public Partner Manager 5 2012, Phone Interview, October 15).

hospital operations; and second, the bundling of all non-clinical service contracts puts financial pressure on the hospital board given that these payments come from uncertain future budgets. With the Brampton hospital, for example, the facility's lease payments are covered by the province, but the service contract is not. In lean years the hospital board may be pressured into allowing greater hospital commercialization given that these costs amount to roughly half of the WOHC's hospital budget over the length of project agreement (OHC 2008a, 9).

The effects of this internal bifurcation of authority were made especially visible within the first few years of the Royal Ottawa's operations. As mentioned earlier, the many significant concerns that emerged with the building's design and equipment functionality not only negatively impacted patients, staff, and visitors but also raised the issue of who is actually accountable and responsible for decision-making in this P3 hospital. The union representing staff within the hospital reported that the "lines of accountability and authority have become blurred" (OPSEU 2007, 2) and that clarifying which partner is actually accountable for particular tasks is difficult to achieve since managers are not allowed to view any of the contracts and "are simply expected to accept the word of Carillion managers with respect to entitlements" (ibid, 14). This can lead to a tense work environment for staff because, as one union member described it, "everything is a fight" (ibid). Lack of transparency and accountability also raise the concern that health services might be threatened. For example, the union claims that maintenance costs have been downloaded onto clinical program budgets since "hospital program budgets are billed for damage/maintenance considered by Carillion not to be due to 'normal use'" (ibid, 2).

Concerns continue to emerge. In 2011 an issue arose surrounding which partner picks up the cost associated with the administrative dietician that oversees food services provided by Carillion. This position is supposed to be covered by Carillion but one interviewee suggests that Carillion changed the job title to avoid this cost (Janson 2012, Personal Interview, June 22).

Labour relations in Ontario's public health care system differ from the situation in BC in two important respects: contracting-out has been far less extensive (there is currently no legislation akin to BC's Bill 29-2002) and, related to the former, health care support staff receive similar wages in Ontario's public and private sectors. The 1997 *Public Sector Labour Relations Transition Act* (PSLRTA) essentially allows workers to take their contract with them – if work is contracted-out, the terms and conditions set in the public sector are applied to the private contractor. Thus terms and conditions are roughly identical for hospital staff working in P3 settings and traditional settings (Allan 2012, Phone Interview, July 18). Without a significant reduction in labour costs associated with contracting-out, privatization efforts are stymied.

## Observations

Ontario's change in government in 2003 held important consequences for its first P3 hospitals and future P3s developed in the province. This includes the subsequent implementation of its enabling field in 2004 and 2005, composed primarily of a capital planning framework (AFP and the Infrastructure Planning Financing and Procurement Framework, IPFP) and a specialized government agency dedicated to P3 development (Infrastructure Ontario). Given the timing of these developments, both the Brampton Civic Hospital and the Royal Ottawa Hospital were largely unaffected by the routines, institutional support, and depoliticization offered by the Liberal enabling field. In both cases negotiations with the preferred bidder were nearly complete just prior to the 2003 election but the project agreements had not yet been finalized. Based on all available evidence one may reasonably conclude that the changes implemented by the Liberals were of some benefit to health care users, hospital workers, and taxpayers. For instance, had these P3s project agreements not been renegotiated by the Liberals, they would have been decades longer and contained additional elements of privatization (i.e., private ownership of land and facilities). Features such as these exacerbated value for money and governance concerns.

However it is also important to not overstate the degree to which these P3s (and those that followed) were altered by AFP and the rest of the enabling field. The main difference between the model of public-private partnerships established by the PC government and the Liberal version is that with the latter the facilities and land remain in public hands – and this is basis upon which Liberals claim that their AFP model is not a 'P3' (e.g., Ontario Ministry of Infrastructure 2011). But this claim ignores many other essential similarities: project agreements remain multi-decade in length and the design, building, financing, and operating of the infrastructure is conducted by for-profit private partners. Further, whether these hospitals will one day be fully public remains to be seen. There is no evidence at this point to suggest that once P3 project agreements expire, several decades from now, operation and maintenance services will be returned to the public sector. In fact the full scale privatization of the Highway 407 P3 suggests that P3s can also open the door to more permanent forms of privatization.

Having been initiated during the SuperBuild era, the controversy and problems experienced with the pioneering P3s examined here can be attributed at least in part to the failures of this proto-enabling field. The experience taught proponents two main lessons. First, it guided the subsequent development of a sector-wide P3 program in health care. This P3 program now focuses exclusively on large infrastructure development (i.e., projects above \$20

million), conducted with the support of Infrastructure Ontario – smaller projects have entirely different funding streams and procurement protocols (see chapter 5). Infrastructure procurement innovations occurred for both traditional and P3 projects, securing the P3 niche in the health sector. Second, it helped mould the Liberal AFP approach, its emphasis on public ownership of land and facilities, and the development of P3 routines (more on the AFP ‘difference’ in the subsequent section). Thus the failures of Ontario’s initial P3 hospitals were used not, as one might suppose, to justify a return to traditional procurement but instead firmed up a role for P3s in the area of large hospital infrastructure development; and helped to improve routinization, institutionalization, and depoliticization of the P3 model overall.

One major contradiction of the SuperBuild era, revealed in different ways through both hospital cases, relates to the problems that can arise when ideologically-driven Cabinet level decision-making unfolds at the ground level without the support of routines and institutions that can help smooth out and depoliticize the process. The decision to use a P3 in both cases was made by government simply on the basis that the private sector *ought* to be involved – that it would be inherently less costly, quicker, and better to do so. Yet the responsibility for carrying out most stages of development was shifted onto the shoulders of inexperienced hospital boards.

With the Brampton Civic Hospital the lack of P3 procurement routines and value for money expertise led to several errors and missteps along the way. First, it meant that the costs of traditional procurement were vastly overestimated (by \$289 million), allowing the P3 option to be presented as being cheaper when in fact it was of worse value for money. This methodological error not only indicates bias but also the difficulty that an inexperienced agency can have when carrying out this important role. The use of different private consultants’ reports to establish value for money at various stages of procurement was also a disorganized process and led to many different cost estimates and multiple revisions. Under AFP these processes have been standardized and made uniform across projects and sectors (see chapter 5 for AFP procurement steps), though this has not necessary led to better value for money, as the next section on proliferation will discuss.

With the Royal Ottawa Hospital, procurement stages appear to have been well structured by the hospital board but the process suffered from a high level of secrecy which led to greater civil society resistance. Transparency has been improved with the creation of Infrastructure Ontario as it posts bidding information and documents related to projects and value for money on its website. Yet here too concerns persist. More information and greater

predictability has not translated into substantially improved transparency given the significant redactions and lack of financial data contained in the documents provided to the public.

The low level of expertise, routines, and standardization also led to problems with the operational phase of these projects. With the Brampton case this takes the form of a difficult to monitor service agreement and with the Royal Ottawa Hospital it has led to accountability issues. One of the most significant changes made to Ontario's health sector P3 program was therefore the December 2006 Ministry of Health and Long Term Care exclusion of soft facility services such as laundry, linen, patient portering, housekeeping, and food services from future P3 hospital deals. This does not mean that soft services cannot be privatized through contracting-out but they can no longer be bundled within a P3 project agreement. Hard facility services that encompass day-to-day management of a hospital such as heating, electricity, lighting, security, and parking are still included in P3 deals.

Performance of support service providers at the Brampton Civic Hospital reflects this division. One interviewee reports that hard facility services have "been performing fine" whereas with soft facility services "it has been variable" – problems exist with discharge cleaning and portering in particular (Public Partner Manager 4 2012, Phone Interview, November 12). However, a penalty has not yet been applied. Non-patient food, parking, and security have been subcontracted by Carillion and the security vendor has been changed due to poor performance. A private partner manager interviewed for this study supports the decision to exclude most soft services; in their words: "there needs to be a reason to put [services in] ... why would you have patient food services in the model? It's 35 percent food costs and 45 percent labour, it doesn't matter how long the contract is ... I don't see what you get by adding that in" (Private Partner Manager 1 2012, Phone Interview, October 29). In contrast, this private partner manager suggests that transferring risk for hard facility services (and the interviewee includes housekeeping in this category) to the private partner ensures that once a project agreement has expired the facility is returned to the public partner in good working order (ibid).

The wider implications of this exemption for the P3 model are more complex. On the one hand it is a positive development since it reduces concerns related to the internal bifurcation of authority – but it does not entirely eliminate these problems given that many hard facility services (such as the helpdesk, upkeep of electrical and HVAC systems) are also important to hospital service planning and management. On the other hand, as discussed in chapter 5, even though this was a victory for P3 opponents it has also extended the longevity of the model. As Ron Sapsford, then deputy Health Minister (2009), put it, the decision was made to exclude these services "because of the operating difficulties that can arise ... [and] leaving



those services out simplifies substantially the contractual understandings and agreements that have to be put into place” (Ontario Standing Committee on Public Accounts 2009). To the extent that the major concerns of those most vocally opposed to P3 hospitals have been neutralized, P3s are able to flourish now more than ever in the public health care sector.

The SuperBuild era also suffered from thinly institutionalized P3 policy. The Cabinet Committee on Privatization and SuperBuild could have potentially developed into a centre of expertise and method of institutionalization like Infrastructure Ontario, but this had not taken place prior to the 2003 election. Neither pioneering hospital therefore benefited from the support provided by a specialized government agency dedicated to promoting and developing P3s. With the creation of Infrastructure Ontario, the provincial health sector P3 program was solidified. However, institutionalization has occurred without any systematic evaluation of whether the track record of these initial projects warranted their future use, and the Liberals sought very little public input. Natalie Mehra, director of the Ontario Health Coalition, reports that the invitation-only consultations that informed the creation of Infrastructure Ontario were held mainly with P3 market participants and “all the questions were about how to do P3s, not whether or not to do P3s” (Ontario Standing Committee on Government Agencies 2008).

P3s were also institutionalized as the de facto standard model of large hospital development without any prior evaluation of traditional project success. When asked whether he had ever been required to conduct an analysis of the history of traditional procurement in the province (i.e., how many hospitals were delivered on time, on budget, etc.), David Livingston, the President and Chief Executive Officer of Infrastructure Ontario in 2008, confirmed that this type of assessment had never been done (Ontario Standing Committee on Government Agencies 2008). The track record of the traditional model was therefore not the basis on which the decision to use P3s in Ontario’s health sector was made, again revealing the ideological nature of this policy.

## **Proliferation**

Ontario’s health sector has become the major target of P3 development in the province. This has been accomplished through the creation of an enabling field and its routinization, institutionalization, and depoliticization of private for-profit involvement within the public health care system. These efforts may have made P3s more palatable but have they actually improved the P3 model and project success? Some glaring problems have certainly been smoothed out through process standardization and public sector expertise building, but several

core concerns remain. In particular, the AFP program has led to the flourishing of P3s without any substantial improvement in transparency and value for money.

Reflecting on the Auditor General's criticisms of the Brampton Civic Hospital project, public officials representing the hospital board, Infrastructure Ontario, and Ministry of Health assured the public at a Standing Committee on Public Accounts hearing held in 2009 that early P3s are significantly different from AFP today. In addition to the principle of public ownership, the standardization of value for money procedures is held up as a central benefit of the AFP model today (Ontario Standing Committee on Public Accounts 2009). Each new project is now subjected to three value for money assessments at different stages of development, and Infrastructure Ontario provides technical assistance along the way. The presence of a P3 unit and procurement routines avoids the use of multiple private consultants (eliminating contradictory cost estimates) and reliance upon ill-equipped hospital boards to assess value for money. The results of these assessments are also made available online through Infrastructure Ontario's website, supposedly increasing transparency.

On the surface it would appear as though the process has improved greatly. Delving deeper, several problems emerge. First, value for money is derived mainly through risk transfer. This is made clear in Infrastructure Ontario's Value for Money manual which demonstrates that base costs, financing costs, and transaction costs are actually lower for the public sector comparator (discussed in chapter 2). Yet justifying a P3 on the basis of risk transfer alone is highly problematic since it assumes that a well designed traditional contract will not be able to adequately mitigate risk. Second, specific to AFP, Infrastructure Ontario's risk transfer matrices appear to have been institutionalized without any rigorous confirmation of their methodology (see chapter 2 and Loxley 2012). Third, when private consultants are hired by Infrastructure Ontario to 'independently' verify value for money they do not actually "audit or attempt to verify the accuracy or completeness of the information or assumptions underlying the [public sector comparator]," leading Loxley (2012, 22) to ask 'what exactly are they doing'?

Fourth, risk estimates are extremely sensitive – even modest changes made to the estimates of public and private sector costs produce significant differences. Sheila Block (2008) recalculated the value for money offered by 14 of Ontario's more recent P3 (AFP) hospitals using "more realistic assumptions about public/private cost differentials" and came up with the following results. In her words, "rather than saving the province \$341 million as Infrastructure Ontario calculations show, these projects cost the province an additional \$585 million for a net difference of \$926 million" (2008, 5).

Results such as these are alarming but difficult to substantiate because of the second major unresolved problem with AFP: the level of disclosure and transparency remains so low that it is impossible for the public to definitively recalculate value for money. Documents available online are missing critical financial information.

AFP was supposed to have fixed the problems of the earlier P3 process but for many of the most significant concerns improvements have been more rhetorical than real. AFP has been characterized as a better way of delivering value for money, transferring risk, and ensuring transparency given the Infrastructure Planning, Financing, and Procurement Framework (IPFP) recognition of principles such as ensuring the public interest and a transparent process, and demonstrating value for money. However there is no legislation in place to actually guarantee that IPFP principles are upheld with each P3. In fact the case study evidence indicates that the public interest, value for money, transparency, and accountability are all *undermined* by P3s. Shifting P3 selection into the realm of the technocracy thus misleads the electorate while offering no real protection for the public interest. An editorial in the Toronto Star (2005, H06) nicely summarizes the situation by stating that the Liberal's AFP is "just another name for the unloved P3s, public-private partnerships, first introduced by the former Conservative government of Mike Harris and Ernie Eves."

## **Concluding Remarks**

Much like in BC, Ontario's initial P3 hospitals were highly politicized, offered poor value for money, and came in much later and at a higher price than originally promised. Aside from these similarities, there is one major difference: their timing vis-à-vis the creation of the wider provincial enabling field. In BC, P3 hospitals were developed together with the enabling field, in Ontario the first P3 hospitals were initiated several years prior. A related difference is the political upheaval caused by the Ontario provincial election (October 2003) which occurred well after these projects were first announced (November 2001). This greatly increased the level of policy debate, public awareness, and the need for strong and overt support by Cabinet (and the Premier in particular) to push these deals through to completion. For all these reasons, critics had a relatively louder voice in Ontario than in BC.

The Brampton Civic Hospital and Royal Ottawa Hospital were the first in a long and ever-growing line of P3 hospitals developed in Ontario. Without any prior examples within the province it is understandable that some mistakes and problems would have emerged with these pioneers. However, the number and magnitude of the issues that have since been uncovered

are significant. Neither hospital was delivered on time or on budget; nor did these facilities provide a fully desirable level of functionality, design, and security/wellbeing for patients and staff. Further, not only was value for money never established ahead of time but serious methodological errors occurred along the way that erroneously supported the P3 option. Problems did not cease once they were operational, and these projects have remained the subject of much controversy. Worse still, these issues have not led to an abandonment of the policy but instead were used to guide the development of a sector-wide P3 program in health care.

The P3 health sector program initiated by the Liberals in the mid-2000s was designed to correct some obvious problems but it also succeeded at hiding and ignoring others. The role played by the pioneering projects was not to act as a yardstick for evaluating whether future P3s should be developed but instead to guide the unfolding of the enabling field. As the Brampton and Royal Ottawa cases demonstrate, if pragmatism were to trump ideology then the opposition and internally generated problems with these first P3 hospitals should have put an end to experimentation with the model. Instead these projects helped to indicate where sources of resistance lay, and what types of market-like rules would be needed in the public sector in order to more successfully allow for privatization. Thus routinization and institutionalization have produced some improvements to P3 processes without substantially improving outcomes. Depoliticization has further normalized their use by obscuring the overtly ideological, political, and privatized nature of P3 projects. All things considered, despite a few relatively minor improvements made to the process of P3 development, the Ontario P3 enabling field has largely proven to enhance the appearance of P3 superiority whilst doing very little to address the essential pitfalls that accompany P3 projects.

## **Conclusion. Stabilizing dispossession: P3 policy, projects, and (limits to) alternatives**

The litany of problems associated with P3 projects suggests the potential for two types of crises with this model: crises of faith on the part of policy makers (which is significant given that ideological support for privatization remains crucial) and crises induced by internal contradictions. There is an obvious interrelation between the two as well, magnifying the potential for policy abandonment. For instance, P3s are touted as cost saving instruments but the empirical record demonstrates higher long run expenses than traditional public procurement. Once P3s become the standard way in which large public infrastructure is provided, these additional cost burdens expand and this may eventually make it more difficult to justify their use. Evidence of indefensibly higher P3 costs is emerging in the UK, the homeland of the model, and especially so within the health sector (e.g., see Hope 2012; Alleyne 2012). As another example, the heart of P3 justification relates to risk transfer, yet many (new) risks are simultaneously created through reliance upon volatile financial markets and for-profit operators. P3 projects and policies are therefore in need of stabilization lest internal contradictions lead to collapsed deals and/or a rejection of the model by policy makers. Despite their higher economic and social costs, and the financial market turbulence in 2008-9, neither form of crisis has yet to truly emerge in Canada. P3s similarly continue to proliferate around the world. The theme of stabilization, and how it occurs in light of these intrinsic problems, runs throughout this chapter.

The first section will summarize the P3 hospital track record as witnessed through the cases examined in chapters 6 and 7, and will indicate how, despite all of the concerns, health sector P3 program stabilization has occurred in BC and Ontario. The second section of this chapter will look at the additional concerns produced by the 2008 financial crisis and explain how policy stabilization occurred in 2009 and beyond. Finally, the conclusion wraps up with a description of alternatives, and the limits to alternatives (particularly in light of the constraints imposed by P3 enabling fields), to the P3 model in health care, including avenues for future research and resistance.

### **P3 hospitals & project stabilization**

Despite their growing popularity, P3 hospitals have proven unable to genuinely meet the expectations and promises of proponents. With all four cases examined here (the Abbotsford Regional Hospital and Cancer Centre, the Diamond Centre, the Brampton Civic Hospital, and

the Royal Ottawa Hospital), bidding and negotiation delayed construction significantly and cost creep occurred across the board. All four have nonetheless been labeled as being 'on time and on budget' given that once the project agreements were signed these hospitals opened on schedule and without added cost to the public partner – or did they? There are two additional problems with these 'on time and on budget' claims. First, P3 hospitals are not always completely functional when they first open. The Royal Ottawa Hospital had serious problems with its infrastructure and security which took at least six months to remedy (including its wireless systems, and patient and staff facilities), and the Brampton Hospital is still not running at full capacity.

Second, how well risk was transferred, a central component of 'on budget' and P3 value for money superiority claims, is debatable. Changes made to the Diamond Centre's functionality after the project agreement was signed meant that key aspects of cost increase were borne solely by the public partner, and there are no provisions for withholding service payments in the case of poor private partner performance. Similarly, changes made in the Brampton case also caused the public partner to bear the entire cost of items that were supposed to be transferred, and the service agreement is so complex that it is unclear whether the public partner is getting as much value out of the agreement as possible. The Abbotsford hospital agreement is more robust and ten of twelve services will be likely be provided by a new subcontractor in 2013. However this too indicates just how little risk is borne by the private partner given that deductions and penalties are passed on to their subcontractors. Further, the Abbotsford public partner has proven unwilling to enforce payment deduction provisions, rendering contractually-based guarantees irrelevant. The rhetoric of P3s as mechanisms to insulate the public from project risks thus gives way to the reality that P3s reorient public sector decision-making by thoroughly incorporating the needs and interests of private partners.

The cases examined in chapters 6 and 7 also provide clear examples of methodological deception (e.g., overly high discount rates) and illustrate the higher costs associated with private financing. Problems for privatized staff (e.g., lower wages and more precarious working conditions) and privatized support services (e.g., concerns with cleanliness and training), familiar features of P3 projects, are present in all four hospital cases examined here as well.

Aside from issues that tend to occur with all P3s regardless of the type of project, the three most important concerns unique to P3 hospitals (identified in chapter 3) are also indicated through these four projects. First, their internal bifurcation of authority has made addressing the challenges associated with support service privatization a time consuming and frustrating ordeal. Second, third sector and local community contributions were ratcheted up due to more

expensive capital costs. Third, infrastructure design arrived at in the early 2000s must suffice for the next three decades, reducing policy flexibility and the opportunity to incorporate technological innovations well into the future. Physical alterations in response to future innovation can certainly be made to P3 hospital infrastructure, but this will come at a high cost. For instance, as the Diamond Centre example indicates, any changes made to the building must be arranged through the private partner, not the most cost effective or efficient service provider, and for this P3 there is also an automatic 15 percent overhead fee added to the price of any spatial and design reconfiguration.

The higher costs associated with privately financed P3s not only undermine proponents' arguments that they help curb wasteful government spending (e.g., CCPPP 2003a), but it means that less is available to be spent on other health infrastructure and social concerns. The model also represents a significant departure from a traditional hospital setting where authority and control are fully retained by public sector health authorities, constituting a notable – albeit relatively invisible – restructuring of state and society. Even in the case of hospitals that have been subject to extensive support service contracting-out, the power sharing inherent to a P3 goes far deeper. With contracting-out, agreements are only in place for a few years at a time rather than several decades, and service contracts are most often kept separate rather than bundled.

Shortly after initiating these pioneering projects, BC and Ontario began to unroll their health sector P3 programs. These programs were launched without actually evaluating the problems and potentials offered by the model, as established through their pioneering P3 hospitals. Instead, proliferation was a foregone conclusion from the start. By creating enabling fields, and the new capital planning frameworks, P3 units, and enabling legislation that allow for the flourishing of P3 programs, policy makers moved the P3 agenda forward in these provincial health sectors in ways that may not have been possible earlier. Enabling fields have normalized the model through features such as the capital planning routines that favour and depoliticize P3 selection, and the creation of P3 units that provide institutional stability and embed the P3 model within public sector decision-making. These efforts have turned the once highly politicized P3 model into the standard way in which hospital projects with a public sector cost in excess of \$20 million are delivered in both provinces – meaning P3s are effectively the 'new traditional' given that all such projects have since gone forward in this manner.

In both Ontario and BC, P3 enabling fields have helped to greatly improve the appearance of P3 processes, for instance by institutionalizing multiple value for money assessment stages, offering protections for the public interest through principles enshrined in

capital planning frameworks, standardizing routines and legal documents, and publicizing project information. However, actual improvements in P3 outcomes remain elusive and thus P3 enabling field improvements are largely illusory. Value for money remains a fundamentally flawed evaluation procedure and continues to employ deceptive methods to help justify privatization,<sup>122</sup> capital planning frameworks' principles remain toothless and P3s inherently violate most principles in BC and Ontario, and greater transparency has not translated into the publication of substantially informative project details. The major improvement offered by AFP in Ontario is restricted to items that went far beyond typical practice in BC – bringing contract lengths down from over half a century to three decades, and institutionalizing lease arrangements rather than the full privatization of land and facilities.

Inherent to the entrenchment of P3s has been a re-conceptualization of the 'public interest'. Given that society is class divided, its interests are too; and thus it is no surprise that the 'public interest', as represented by public policy, will be as well (Mahon 1977, 170). Health- and health care-related concerns remain the key factor in hospital infrastructure design and development, for instance through a focus on infection control and ensuring reasonable access to health services. Yet these concerns are now subsumed within the matrix of market-based logics and market-like calculus: hospitals only leave the proposal stage when they deliver value for money through the transfer of commercially-bearable risk. Transferring risk can potentially benefit the wider public interest by helping to keep costs down, thereby improving the long run sustainability of the public health care system given that hospitals are a leading cost pressure within the system. However the myopic focus on certain risks – risks that can generate profit for private partners – ignores other aspects of the public interest such as long run uncertainties, policy inflexibility, bifurcated hospital decision-making, pressures added to health sector charities and auxiliaries, and an erosion of working conditions for staff, service quality, democratic control, accountability, and transparency. The 'public interest' is therefore reconceptualized for the benefit of privatization-enabling concerns, and all other interests are made to fit within that prism. Tradeoffs are made, most often to the detriment of broader social concerns.

An important part of this process has been the creation of a new layer of unequal representation (Mahon 1977): the P3 unit that now makes decisions for all Ministries on the

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<sup>122</sup> As discussed in chapter 2 (with many items exemplified in chapters 6 and 7), value for money methodology is biased for the following reasons: discount rates are often far too high, risk is double counted to the detriment of the public sector comparator (and it is assumed that a PSC cannot transfer risk), risk matrices are unjustified, uncertainties and risks created by P3s are ignored, and P3 value for money cannot be truly ascertained until after the project agreement expires (which will not happen in any Canadian provincial health sector for decades to come).



basis of P3-biased value for money methodology. It should be noted, however, that there are certain variations between these two provinces in terms of how P3 units have been institutionalized. Whereas Infrastructure Ontario is largely a creature of the Ministry of Infrastructure and is assigned work by Ministries seeking to build capital projects; Partnerships BC is more independent from government, though it ultimately reports to the Ministry of Finance, and it charges work fees to its public sector clients. In both provinces, capital planning frameworks dictate that P3s must be considered for all large capital projects and thus the inclusion of P3 unit decision-making in other Ministries' processes is mandatory in each jurisdiction.

### **Financial crisis & policy stabilization**

Longstanding problems associated with P3s were recently compounded by the 2008 global financial crisis. Financial market volatility led to project delays, renegotiations, and collapsed deals in many sectors and this affected P3 hospitals that had yet to reach financial close (Mackenzie 2009). By the onset of the 2008 financial crisis, the four pioneering P3 hospitals in Ontario and BC had already entered the relatively low-risk operational phase of their agreements, and thus none of the hospitals examined here were adversely affected. Despite serious cost pressures imposed by the global financial crisis and ensuing credit crunch, BC and Ontario continued to initiate new P3 hospital deals throughout the crisis. With the onset of a new round of fiscal austerity in several Canadian jurisdictions in 2011/2012, one might reasonably expect that the P3 model would be scrapped in favour of lower cost public procurement. Instead, as has been the case since rebounding in 2010, the model is flourishing once again. A crisis of faith was therefore averted and the P3 model stabilized.

That the attractiveness of P3s suffered only minor setbacks makes little sense from a strict value for money perspective. The stabilization of P3 policy indicates that at base this form of 'alternative service delivery' has always been ideologically-driven – not an inherently superior procurement model. In fact, as discussed in the previous section, the reality of P3s is such that instead of offering better value for money, from a long run perspective their use may hinder the overall sustainability of the public health care system since P3 hospitals are more costly than the public option, service quality is poorer, innovation is stifled through inflexible multi-decade long contracts, the use of private financing exposes public health care to crisis-prone global financial markets, and hospital service planning suffers from disintegration. Long term commitments made to more expensive hospital infrastructure can also create a serious debt

overhang, producing cost pressures that may lead to service cuts in other areas given the rigid nature of P3 contracts. As it currently stands in early 2013, P3 use shows little signs of abating in Canada, due in large part to the cushioning effects of enabling fields.

The tenacity of enabling field support holds important implications for the future of neoliberalism as it embeds within the public sector the marketized logics of accumulation through dispossession and financialization. By entrenching these features, neoliberal market politics are intensified and the politics of the market become more pronounced. There are two key aspects to the role that P3s are currently playing in this process: the locking-in of accumulation by dispossession and the promotion of financialization.

First, lock-in: P3s help entrench neoliberalism through decades-long, legally binding contracts. Most project agreements last for thirty years or more which is extremely long when compared with another leading form of privatization, contracting-out, which typically lasts for only a few years at a time. Of course governments do have the option of rescinding P3 agreements but in light of other important features of neoliberal lock-in (e.g., trade agreements like NAFTA that protect the rights of foreign investors through binding arbitration) this may be far too costly an option for most governments to consider.

A related issue is the contract bundling that is a core feature of the P3 model, meaning that no one element of the project can be severed from the agreement on the basis of poor performance or a change in government ideology. This makes it extremely difficult/costly to renegotiate P3 contracts given that all components (e.g., infrastructure, support services, land agreements) are legally bound together (Shrybman 2007b, 200). This feature would also make it difficult, though never impossible, for a normative or ideological shift to sweep away any one undesirable component of an existing P3.

Second, P3s are a microcosm of the larger neoliberal accumulation strategy: P3s support and benefit from neoliberal financialization (as the private finance portion is typically linked to international bond markets and involves large institutional investors such as pension funds or multinational banks/financial institutions), along with being a form of accumulation by dispossession. Thus P3s rely upon neoliberal market politics and simultaneously entrench neoliberal rule with each new partnership agreement. Further, the use of private financing to fund public services and infrastructure raises the even greater concern that this practice could recreate the very same conditions that triggered the financial crisis in 2008. Examples of this include the following: P3s promote off balance sheet accounting practices, they allow for the securitization and offshoring of funds which are then re-circulated into important areas of social welfare and public policy (with risks ultimately backed by the taxpayer), the commercial

confidentiality that accompanies all P3 agreements encourages low levels of corporate accountability, and they allow for profit-seeking behaviour using market refinancing and equity sales – practices that are largely beyond public control once the project agreements are in place (see Reynolds 2011; Sandborn 2008; Whitfield 2009). In sum, efforts to support and promote P3s are not only expressions of neoliberal policy but also help to reinforce its practice and discourse.

## **Alternatives (and their limits)**

The entrenchment of P3 policy proceeds not only through the nature of these contracts but also through the normalization of privatization. Depoliticization occurs when authority and decision-making in areas of social concern (such as health care and health services) are shifted away from government and into the private sector. With P3s this happens through the awarding of multi-decade contracts to the for-profit managers who operate these projects; as well as through the private consultants, transaction advisors, accountants, and auditors that come to inform P3 policy. Colin Hay (2007, 80-87) also suggests that depoliticization can occur when social issues are demoted from the governmental sphere to the public sphere. P3s conform to this type of depoliticization when they shift public infrastructure and service decisions out of the formal democratic arena (where decision-makers are accountable and public deliberation takes place) into the far less transparent realm of arm's length public sector managers. In BC and Ontario, this role is dominated by P3 units, the quasi-public sector agencies created to promote and evaluate P3s.

Structured as semi-autonomous Crown corporations, Partnerships BC and Infrastructure Ontario are relatively insulated from public accountability and their decision-making reflects private sector rationales (such as market-oriented value for money and risk transfer). The historical relationship between Canadian Crown corporations and capital has always been less black and white than privatization promoters may suggest – state owned enterprises have seldom been established to expropriate private assets, crowd out private for-profit competitors, and displace private markets. Notwithstanding their social obligations, Crown corporations (particularly those that are commercially-oriented) have most often supported capital by socializing the costs of production (e.g., Ontario Hydro), reducing what Harvey (2001) calls the 'socially necessary turnover time' of capital by aiding capital circulation across this vast country (e.g., CN Rail and Air Canada), paying for research and development (e.g., Petro-Canada), and propping up production and demand in rural and remote locations (e.g., Manitoba Telephone

Systems) (discussed in Whiteside 2012). Yet for the first time in Canadian history the legal status of the Crown corporation, with its exemption from certain public sector regulations (e.g., relating to employee pay structures), is being used to facilitate ongoing privatization within the public sector. This constitutes a significant neoliberal reinterpretation of the policy advantages offered by a Crown corporation.

Institutionalization through P3 units, along with routinization through new capital planning procedures and depoliticization, present a formidable challenge to effective resistance and the search for alternatives to privatization. Attempts to resist P3s must be aimed at the (re)politicization of public infrastructure and service procurement. This means targeting not only the outcomes of privatization (i.e., dispossession) but also the processes encouraging and supporting P3 selection (i.e., enabling fields).

Public sector unions and public service advocacy organizations drive resistance to P3s, and while some efforts have been successful, ultimately P3s are proliferating now more than ever. Resistance has produced several important changes in health sector P3 programs over the past five years, although it has not yet affected *whether* P3s are used but instead *how* they move forward. One of the most significant changes is the 2006 exemption of soft support services (e.g., housekeeping, food, patient portering) from Ontario's hospital P3 deals; and hospitals recently developed in BC have excluded cleaning services. Concerns around debt refinancing have also led to the inclusion of clauses within Ontario's P3 hospital project agreements which stipulate that financial gains reaped through debt refinancing must now be shared with the relevant public hospital board (Loxley 2010, 110). A reversal of some elements of privatization-enabling legislation has also occurred. Most notably, in 2007 the Supreme Court of Canada sided with BC's Hospital Employees' Union, and other health sector unions, in their fight against BC Bill 29-2002 (*the Health and Social Services Delivery Improvement Act*) which unilaterally rescinded provisions in signed collective agreements and paved the way for unprecedented privatization of health care support staff in the province. This forced changes to similar unconstitutional provisions in P3-related legislation (BC Bill 94-2003 *The Health Sector Partnerships Agreement Act*) as well.

The need to protect the public must come in other ways as well. In this struggle it is important to keep in mind that many/most enabling field items are presented as protections for the 'public interest'. BC's Capital Asset Management Framework (CAMF) and Ontario's Infrastructure Planning, Financing, and Procurement Framework (IPFP) are touted as both improvements made to the way P3s used to be developed and as innovations that proactively

address public concern. Yet CAMF and IPFP best-practice principles<sup>123</sup> not only offer misleading protections (in fact P3s violate nearly every principle), they are also toothless – mechanisms have yet to be put in place which would actually guarantee that their principles are upheld.

Recent legislation in Manitoba offers one way of rectifying this. In 2011/12 the Province took an important step toward expanding protections for the public with its Bill 34 (*The Public-Private Partnerships Transparency and Accountability Act*) which *requires* greater public consultation and involvement of officials such as the provincial Auditor General and fairness monitors. However, as beneficial as fairness monitors and Auditors General may be (provincial auditors' reports have thus far proven to be a leading source of support for anti-P3 campaigns) actual progress will remain illusory until the P3 model is scrapped altogether. Victories and initiatives such as those mentioned above help dampen the more deleterious effects of dispossession but they do not entirely counter it, nor do they root out the specific elements of privatization-driven state restructuring that have occurred over the past decade.

Furthermore, auditors' reports are extremely helpful but they amount to little if their findings do not translate into substantial policy change. The campaign to depoliticize P3 use is only as effective as researchers and activists allow it to be. For many groups and individuals P3s are seen as a highly politicized and ideologically-based policy, but this is not necessarily a common perspective – most clearly indicated through relative apathy in the face of P3 proliferation. A greater focus on P3 enabling fields would be useful for opponents as it helps to uncover the ways in which privatization by stealth proceeds through the support of even more obscure changes being made to public sector decision-making in some jurisdictions. This includes politicizing the institutionalization, routinization and normalization of the market-based rationale that informs P3 policy and reorients public sector decision-making.

Academic and civil society research into P3s must continue to push forward into new areas. The stabilization of P3 programs and policies in the wake of the 2008 financial crisis was greatly facilitated by transnational and translocal policy transfer, and so too was the initial set up of P3 enabling fields in Ontario and BC. The issues surrounding an inter- and intra-jurisdictional (as well as sectoral) sharing of experience and expertise on P3 routinization, institutionalization, and depoliticization were not tackled in this study and this topic remains largely unexplored in the relevant literature. Yet P3 policy practices and techniques, including how the 'public interest'

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<sup>123</sup> CAMF: sound fiscal management, strong accountability, value for money, protecting the public interest, and competition and transparency; IPFP: the public interest is paramount, value for money must be demonstrated, appropriate public ownership/control must be preserved, accountability must be maintained, all processes must be fair, transparent, and efficient.

is re-conceptualized and risk and value for money are assessed, are now generated within increasingly sophisticated policy networks that involve public and private sector actors around the world. Exposing and disrupting these networks presents a fruitful avenue of future research and resistance.

Provincial elections also offer the opportunity for policy change in BC and Ontario. Should future results upset current power and policy dynamics, it is difficult to say what exactly will happen to P3 programs and enabling fields. As always, the devil will be in the details and thus scrutiny of any changes to capital planning procedures, P3 enabling legislation, and P3 units will be necessary. A better understanding of supportive secondary reforms (e.g., changes in the relative power and autonomy of regional health authorities and local health integration networks) is also important, and local level politics can be greatly affected by provincial election results. While future provincial governments will likely not cancel or nationalize P3 projects, P3 policy can more easily shift – for good or ill.<sup>124</sup> Given the larger political economy climate of fiscal austerity, debt, recession, and calls for significant health spending and program reform (e.g., Drummond 2012), exposing the legacy of P3s has become all the more urgent. The lack of a robust social democratic alternative at election time also suggests that, regardless of election results, P3 normalization will likely continue in the future. The initiation of P3 projects under the NDP in Ontario and P3 language under the NDP in BC indicates some degree of complicity and casts doubt upon whether a change in government would actually lead to a full rejection of private financing and marketization, especially now in the context of greatly intensified neoliberalism and a renewed climate of fiscal austerity.

Finally, it is crucial that P3 opponents develop tangible, viable solutions to the problem of financing public infrastructure. All four P3 hospitals examined in this study languished in the proposal stage for years, sometimes decades. This is unacceptable and drove the justification for P3s at the local level. It also dampens resistance. If the choice offered to a community is either a new P3 hospital or no new hospital at all, it ought to be no surprise that opposition to privatization has been marginalized. CUPE (2011, 15-6) describes two excellent solutions to the funding dilemma: greater federal support for the costs of public health care infrastructure (e.g., the creation of a federal Public Asset Fund, as proposed by the Canadian Centre for Policy Alternatives), echoing similar demands by the Canadian Healthcare Association and Association of Canadian Academic Healthcare Organizations; and the use of public bonds to

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<sup>124</sup> Ontario's Bill 115-2012 ('Putting Students First Act' or *An Act to implement restraint measures in the education sector*) may foreshadow even greater austerity and retrenchment of public sector workers' rights in the future. The P3 model tends to flourish amid such conditions.

finance hospital infrastructure.<sup>125</sup> Solutions such as these would ensure that new projects proceed, and that this is accomplished through the most cost effective (and publicly beneficial) fashion possible.

P3s have for far too long been misleadingly justified as a 'build now, pay later' solution fit for times of fiscal restraint. With the recent return of fiscal austerity, the model is poised to make even greater inroads into public service and infrastructure provision, particularly at the municipal/local level for it bears the greatest burden associated with budget cuts at a time of dwindling revenue. The federal government has also begun to encourage P3 expansion within Aboriginal communities as a way of financing and delivering infrastructure renewal. At all levels of government, and regardless of sector, P3s do not come cheap. Private financing is more expensive, social costs are greater, and the loss of public control, oversight, and accountability is anti-democratic. The implications of P3 proliferation today will reverberate for decades to come. Passing on higher cost, lower quality, riskier and less innovative infrastructure and service forms to future generations is no solution to meeting the needs of today.

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<sup>125</sup> However, greater public sector reliance upon bond markets would certainly bring its own particular challenges and contradictions, in line with financialization of all stripes.

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## Appendix. Canada's Pioneering P3 Hospitals: timeline & milestones

### Abbotsford Regional Hospital and Cancer Centre –

#### **2001**

- **Spring 2001:** NDP approve a new public hospital in Abbotsford
- **August 2001:** Liberals commission PricewaterhouseCoopers to evaluate the P3 option

#### **2002**

- **February 2002:** Budget 2002 introduces a “new approach to capital planning” (P3s), but the Abbotsford hospital still appears as a public hospital in the capital plans
- **March 2002:** PricewaterhouseCoopers report released. It finds a cost savings of 1% over 30 years, assumes the cost of the hospital will be \$210 million
- **November 2002:** Premier Campbell announces that the new hospital will be a P3

#### **2003**

- **January 2003:** Request for Expression of Interest (REOI) issued
- **February 2003:** Budget 2003 reveals that the hospital no longer appears in the government's capital spending plans
- **May 2003:** four short-listed bidders announced
- **September 2003:** Request for Proposals issued to four short-listed consortia
- **October 2003:** Fraser Health Authority awards a \$73 million, 5-year contract to Sodexo Canada for housekeeping in the health authority (in force January 1, 2004)
- **November 2003:** only two bidders remain, the other two pulled out

#### **2004**

- **January 2004:** support services at the Matsqui-Sumas-Abbotsford hospital are contracted-out to Sodexo
- **February 2004:** one bidder remains: Access Health Abbotsford (the other pulled out)
- **March 2004:** Partnerships BC announces it will conduct a value for money assessment by comparing the P3 option to a public sector comparator over a year after the REOI is issued
- **May 2004 to December 2004:** contract negotiation and finalization phase
- **October 2004:** Partnerships BC sets up Abbotsford Regional Hospital and Cancer Centre Inc. to deal with Access Health Abbotsford and to oversee the construction process
- **December 2004:** project agreement is signed: private partner will design, build, finance, and operate all non-clinical care services at the facility (operational component will run for 30 years, to begin in 2008)
- **December 2004:** site preparation begins

#### **2005**

- **February 2005:** the Auditor General releases his attestation report on Partnerships BC's value for money calculations
- **March 2005:** start of construction of foundations

#### **2008**

- **April 2008:** substantial completion of construction

- **August 2008:** 121 patients are moved from the Matsqui-Sumas-Abbotsford Hospital to the new Abbotsford Regional Hospital and Cancer Care Centre
- **September 2008:** the hospital opens to new patients
- **September 2008:** the Abbotsford cleaners and food workers vote 100% in favour of joining the Hospital Employees' Union

### **Gordon and Leslie Diamond Health Care Centre –**

#### **2001**

- **2001:** site redevelopment approved by the City of Vancouver

#### **2002**

- **May 2002:** business case is finalized by the Vancouver Coastal Health Authority, it concludes that a P3 would be most cost effective approach
- **July 2002:** the Province approves plans to deliver the project as a P3 (at this time it is known as the Academic Ambulatory Care Facility).
- **October 2002:** Premier Campbell publicly announces that a P3 will be used
- **October 2002:** the Request for Expression of Interest (REOI) is issued (9 proponents submit responses)

#### **2003**

- **April 2003:** three bidders shortlisted
- **June 2003:** the Request for Proposals (RFP) is issued (2 are invited to submit bids, both sent in bids)

#### **2004**

- **January 2004:** preferred proponent selected. Negotiation with the preferred bidder begins (the Vancouver Coastal Health Authority refuses to publicly name the preferred bidder)
- **January 2004 to September 2004:** contract negotiation and finalization phase
- **September 2004:** project agreement is signed: private partner will design, build, finance, and operate all non-clinical care services at the facility (operational component will run for 30 years, to begin in 2006)
- **September 2004:** site preparation begins
- **November 2004:** Partnerships BC releases to the public a value for money report

#### **2006**

- **June 2006:** Vancouver philanthropists Gordon and Leslie Diamond donate \$20 million (not related to P3 financing)
- **October 2006:** Premier Campbell officially opens the Diamond Centre

#### **2007**

- **January 2007:** Shoppers Drug Mart opens on the main level

### **Brampton Civic Hospital –**

#### **1971**

- **1971:** the Chinguacousy County Council votes to spend \$300,000 of public money to buy 20 hectares at the northeast corner of Bramalea Rd. and Bovaird Dr., and passes a bylaw restricting its use to building a public hospital

### **1997**

- **1997:** the Hospital Services Restructuring Committee (HSRC) recommends the amalgamation of Peel Memorial Hospital with Georgetown and District Memorial Hospital and Etobicoke General Hospital. In 1998 these three come under the administration of the newly created Northwest GTA Hospital Corporation, later renamed the William Osler Health Centre (WOHC). The HSRC also reaffirms the need for a new hospital in the Brampton region, and suggests that Peel Memorial should also be renovated and redeveloped

### **2000**

- **Spring 2000:** the PC government earmarks funds for a new hospital in Brampton. The facility will be the first new hospital built in the area in 30 years

### **2001**

- **November 2001:** Tony Clement (then Minister of Health) and Jim Flaherty (then Minister of Finance and the minister responsible for SuperBuild) announce that the new Brampton hospital will be a P3

### **2002**

- **March 2002:** the Request for Expression of Interest (RFEI) is issued. (The RFEI asks for bidders to state their interest in contracting for some or all of the work necessary to design, build, finance, own/lease and maintain the health care facility.)
- **May 2002:** the Request for Qualifications (RFQ) is issued (the RFQ stipulates that the agreement will involve components relating to designing, building, financing, operating and managing the facility)
- **July 2002:** groundbreaking ceremony is held to launch the early site preparation works (e.g., major earthworks, connections to sewage and water systems, creation of a storm water retention facility)
- **December 2002:** Ontario cabinet approves the use of a P3 for the Brampton hospital

### **2003**

- **January 2003:** the hospital board (William Osler Health Centre, WOHC) produces its initial estimate of what the hospital would cost if a traditional public approach was used, almost a year after the RFEI was issued
- **April 2003:** the preferred bidder is selected and contract negotiation begins
- **Spring/summer 2003:** Dalton McGuinty, Liberal party leader, vows to dismantle plans to develop the Brampton hospital as a P3
- **September 2003:** a coalition of labour unions and public health care advocates (CUPE, the Ontario Public Service Employees Union and the Ontario Health Coalition) launch a court action to stop the signing of the P3 deal
- **October 2, 2003:** the Ontario general provincial election is held. Liberals win 72 seats, PC 24, NDP 7
- **October 2003:** the coalition of unions and public health care advocates lose their court case on the grounds that there was insufficient evidence to back their claim that P3 hospitals contravene the *Public Hospitals Act* and *Canada Health Act*
- **November 2003:** newly appointed Liberal Health Minister George Smitherman announces that the Brampton hospital project will proceed but the P3 plan will be

renegotiated. (According to Smitherman, the biggest difference with the Liberal version is that the public will now pay a “mortgage” and fully own the facility once the project agreement expires. Under the PC plan, the facility would have been a lease-to-own agreement with the land and facility privately owned for the length of the project agreement)

- **November 2003 to November 2004:** contract re-negotiation and finalization phase

#### **2004**

- **November 2004:** financial close is reached on the project
- **November 2004:** WOHC updates its estimate of what the hospital would cost if a traditional public approach was used, after negotiations with the preferred bidder had concluded
- **November 2004:** the project agreement is finalized. The Healthcare Infrastructure Company of Canada (THICC) is chosen to design, build, and finance the new hospital; the 25 year non-clinical care support service contract begins in October 2007
- **November 2004:** construction begins

#### **2007**

- **July 2007:** construction is completed and the hospital officially opens
- **October 28, 2007:** patients are transferred from Peel Memorial Hospital to Brampton Civic Hospital
- **October 29, 2007:** Brampton Civic Hospital begins admitting new patients

### **Royal Ottawa Hospital –**

#### **1995**

- **1995:** non-clinical care services are contracted out at the Royal Ottawa Hospital

#### **1997**

- **February 1997:** the Health Services Restructuring Commissions (HSRC) announces that the Brockville Psychiatric Hospital will be closed down within two years and 140 patients will be moved to the Royal Ottawa Hospital

#### **1999**

- **1999:** the hospital board initiates redevelopment plans for the facility

#### **2000**

- **May 2000:** ROHCC announces that negotiations have begun with the provincial government to demolish the facility and replace it with a new hospital (guided by the SuperBuild capital planning framework)

#### **2001**

- **May 2001:** the PC government announces that P3s would have to be first considered before the government would commit to funding any new hospitals
- **November 2001:** Tony Clement (then Minister of Health) and Jim Flaherty (then Minister of Finance and the minister responsible for SuperBuild) announce that the new Royal Ottawa hospital will be a P3
- **December 2001:** the plans to develop the Royal Ottawa Hospital as a P3 are formally approved by Cabinet

## **2002**

- **June 2002:** the Request for Qualifications phase begins
- **September 2002:** the hospital board announces that the Request for Qualifications has produced three shortlisted candidates
- **December 2002:** the Request for Proposals stage begins

## **2003**

- **May 2003:** negotiations begin with the preferred bidder
- **Spring/summer 2003:** Dalton McGuinty, Liberal party leader, vows to dismantle plans to develop the Royal Ottawa Hospital as a P3
- **September 2003:** a coalition of labour unions and public health care advocates (CUPE, the Ontario Public Service Employees Union and the Ontario Health Coalition) launch a court action to stop the signing of the P3 deal
- **September 2003:** mere days before the election is held, ROHCC is reported to have finalized the P3 agreement with the preferred proponent, however the agreement had yet to reach commercial and financial close. After the election, Liberals made several changes to the project agreement (ensuring public ownership of the land and facility)
- **October 2, 2003:** the Ontario general provincial election is held. Liberals win 72 seats, PC 24, NDP 7
- **October 2003:** the coalition of unions and public health care advocates lose their court case on the grounds that there was insufficient evidence to back their claim that P3 hospitals contravene the *Public Hospitals Act* and *Canada Health Act*

## **2004**

- **July 2004:** renegotiations with the preferred partner conclude (commercial close is achieved)
- **July 2004:** the Royal Ottawa Hospital project agreement is signed. It is to be a 21 year design, build, finance, operate and maintain P3 with The Health Infrastructure Company of Canada (THICC). Alterations made under the McGuinty Liberals include a reduction in the length of the operational phase of the P3 (from what would have likely been 66 years), and amendments made to the legal arrangements relating to the ownership of the land and facility (similar to the Brampton hospital)
- **December 2004:** financial close is reached
- **December 2004:** construction begins

## **2006**

- **October 30, 2006:** official opening of the Royal Ottawa Hospital
- **November 1, 2006:** patients are transferred into the new facility